PCA Operating Standards

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Note: To ensure the Prior Authorization Unit (PAU) is able to follow through on tasks described in the enclosed operating standards, each Personal Care Management (PCM) Agency must identify at least 2 staff members who will be the contact for the PAU when the standard requires the PAU to contact the PCM Agency. PCM Agencies are asked to notify the PAU of changes to the PCM Agency contact name and contact information, through the PCA mailbox (PCAinfo@umassmed.edu).

APPENDICES

I. <u>Extensions:</u> PCM Agencies are responsible for submitting prior authorization requests (re-evaluations) to MassHealth at least 21 days prior to the expiration date of the prior authorization. NOTE: This standard applies to consumers in facilities as well.

A. <u>When PCM Agency initiates a request(s) for extension prior to prior authorization expiration:</u> A PCM Agency may request MassHealth to extend the expiration date of a prior authorization when the current prior authorization is due to expire, and the PCM Agency has completed the re-evaluation but was unable to submit the new prior authorization request to MassHealth before the prior authorization expiration date due to circumstances beyond the control of the PCM Agency.

1) **<u>PCM Agency submits a new prior authorization request on the POSC to extend the current prior authorization.</u>** PCM request must include:
   a) In the **Provider Comments** section of POSC:
      i) EXTENSION
      ii) Prior authorization# that requires extension
      iii) Reason for extension
      iv) Number of days being requested for extension
      v) New expiration date
   b) Procedure code(s)/modifier with number of units for each code/modifier being requested for extension (ensure inclusion of TV modifier if appropriate).
      i) For pediatric prior authorizations, the PCM Agency will ensure the requested units reflect vacation or school weeks, as appropriate.
2) PAU receives the request and contacts the PCM Agency if any of the above criteria are missing.
   a) If the "Reason for extension" is not included in the request, the request will be deferred and the PAU will request that the PCM Agency provide the reason for extension.
   b) If the PAU denies the request, the PCM Agency may submit a re-evaluation for review.
3) PAU downloads the prior authorization request and distributes to the appropriate staff (Operational).
4) PAU verifies in MMIS that no other prior authorizations or requests for prior authorizations (including extensions) for PCA services exist to ensure no overlap in prior authorization dates.
   a) If there is a re-evaluation awaiting decision, PAU will attempt to process the re-evaluation in lieu of the extension, however this may not always be possible. **NOTE:** PAU will not automatically extend a prior authorization when the PCM Agency has submitted a prior authorization request prior to the prior authorization expiration date, but not within 21 days of expiration. PCM Agency can request an extension to ensure no gap in service, and the PAU will either process the prior authorization and void the extension request, or process the

extension request and then process the new prior authorization request to ensure no gap in service. In this instance, the PCM Agency should not submit a correction request to the PCA info e-mail address.

5) If all information is in order, PAU extends CURRENT prior authorization based on information provided in # 1, and VOIDS the new prior authorization requested by the PCM Agency.
   a) When extending the CURRENT prior authorization, the PAU will ensure that end dates for all lines are consistent and have been changed to the requested date.
6) Prior authorization notice is generated to the consumer, PCM Agency and FI with the following external text message "*Date* MassHealth is extending your current prior authorization for PCA services per request of your PCM Agency. PCA approved hours remain the same. XX hours and XX minutes per week day/evening and XX hours per night. New expiration date is XXXXX. Total Holiday Time XX hours and XX minutes. Extension of dates of service is not an appealable action."
7) A message is entered as a Provider Comment in the new prior authorization request that has been voided: "*Date* Please see PA XXXXX for extension on POSC."
8) **<u>A prior authorization will not be extended for more than a total of 90 days.</u>**
9) **The effective date (start date) of the extended prior authorization is the day after the end date of the expired prior authorization.**

B. <u>When PCM Agency initiates a request for extension due to a gap in service:</u> The PCM Agency may request an extension of a consumer's prior authorization when the prior authorization has expired and the PCM Agency failed to complete or submit a new prior authorization request to MassHealth prior to the expiration date of the prior authorization; resulting in the current prior authorization expiring, and a "gap in service" for the consumer due to no fault of the consumer. An extension will not be granted if the consumer was not using PCA services during the period in question, or if the consumer failed to cooperate with the PCM Agency in having the PCA evaluation conducted. MassHealth encourages PCM Agencies to submit all prior authorization requests in accordance with the PCM Agency contract requirements. Please note that MassHealth may impose sanctions in accordance with Section 5.9 F(1)(j) of the PCM Agency Contract if a PCM Agency consistently fails to meet requisite timelines when submitting prior authorizations to MassHealth.

