MassHealth Application

to Request Prior Authorization for PCA Services

MassHealth

THE COMMONWEALTH OF MASSACHUSETTS
Executive Office of Health and Human Services

Personal care management (PCM) agencies must complete this application in full when requesting prior authorization (PA) for PCA services, and submit it via the MassHealth Provider Online Service Center (POSC) along with the completed and signed *MassHealth PCA Evaluation* form (PCA-2) or the *MassHealth PCA Reevaluation (No Change)* form (PCA-R), as appropriate. Include all relevant supporting documentation and attach a separate sheet if needed.

Note: Section VII does not need to be completed if the PA request is for the same number of PCA hours authorized at the start date of the PA, and the 3rd box below is checked.

Check one: ☐ Initial evaluation
☐ Reevaluation for consumer (**change** in PCA hours since start date of current PA)
☐ Reevaluation for consumer (**no change** in PCA hours since start date of current PA)

SECTION I: Personal Care Management (PCM) Agency

PCM agency name: | PCM ID no.:

SECTION II: Consumer Information

Consumer name and address: | Consumer phone:

Birth date: | Age: | Date of evaluation: | MassHealth ID no.:

Does the consumer have a legal guardian? . . . . . ☐ Yes ☐ No
If **yes**: Consumer's legal guardian's name and address and telephone number:

Site of in-person evaluation (Check one and provide address and name of facility if applicable.):

☐ Home Address:

☐ Nursing facility (NF) Address:

☐ Hospital Address:

☐ Other (describe): Address:

Note: MassHealth cannot pay for PCA services provided while the consumer is in a nursing facility or other inpatient facility. Include discharge date for consumers in a facility at time of evaluation: _____

Address for service delivery:

Date of initial referral to PCM agency: | Referral source:

For new applicants, the event(s) that precipitated the request for PCA services:

Living arrangements (Check one.): ☐ Lives with family ☐ Lives independently ☐ Assisted living ☐ Nursing facility ☐ Transitional living

State/federal funded residential supports (Check one, if applicable.):

☐ MassHealth Group Adult Foster Care (GAFC) ☐ MassHealth Adult Foster Care (AFC)
☐ Dept. of Developmental Services (DDS) residential support (less than 24/7) ☐ Dept. of Children and Families (DCF) foster care
☐ Dept. of Mental Health (DMH) residential ☐ Mass. Rehabilitation Commission (MRC) residential ☐ Rest Home
☐ Other state funded (describe):

Consumer Name _____

Lives with (Check all that apply.): ☐ Mother ☐ Father ☐ Spouse ☐ Alone ☐ Other family members ☐ Other caregiver
☐ Children (number and age: _____) ☐ Siblings(number and age: _____)
☐ Roommates (number and age: _____) ☐ Other (describe: _____)

Is anyone else in the home receiving MassHealth PCA services? . . . . . ☐ Yes ☐ No
If **yes**, list names of other persons receiving MassHealth PCA services:

Are individuals in the home currently providing personal care to consumers? . . . . . ☐ Yes ☐ No
If **yes**, explain why caregiver cannot continue to provide care. For example, the caregiver has been diagnosed with a terminal illness.

Has consumer received PCA services from MassHealth in the past? . . . . . ☐ Yes ☐ No
If **yes**, identify the following:

PCM agency:	PA no:	Dates of service:

SECTION III: Consumer PCA Schedule

Current PCA schedule (weekdays/weekends):

Current PA no.:	Current authorization: day/evening hours/week	Current night hours per night:	Expiration date:

Day/evening PCA hours being requested per week:	Night hours being requested per night:

SECTION IV: In-Home Services

Is the consumer receiving or about to receive any other services in his or her home? . . . ☐ Yes ☐ No
If **yes**, check all applicable boxes below, enter dates of service or projected start date, and describe the services being provided.

a) Home health ☐ Yes ☐ No

Name of agency: Dates of service or start date:

Service type (nursing; home health aide, etc.): Number of hours:

Schedule: Telephone:

b) Continuous skilled nursing (private duty nurse) ☐ Yes ☐ No

Name of agency: Dates of service or start date:

Number of hours: Schedule: Telephone:

c) Respite ☐ Yes ☐ No

If **yes**, identify funding source: Name of agency:

Dates of service or start date: Number of hours:

Schedule: Telephone:

d) Elder services ☐ Yes ☐ No

Name of agency: Contact:

Telephone: Dates of service or start date:

Service type(s) (homecare, chore service, meals on wheels, etc.): Number of hours:

Schedule:

e) DDS contracted (respite care, family support, day program, etc.) ☐ Yes ☐ No

Name of agency: Contact:

Telephone: Dates of service or start date:

Service type(s) (nursing, hospice aide, etc.): Number of hours per week

Schedule:

f) MRC contracted ☐ Yes ☐ No

Name of agency: Contact:

Telephone: Dates of service or start date:

Schedule:

g) Hospice ☐ Yes ☐ No

Name of agency: Contact:

Telephone: Dates of service or start date:

Schedule:

h) Other in-home services (describe)

SECTION V: Out–of–Home Activities

Does the consumer participate in any other activities outside his or her home?. . . . . ☐ Yes ☐ No

If **yes**, check all applicable boxes and complete the information below, including a description of the activities.

a) Adult day health ☐ Yes ☐ No

Program: Contact:

Telephone: Dates of service or start date:

Schedule:

b) Day habilitation ☐ Yes ☐ No

Program: Contact:

Telephone: Dates of service or start date:

Schedule:

c) DMH contracted services ☐ Yes ☐ No

Program: Contact:

Telephone: Dates of service or start date:

Schedule:

d) DDS contracted services (respite care, family support, day program, etc.) ☐ Yes ☐ No

Program: Contact:

Telephone: Dates of service or start date:

Schedule:

e) School ☐ Yes ☐ No

Ch. 766-Special Education Program: Contact:

Telephone: Dates of service or start date:

Schedule:

f) MRC contracted services ☐ Yes ☐ No

Program:	Contact:
Telephone:	Dates of service or start date:
Schedule:	

g) Employment ☐ Yes ☐ No

Place of employment:	Contact:
Telephone:	Dates of service or start date:
Schedule:	

h) Early Intervention: ☐ Yes ☐ No

Program:	Contact:
Telephone:	Dates of service or start date:
Service type (occupational therapy, physical therapy, OCC therapy, nursing, etc.)	
Schedule:	

i) Other out-of-home activities: ☐ Yes ☐ No

Program:	Contact:
Telephone:	Dates of service or start date:
Service type:	
Schedule:	

This section must be completed by the PCM agency's RN.

SECTION VI: Diagnosis (Primary diagnosis affecting functional status and warranting PCA services)

What is the chronic condition(s) that prevents the consumer from performing his or her activities of daily living (ADLs) and instrumental activities of daily living (IADLs) without physical assistance? (List all conditions.):

Date of onset:	Current height:	Current weight:

SECTION VII: Medical History

List consumer's medical history relevant to application for PCA services, such as changes in the consumer's medical condition from previous year's evaluation, diagnoses, hospitalizations, and surgical procedures and attach any recent documentation, such as discharge summaries, home health care plan (485), etc., that further describes the consumer's functional abilities and limitations. Attach a separate sheet if necessary.

Note: This section does not need to be completed when submitting a PA request with no change in PCA hours.

Instructions for Completing the MassHealth Application to Request Prior Authorization for PCA Services

The following instructions are provided to guide personal care management (PCM) agencies in the completion of the *MassHealth Application to Request Prior Authorization for PCA Services* form (PCA-1). PCM agencies must complete this application form in full and submit it along with the appropriate completed, signed, and dated evaluation or reevaluation form via the MassHealth Provider Online Service Center (POSC), when requesting prior authorization for PCA services. Include any relevant supporting documentation (attach a separate sheet if needed). MassHealth may deny or defer the prior authorization (PA) request if the application is incomplete.

Please Note: Section VII does not need to be completed if the PA request is for the same number of PCA hours authorized at the start date of the PA, and the request is submitted using the *Personal Care Agency Reevaluation Form (No Change)*. **Enter the consumer's name in the space at the top of each page of the application.**

Instructions for Section I: Personal Care Management (PCM) Agency

Enter the name and MassHealth provider number of the PCM agency requesting the PA.

Instructions for Section II: Consumer Information

Consumer name and address: Enter the consumer's name and address at the time the PA request is submitted to MassHealth. If the consumer is residing in a nursing facility or other inpatient facility at the time the PA request is submitted to MassHealth, state the name and address of the facility, and include the projected date of discharge.

Please Note: MassHealth cannot pay for PCA services while a member is residing in a nursing facility or other inpatient facility.

Birth date: Enter consumer's date of birth.

Age: Enter consumer's age.

Date of evaluation: Enter the date that the PCM RN conducted the PCA evaluation included in this PA request.

MassHealth ID: Enter the consumer's MassHealth 12-digit identification number.

Does consumer have a legal guardian?: Check the appropriate box to indicate if the consumer has a legal guardian. If **yes**, enter the legal guardian's name, address, and phone number.

Site of evaluation: Check one of the boxes to identify the location where the PCA evaluation was conducted in the presence of the consumer (home, nursing facility, hospital, or other), and provide the address of the site.