1) **<u>PCM Agency submits a new prior authorization request on the POSC to extend the current prior authorization.</u>** PCM Agency request must include:
   a) In the **Provider Comments** section of POSC:
      i) EXTENSION – GAP IN SERVICE
      ii) Prior authorization # that requires extension

iii) Reason for extension, including full explanation of why the PCM Agency is requesting an extension
iv) Number of days for extension
v) New expiration date

b) Procedure code(s)/modifier with the number of units being requested for each code/modifier for extension
i) For pediatric prior authorizations, the PCM Agency will ensure the requested units reflect vacation or school weeks, as appropriate.

2) PAU receives the request and contacts the PCM Agency if any of the above criteria are missing.
a) If the "Reason for extension" is not included in the request or is incomplete, the request will be deferred and the PAU will request that the PCM Agency submit the required information.
b) If the PAU denies the request, the PCM Agency may submit a re-evaluation for review.

3) PAU downloads the prior authorization request and distributes to the appropriate staff (Operational).

4) PAU verifies in MMIS that no other PCA prior authorizations exist to ensure no overlap in prior authorization dates.
a) If there is a re-evaluation awaiting decision, the PAU will process the re-evaluation in lieu of the extension, however this may not always be possible.

5) If all information is in order, PAU extends EXPIRED prior authorization based on information provided in # 1, and VOIDS the new prior authorization requested by the PCM Agency.
a) When extending the EXPIRED prior authorization, the PAU will ensure that end dates for all lines are consistent, have been changed to the requested date, and that there is no interruption in service.

6) Prior authorization notice is generated to the consumer, PCM Agency and FI with the following external text message "*Date* MassHealth is extending your current prior authorization for PCA services per request of your PCM Agency. PCA approved hours remain the same. XX hours and XX minutes per week day/evening and XX hours per night. New expiration date is XXXXX. Total Holiday Time XX hours and XX minutes. Extension of dates of service is not an appealable action."

7) A message is entered as a Provider Comment in the new prior authorization request that has been voided: "*Date* Please see PA XXXXX for extension on POSC."

8) <u>A prior authorization will not be extended for more than a total of 90 days.</u>

9) A prior authorization will not be extended due to gap in service if the gap is greater than 60 days. The PCM Agency must then submit a new prior authorization request and include the required documentation (PCA application, re-evaluation, etc.). The PAU will process the prior authorization, and the effective date of the prior authorization will be the date the new prior authorization request was received by MassHealth.

10) **The effective date (start date) of the extended prior authorization is the day after the end date of the expired prior authorization.**

C. **When the PCM Agency initiates a request(s) for extension due to a transferred case: A prior authorization can be extended to allow the new (receiving) PCM Agency sufficient time to conduct the re-evaluation when the current prior authorization is about to expire. The prior authorization extension for consumer transfers will be handled via a new prior authorization under the new (receiving) PCM Agency, and end the current prior authorization under the current (transferring) PCM Agency. NOTE: This process is for consumer transfers between PCM Agencies when the FI remains the same. Consumer transfers between PCM Agencies when there is a change in FI can only occur at the end of the calendar year, in accordance with Operating Standard II: Consumer Transfers.**

1) ***NEW (receiving)* PCM Agency submits a new prior authorization request on the POSC to extend the current prior authorization via a new prior authorization.** PCM Agency request must include:
   a) In the **Provider Comments** section of POSC:
      i) EXTENSION – CONSUMER TRANSFER
      ii) Prior authorization # of the current prior authorization
      iii) PCM Agency (transferring) of the current prior authorization
      iv) New expiration date for the current prior authorization (this date should be the day before the start date of the new prior authorization)
      v) Reason for extension
   b) Procedure code(s)/modifier with number of units for each code/modifier being requested for extension (ensure inclusion of TV (holiday) modifier if appropriate).
      i) For pediatric prior authorizations, the PCM Agency will ensure the requested units reflect vacation or school weeks, as appropriate.
2) PAU receives the request and contacts the PCM Agency (receiving) if any of the above criteria are missing.
   a) If the "Reason for extension" is not included in the request, the request will be deferred and the PAU will request that the PCM Agency (receiving) submit the reason for extension.
   b) If the PAU denies the request, the PCM Agency may submit a re-evaluation for review.
3) PAU downloads the prior authorization request and distributes to the appropriate staff (Operational).
4) PAU verifies in MMIS that no other prior authorizations or requests for prior authorizations (including extensions) for PCA exist to ensure no overlap in prior authorization dates.
5) If there is a re-evaluation awaiting decision, PAU will attempt to process the re-evaluation in lieu of the extension, however this may not always be possible.

6) If all information is in order, PAU ENDS the CURRENT prior authorization based on information provided in # 1, and ADJUDICATES the new prior authorization requested by the new (receiving) PCM Agency.
   a) When ending the CURRENT prior authorization, the PAU will ensure that end dates for all lines are consistent and have been changed to the requested date.
7) Prior authorization notice is generated to the consumer, PCM Agency (receiving) and FI for the NEW prior authorization with the following external text message "*Date* MassHealth has extended your current prior authorization for PCA services via a new prior authorization per request of your new PCM Agency. PCA approved hours remain the same. XX hours and XX minutes per week day/evening and XX hours per night. Beginning XXXX and ending XXXX. Total Holiday Time XX hours and XX minutes. Replaces prior authorization XXXX. Extension of dates of service due to a change in MassHealth Providers is not an appealable action."
8) Prior authorization notice is generated to the consumer, PCM Agency (transferring) and FI for the CURRENT prior authorization with the following external text message "*Date* MassHealth has ended your current prior authorization for PCA services with XX PCM Agency per request of your new PCM Agency. New end date XXXX. Changing MassHealth Providers is not an appealable action."
9) A message is entered as a Provider Comment in the current PA request that has been ended: "*Date* Please see PA XXXXX for extension on POSC."
10) **A prior authorization will not be extended for more than a total of 90 days.**
11) **The effective date (start date) of the extended prior authorization is the day after the end date of the expired prior authorization.**

D. When the PCM Agency initiates a request for extension of the current prior authorization for consumers in facilities: A prior authorization can be extended to ensure that a consumer is discharged home with PCA services and to allow the PCM Agency sufficient time to conduct a re-evaluation.

1) **PCM Agency submits a new prior authorization request on the POSC to extend the current prior authorization.** PCM Agency request must include:
   a) In the **Provider Comments** section of POSC:
      i) EXTENSION
      ii) Prior authorization # that requires extension
      iii) Reason for extension
      iv) Facility admission date
      v) Projected facility discharge date
      vi) Number of days being requested for extension

vii) New expiration date

b) Procedure code(s)/modifier with number of units for each code/modifier being requested for extension (ensure inclusion of TV modifier if appropriate).
   i) For pediatric prior authorizations, the PCM Agency will ensure the requested units reflect vacation or school weeks, as appropriate.

2) PAU receives the request and contacts the PCM Agency if any of the above criteria are missing.
   a) If the "Reason for extension" is not included in the request, the request will be deferred and the PAU will request that the PCM Agency provide the reason for extension.
   b) If the projected facility discharge date is not included, or is greater than 90 days from the date of the facility admission, the extension request will be denied.
   c) If the consumer was discharged home without notice to the PCM Agency, the PAU will allow extension of the current prior authorization only. If the prior authorization has expired, please refer to section E in this operating standard.
   d) If the PAU denies the request, the PCM Agency may submit a re-evaluation for review.
3) PAU downloads the prior authorization request and distributes to the appropriate staff (operational).
4) PAU verifies in MMIS that no other prior authorizations or requests for prior authorizations (including extensions) for PCA exist to ensure no overlap in prior authorization dates.
   a) If there is a re-evaluation awaiting decision, PAU will attempt to process the re-evaluation in lieu of the extension, however this may not always be possible. **NOTE:** PAU will not automatically extend a prior authorization when the PCM Agency has submitted a prior authorization request prior to the prior authorization expiration date, but not within 21 days of expiration. PCM Agency can request an extension to ensure no gap in service, and the PAU will either process the prior authorization and void the extension request, or process the extension request and then process the new prior authorization request to ensure no gap in service. In this instance, the PCM Agency should not submit a correction request to the PCA info e-mail address.
5) If all information is in order, PAU extends CURRENT prior authorization based on information provided in # 1, and VOIDS the new prior authorization requested by the PCM Agency.
   a) When extending the CURRENT prior authorization, the PAU will ensure that end dates for all lines are consistent and have been changed to the requested date.
6) Prior authorization notice is generated to the consumer, PCM Agency and FI with the following external text message "*Date* MassHealth is extending your current prior authorization for PCA services per request of your

PCM Agency. PCA approved hours remain the same. XX hours and XX minutes per week day/evening and XX hours per night. New expiration date is XXXXX. Total Holiday Time XX hours and XX minutes. Extending a prior authorization per request of your PCM Agency is not an appealable action."