Address for service delivery: Enter the address where the consumer will be receiving PCA services. A P.O. box **is not** acceptable.

Date of initial referral to PCM agency: For new consumers only, enter the date that the consumer was referred to the PCM agency for PCA services.

Referral source: For new consumers only, enter the name of the individual who referred the consumer to the PCM agency for PCA services. Include the individual's relationship to the consumer and name of organization, if applicable.

Event that precipitated the request for PCA services: For new consumers only, state why the consumer is being referred for PCA services at this time, including any particular event that led to the referral (such as caregiver no longer available to provide care, etc.).

Living arrangements: Check the box that most accurately describes the consumer's living arrangements.

Please note the following:

MassHealth cannot pay for PCA services while a consumer is receiving MassHealth group adult foster care (GAFC) or MassHealth adult foster care (AFC) services. If a consumer is receiving GAFC or AFC services at the time the PA request is submitted, PCM agencies must provide the date the consumer will be discharged from GAFC or AFC. If the consumer is being discharged from AFC, the PCM agency must include a copy of the AFC discharge plan.

MassHealth can pay for PCA services if the consumer is living in a rest home, if the PCA services do not duplicate services the member is receiving in the rest home.

MassHealth is the payer of last resort. If a consumer receives residential supports and is also requesting PCA services, PCM agencies must include additional supporting documentation that describes the residential supports the consumer is receiving.

Consumers receiving residential support on a 24/7 basis, through the Department of Developmental Services (DDS), are not eligible for PCA services because DDS provides for all assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs).

PA requests for consumers receiving residential support on less than a 24/7 basis through DDS must include the DDS PCA referral documentation as required by the DDS/EOHHS Interagency Service Agreement (ISA).

PA requests for consumers receiving residential support through other state agencies such as the Department of Mental Health (DMH), the Department of Children and Family Services (DCF), the Massachusetts Commission for the Blind (MCB), or the Massachusetts Rehabilitation Commission (MRC) must include a copy of the residential support contract with the agency's vendor.

Lives with: Check all applicable boxes that describe who the consumer is living with.

Is anyone else in the home receiving MassHealth PCA services?: Check as appropriate and, if **yes**, provide the names of the other PCA consumers.

Are individuals in the home currently providing personal care to consumers?: Check as appropriate to identify if anyone in the consumer's home is providing nonpaid personal care. If **yes**, explain why the caregiver can no longer provide the care.

Has consumer received PCA services from MassHealth in the past?: Check as appropriate. If yes, provide the name of the PCM agency, the PA numbers, and the dates of service.

Instructions for Section III: Consumer PCA Schedule

Current PCA schedule: Enter the hours and days the consumer currently schedules his/her PCAs to work (for example, Sat and Sun 8-10 A.M. and 4-8 P.M. each day; Mon- Friday 4-8 P.M. each day). The PCA schedule reflects the consumer's daily schedule. For example, a consumer who is at adult day health during the weekdays and at home all day on weekends.

Current PA number, current authorization, day/evening, and night hours, expiration date being requested: Enter the information as requested.

Instructions for Section IV: In-Home Services

Is the consumer receiving or about to receive any other services in his or her home?: Check the appropriate box. If **yes**, check **all** applicable boxes that describe the other services the consumer receives, or plans to receive, in his/her home. Include all information as requested.
If the consumer is receiving services from a home health agency, attach the "485" from the home health agency that describes the services the consumer is receiving. If the consumer is receiving hospice services, attach the hospice provider's plan of care for the consumer.

Please Note: PCA services cannot duplicate services the consumer is receiving through another source.

Instructions for Section V: Out–of–Home Activities

Does the consumer participate in any other activities outside his/her home?: Check the appropriate box. If **yes**, check **all** applicable boxes that describe the other services the consumer receives, or plans to receive, outside his/her home. Include all information as requested.

Please Note: PCA services cannot duplicate services the consumer is receiving through another source.

Sections VI and VII must be completed by the PCM agency's registered nurse (RN)

Instructions for Section VI: Diagnosis

State the **primary diagnosis** that affects the consumer's functional ability to perform his or her ADLs and IADLs without physical assistance. List the date of onset of this medical condition. Include the member's current height and weight.

Instructions for Section VII: Medical History

Please Note: You do not need to complete **Section VII** if you checked Box 3 at the top of page one, and if you are submitting the *MassHealth PCA Reevaluation Form (No Change)* with this PA request.

Describe consumer's medical history relevant to this application for PCA services, such as changes in the consumer's medical condition, diagnosis, hospitalizations, and surgical procedures since the consumer's previous PCA evaluation. Attach any recent documentation such as discharge summaries, home health "485" plan, hospice care plan, etc., that describes the consumer's functional abilities and limitations.