7) A message is entered as a Provider Comment in the new PA request that has been voided: "*Date* Please see PA XXXXX for extension on POSC."
8) **A prior authorization will not be extended for more than a total of 90 days.**
9) **The effective date (start date) of the extension prior authorization request is the day after the end date of the current prior authorization.**
10) **MassHealth expects the PCM Agency, to the best of their ability, to communicate with the facility, track the consumer's discharge, and be involved in the discharge process.**
11) **Upon discharge home, the PCM Agency should conduct and submit a re-evaluation request, not an adjustment request, if PCA services need to continue.**

E. When the PCM Agency initiates a request for extension of an expired prior authorization for consumers who have discharged from facilities without notice to the PCM Agency, the prior authorization will not be extended.

PCM Agencies must make every effort to communicate with facilities regarding discharge planning for consumers. However, should a consumer be discharged home without any notice to the PCM Agency, and the consumer's prior authorization had expired while the consumer was in the facility, the PCM Agency may request a NEW, short-term, prior authorization, with the same hours/units as the expired prior authorization, to ensure that the consumer can continue to receive PCA services while allowing the PCM Agency sufficient time to conduct a re-evaluation. The NEW prior authorization will ensure that MassHealth does not pay for PCA services while the consumer was in a facility.

1) **PCM Agency submits a new prior authorization request on the POSC to extend the expired prior authorization via a new prior authorization.**
   PCM Agency request must include:
   a) In the **Provider Comments** section of POSC:
      i) EXPIRED PA, DISCHARGED WITHOUT NOTICE
      ii) Prior authorization# that has expired while consumer was in facility
      iii) Facility Admission Date
      iv) Facility Discharge Date
      v) Number of days being requested for prior authorization (no more than 90 days can be requested)

b) Procedure code(s)/modifier with number of units for each code/modifier being requested (ensure inclusion of TV modifier if appropriate).
   i) Codes, modifiers and units should reflect the services authorized on the expired prior authorization.
   ii) For pediatric prior authorizations, the PCM Agency will ensure the requested units reflect vacation or school weeks, as appropriate.
c) Dates of service, ensuring the new prior authorization starts on the date of facility discharge.
   i) **The NEW prior authorization will not be authorized for more than a total of 90 days.**

2) PAU receives the request and contacts the PCM Agency if any of the above criteria are missing.
   a) If the "Facility Admission Date" or "Facility Discharge Date" is not included in the request, the request will be deferred and the PAU will request that the PCM Agency provide the appropriate dates.
   b) If the PAU denies the request, the PCM Agency may submit a re-evaluation for review.
3) PAU downloads the prior authorization request and distributes to the appropriate staff (operational).
4) PAU verifies in MMIS that no other prior authorizations or requests for prior authorizations (including extensions) for PCA exist to ensure no overlap in prior authorization dates.
5) If there is a re-evaluation awaiting decision, PAU will attempt to process the re-evaluation in lieu of the extension, however this may not always be possible.
6) If all information is in order, PAU authorizes the NEW prior authorization based on information provided in # 1.
7) Prior authorization notice is generated to the consumer, PCM Agency and FI for the NEW prior authorization with the following external text message "*Date* MassHealth has approved a short-term prior authorization for PCA services upon your facility discharge to allow your PCM Agency time to complete a re-evaluation. PCA approved hours remain the same. XX hours and XX minutes per week day/evening and XX hours per night. Beginning XXXX and ending XXXX. Total Holiday Time XX hours and XX minutes. Short-term authorization to allow time for your PCM Agency to conduct a re-evaluation is not an appealable action."

F. **<u>When PAU initiates a request(s) for extension:</u> A prior authorization can be extended when the current prior authorization is due to expire and the PCM Agency has submitted the new prior authorization request at least 21 days prior to the expiration date of the prior authorization, but the PAU was not able to process the prior authorization before the current prior authorization expires. The PAU will administratively extend a prior authorization for 30 days if the PAU is not able to process a new prior**

authorization request before the current prior authorization expires, and adjudicate the prior authorization during the 30 day extension period.

1) PAU extends current prior authorization by changing expiration date and adding units to T1019 and T1019 (TV) (if applicable) to reflect the change in expiration date.
2) Prior authorization notice is generated to the consumer, PCM Agency and FI with the following external text message "*Date* MassHealth is extending your current prior authorization for PCA services while your new request is being reviewed. PCA approved hours remain the same. XX hours and XX minutes per week day/evening and XX hours per night. New expiration date is XXXXX. Total Holiday Time XX hours and XX minutes. Extension of dates of service initiated by MassHealth to avoid a lapse in service is not an appealable action."
3) The prior authorization will be extended for no more than 30 days, and the PAU will process the prior authorization request prior to the new expiration date.
4) PAU will notify the appropriate PCM Agency and FI via e-mail when systemic problems or issues require PAU initiated extension of a prior authorization.

II. Consumer Transfers

A. Consumer Transfers---**NO FI CHANGE**

1) Per the PCM Contract, the current (transferring) PCM Agency must notify the PAU of the transfer of a consumer's prior authorization to a new (receiving) PCM agency.
2) **Current (transferring) PCM Agency will e-mail the PAU at PCAinfo@umassmed.edu to notify the PAU about the transfer, including:**
    a) Consumer Name
    b) Prior authorization #
    c) Current PCM Agency
    d) New PCM Agency
    e) Effective Date
    f) **CONSUMER TRANSFER** – in the subject line
3) PAU staff will document CONSUMER TRANSFER and the related details in the MMIS internal text of the current prior authorization.
4) **NOTE: PCM Agency cannot submit this information through MMIS**

B. Consumer Transfers—**CHANGE IN FI**

1) **The PAU cannot accept a prior authorization request to change FI during the course of a calendar year, in accordance with MassHealth Consumer Transfer Policies as amended in the PCM Agency Contract.** PCM Agencies may only request a change in FI at the end of the calendar year, as advised each year by the MassHealth PCA Program Manager, and must first obtain the exact start date of the new prior authorization from the new (receiving) FI prior to submitting the prior authorization request to MassHealth.
Note: ***The only exception to this rule is if the FI has not paid any Activity Forms for the consumer during the calendar year. The current (transferring) PCM Agency would then need to submit a letter from the current FI to the PAU stating that the consumer has not submitted any activity forms during the calendar year, and therefore a change to another FI would be acceptable.***
2) After obtaining the start date of the new prior authorization from the new (receiving) FI, the new (receiving) PCM Agency submits a prior authorization request on the POSC.
    a) The new (receiving) PCM Agency must obtain the remaining units for each service code and modifier on the existing prior authorization from the old PCM Agency or old FI. The new (receiving) PCM Agency must then enter the remaining units for each applicable procedure code when requesting the new prior authorization on the POSC. The prior authorization expiration date remains the same as the previous prior authorization.
    b) PAU downloads prior authorization request and forwards to the appropriate administrative staff.

c) Prior authorization is processed and prior authorization notice is mailed to consumer, new PCM Agency and new FI with message: "*Date* Consumer transfer from XX PCM Agency and XX FI to XX PCM Agency and XX FI start date XXXX expiration date XXXX. XX hours and XX minutes per week day/evening and XX hours per night. Replaces prior authorization XXXX."
d) PAU will terminate the previous prior authorization by modifying the end dates. Prior authorization notice is generated to the consumer, current PCM Agency and current FI with the following external text message: "*Date* MassHealth has terminated your current prior authorization for PCA services with XX PCM Agency, effective XX date, due to your transfer from XX PCM Agency and XX FI to XX PCM Agency and XX FI effective XX date."

III. <u>Adjustment Requests:</u> The PCM Agency may submit a request to MassHealth to increase or decrease the number of PCA hours on a consumer's existing prior authorization as a result of changes in the consumer's medical condition and/or functional status or a change in the living condition that affects the consumer's ability to perform ADLs/IADLs without physical assistance. In addition, the PCM Agency may submit a request to MassHealth to add units to a current PCA prior authorization due to Jury Duty, or to request units for premium pay for Overtime.

A. **<u>PCM Agency submits a NEW PA request for an increase or decrease in the number of prior authorization hours through the POSC.</u>**

1) PCM Agency request must include:
    a) In the **Provider Comments** Section, enter **ADJUSTMENT**
    b) The completed and signed MassHealth PCA Adjustment Form <u>OR</u>
    c) A cover letter including:
        i) Reason for the adjustment request including the medical condition, functional status or living situation, specific ADLs or IADLs for which an increase or decrease in PCA services is being requested, including the number of units, the number of hours, and the duration of time for which the adjustment is being requested;
        ii) Prior authorization# of the active prior authorization to be adjusted.
        iii) See MassHealth PCA Regulation 130 CMR 422.416 B
        iv) A letter from the consumer's MD or NP stating the reason and medical necessity for adjustment in the consumer's hours, including the specifics as in 2.a. above.
    d) Any documentation from the list of standard documentation, as appropriate.
    e) If the current prior authorization was approved via the "No Change" process, submit the PCA Evaluation conducted by the RN on which the PCM Agency based its "no change" request, or the documentation as required by the Standards for Submission of prior authorization (No Change).
    f) **NOTE: Do not add lines for the same code on a previously approved prior authorization. A new prior authorization must be submitted.**
2) PAU downloads adjustment prior authorization request and distributes to appropriate Clinical Reviewer.
3) PAU Clinical Reviewer processes request in accordance with information provided in Section III (A1).
4) If the request is approved or modified, PAU adjusts the appropriate line item (units and/or dates of service) on the existing PCA prior authorization referenced by the PCM Agency in Section III (A1). PAU will state reasons for modification and adjusted tasks in the external text.

5) If the request is approved or modified, PAU voids the new prior authorization request submitted by the PCM Agency and enters the following provider comment on the voided prior authorization:
    a) "*Date* Please see PA XXXX for adjustment on POSC."
6) If the request is approved or modified, PAU adjusts current prior authorization in MMIS, and prior authorization notice is forwarded to consumer, PCM Agency and FI with the following external text message:
    a) Approvals for increase: "*Date* MassHealth has approved your prior authorization request to increase your PCA hours. Total PCA hours approved XX hours and XX minutes per week day/evening and XX hours per night. Beginning XXXX and ending XXXX. Total Holiday Time XX hours and XX minutes."
    b) Approvals for decrease: "*Date* MassHealth has approved your PCM Agency's request to decrease your PCA hours. Total PCA hours approved XX hours and XX minutes per week day/evening and XX hours per night. Beginning XXXX and ending XXXX. Total Holiday Time XX hours and XX minutes."
        i) The PAU will add 14 calendar days to the date of adjudication to allow for the consumer's receipt of the denial notice and appeal rights.
    c) Modifications: "*Date* MassHealth has modified your prior authorization request to increase (or decrease) your PCA hours. Total PCA Hours: XX hours and XX minutes per week day/evening and XX hours per night. Beginning XXXX and ending XXXX. Total Holiday Time XX hours and XX minutes.
    d) **NOTE: Effective date of an adjustment request (INCREASES ONLY) is the date MassHealth <u>receives</u> the prior authorization adjustment request from the PCM Agency. The effective date of all other prior authorization requests is the date MassHealth sends notice of its decision to the consumer in accordance with 130 CMR 450.303(B)(3).**
7) If the request is approved or modified, PAU updates the current prior authorization with the following internal text message:
    a) "*Date* Please see Tracking # XXXX for supporting documentation."
8) If the request is denied, PAU denies the new PA request submitted by the PCM Agency, and PA decision notice is forwarded to consumer, PCM Agency and FI with the following external text message:
    a) "*Date* MassHealth has denied your prior authorization request to increase (or decrease) your PCA hours. The total PCA hours on your current prior authorization will continue until the prior authorization expires on XXXX."
9) A message is entered as a Provider Comment in the new prior authorization request that has been voided: "*Date* Please see PA XXXXX for adjustment on POSC."

B. **Adjustment Requests for Consumer Transfers:** ***New (receiving)*** **PCM Agency submits a NEW prior authorization request for an increase or decrease in the number of prior authorization hours through the POSC** ***for a consumer that is transferring or has transferred from one PCM Agency to another, and prior to completion of a re-evaluation.*** **The PA adjustment for consumer transfers will be handled via a new prior authorization under the new (receiving) PCM Agency, while the PAU will end the current prior authorization under the current (transferring) PCM Agency.**

NOTE: This process is for consumer transfers between PCM Agencies when the FI remains the same. Consumer transfers between PCM Agencies when there is a change in FI can only occur at the end of the calendar year, in accordance with Operating Standard II: Consumer Transfers.

1) New (receiving) PCM Agency request must include:
   a) In the **Provider Comments** Section, enter **ADJUSTMENT – CONSUMER TRANSFER**
   b) The completed and signed MassHealth PCA Adjustment Form OR
   c) A cover letter including:
      i) Reason for the adjustment request including the medical condition, functional status or living situation, specific ADLs or IADLs for which an increase or decrease in PCA services is being requested, including the number of units, the number of hours, and the duration of time for which the adjustment is being requested;
      ii) Prior authorization# of the current prior authorization to end.
      iii) PCM Agency (transferring) of the current prior authorization.
      iv) New expiration date of the current prior authorization.
      v) See MassHealth PCA Regulation 130 CMR 422.416 B
      vi) A letter from the consumer's MD or NP stating the reason and medical necessity for adjustment in the consumer's hours, including the specifics as in 2.a. above.
   d) Any documentation from the list of standard documentation, as appropriate.
   e) If the current prior authorization was approved via the "No Change" process, submit the PCA Evaluation conducted by the RN on which the current PCM Agency based its "no change" request, or the documentation as required by the Standards for Submission of prior authorization (No Change).
   f) **NOTE: Do not add lines for the same code on a previously approved prior authorization. A new prior authorization must be submitted.**
2) PAU downloads adjustment prior authorization request and distributes to appropriate Clinical Reviewer.
3) PAU Clinical Reviewer processes request in accordance with information provided in Section III (A1).
4) If all information is in order, PAU ENDS the CURRENT prior authorization (for adjustment approvals or modifications only) based on information

provided in # 1, and ADJUDICATES the new prior authorization requested by the new (receiving) PCM Agency.

a) When ending the CURRENT prior authorization, the PAU will ensure that end dates for all lines are consistent and have been changed to the requested date.

5) If the request is approved or modified, PAU ends the current prior authorization and adjudicates the new prior authorization request. PAU will state reasons for modification and adjusted tasks in the external text.
6) Prior authorization notice is generated to the consumer, new (receiving) PCM Agency and FI for the NEW prior authorization with the following external text message:
    a) Approvals for increase: "*Date* MassHealth has approved your prior authorization request to increase your PCA hours and authorized a new prior authorization under your new PCM Agency. XX hours and XX minutes per week day/evening and XX hours and XX minutes per night. Beginning XXXX and ending XXXX. Total Holiday Time XX hours and XX minutes."
    b) Approvals for decrease: "*Date* MassHealth has approved your new PCM Agency's request to decrease your PCA hours and authorized a new prior authorization request under your new PCM Agency. Total PCA hours approved XX hours and XX minutes per week day/evening and XX hours per night. Beginning XXXX and ending XXXX. Total Holiday Time XX hours and XX minutes."
        i) The PAU will add 14 calendar days to the date of adjudication to allow for the consumer's receipt of the denial notice and appeal rights.
    c) Modifications: "*Date* MassHealth has modified your prior authorization request to increase (or decrease) your PCA hours and authorized a new prior authorization request under your new PCM Agency. Total PCA Hours: XX hours and XX minutes per week day/evening and XX hours per night. Beginning XXXX and ending XXXX. Total Holiday Time XX hours and XX minutes.
7) Prior authorization notice is generated to the consumer, current (transferring) PCM Agency and FI for the CURRENT prior authorization with the following external text message "*Date* MassHealth has ended your current prior authorization for PCA services with XX PCM Agency due to an adjustment request by your new PCM Agency. New end date XXXX."
8) **NOTE: Effective date of an adjustment request (INCREASES ONLY) is the date MassHealth <u>receives</u> the prior authorization adjustment request from the NEW (receiving) PCM Agency. The effective date of all other prior authorization requests is the date MassHealth sends notice of its decision to the consumer in accordance with 130 CMR 450.303(B)(3).**
9) If the request is denied, PAU denies the new prior authorization request submitted by the new (receiving) PCM Agency, and prior authorization decision notice is forwarded to consumer, PCM Agency and FI with the following external text message:

a) "*Date* MassHealth has denied your prior authorization request to increase (or decrease) your PCA hours. The total PCA hours on your current prior authorization with XX PCM Agency will continue until the prior authorization expires on XXXX."

C. PCM Agency submits a NEW prior authorization request to increase the PCA hours due to Jury Duty.

1) PCM Agency request must include:
   a) In the **PROVIDER COMMENTS** Section, enter **JURY DUTY**
   b) Prior authorization# that requires Jury Duty
   c) Copy of the Certificate of Juror Service issued by the Massachusetts Office of the Jury Commissioner (state jury service) or the Attendance Sheet issued by the Federal District Court (federal jury service)
   d) Copies of PCA timesheets submitted to the FI to confirm number of hours regularly scheduled to work
   e) Procedure code(s)/modifier with the number of units being requested for each code/modifier for Jury Duty
2) PAU receives the request and contacts the PCM Agency designee if any of the above criteria are missing.
3) PAU downloads the prior authorization request and distributes to the appropriate staff (operational).
4) If all information is in order, PAU adjusts CURRENT prior authorization based on the information provided in #1, and VOIDS the new prior authorization requested by the PCM Agency.
5) Prior authorization notice is generated to the consumer, PCM Agency and FI with the following external text message:
   a) Approved: "*Date* MassHealth has approved your PCM Agency request for an additional XX hours and XX minutes of PCA services to allow your PCA X days of jury duty performed XX to XX."
   b) Modified: "*Date* MassHealth has modified your PCM Agency request for additional PCA hours due to jury duty. MassHealth approves an additional XX hours and XX minutes of PCA services to allow your PCA X days of jury duty performed XX to XX."
6) A message is entered as a Provider Comment in the new prior authorization request that has been voided: "*Date* Please see PA XXXXX for Jury Duty on POSC."
7) If the request is denied, PAU denies the new prior authorization request submitted by the PCM Agency, and prior authorization decision notice is forwarded to the consumer, PCM Agency and FI with the following external text message:
   a) Denied: "*Date* MassHealth has denied your PCM Agency request for additional PCA hours for jury duty."

D. PCM Agency submits a prior authorization request for premium pay for Overtime. For any request for overtime on the same prior authorization,

the PCM Agency must submit a NEW prior authorization request via the POSC. NOTE: PCM Agency must request premium pay for overtime within 2 business days of the consumer's request to the PCM Agency.

1) PCM request must include:
   a) In the **PROVIDER COMMENTS** Section, enter **OVERTIME**
   b) Prior authorization# that requires Overtime
   c) The work-week(s) within which the PCA worked overtime
   d) The name of the PCA who worked the overtime
   e) The number of overtime hours being requested
   f) Documentation describing how this request meets the requirements of 130 CMR 422.418 (A)(3)
   g) Copies of PCA timesheets submitted to the FI for the period during which overtime was accrued
   h) Procedure code/modifier (T1019 TU) with the number of units being requested for Overtime
2) PAU receives the request and contacts the PCM Agency if any of the above criteria are missing.
3) PAU downloads the prior authorization request and distributes to the appropriate staff (operational).
4) If all information is in order, PAU adjusts CURRENT prior authorization based on the information provided in #1, and VOIDS the new prior authorization requested by the PCM Agency. PAU may defer requests that are missing information.
5) Prior authorization notice is generated to the consumer, PCM Agency and FI with the following external text message: "*Date* Your request for prior authorization for XX hours and XX minutes of premium pay for overtime for the period XX to XX has been (approved, modified or denied)."
6) PAU enters a message is entered as a Provider Comment in the new prior authorization request that has been voided: "*Date* Please see PA XXXXX for Overtime on POSC."

IV. <u>Expedited Prior Authorization Requests:</u> PAU will expedite the processing of prior authorization requests (including adjustment requests) for PCA services under the following circumstances:

a) The prior authorization request is for a consumer who is being discharged from an inpatient facility
b) The consumer is receiving, or about to receive, hospice services.
c) Any other adjustment deemed as an urgent need by the PCM Agency (i.e. acute illness, post-op, absence of family member/primary caregiver) and as approved by the PAU Associate Director or designee.

In any of the above circumstances, the PCM agency must notify the PAU (see below) that a prior authorization request is being submitted so that the PAU can expedite the processing of the prior authorization. The PAU will adjudicate prior authorization requests for these circumstances within 2 business days of the date the PAU is notified by the PCM Agency that the prior authorization request has been submitted. <u>Please note:</u> The PCM Agency will also make every effort to expedite their evaluation process for the above circumstances.

A. PCM Agency submits a prior authorization request for an expedited prior authorization through the POSC. PCM Agency prior authorization request must include:
   1) Specify "FACILITY DISCHARGE," "HOSPICE" or "URGENT NEED" in the PROVIDER COMMENTS Section.
   2) If the prior authorization request is also an adjustment request, the PCM Agency must follow the Adjustment operating standard.
   3) Immediately after submitting these requests through the POSC, the PCM Agency must obtain the tracking number for the prior authorization request, and contact the designated PAU staff as follows:
      a) Contact the PAU by phone at (800) 862-8341, or email at PCAinfo@umassmed.edu with "Expedited Request Facility Discharge – Tracking #XXXXXXX," "Expedited Request Hospice– Tracking #XXXXXXX," or "Expedited Request Urgent Need – Tracking #XXXXXXX" in the email subject line.

<u>NOTE: Failure to contact the PAU as described above may result in the prior authorization request not being expedited.</u>

V. <u>Adjudicating a prior authorization when the consumer's MassHealth eligibility has ended:</u> A consumer's MassHealth eligibility can change many times during a prior authorization period. MassHealth reviews requests for prior authorization on the basis of medical necessity only. If MassHealth approves or modifies the request, payment is still subject to all general conditions of MassHealth, including the consumer's current MassHealth eligibility status, service limitations, and program restrictions. It is the responsibility of the PCM Agency and the FI to verify a consumer's MassHealth eligibility prior to providing PCM services or FI services.

A. Upon receipt of a prior authorization request, the PAU will adjudicate the prior authorization based on medical necessity and not on the MassHealth eligibility of the consumer.
B. Upon adjudicating a prior authorization for a consumer whose MassHealth eligibility has ended, the PAU will include the following message in the external text: "*Date* MassHealth has approved/modified your prior authorization request for PCA services. XX hours and XX minutes per week day/evening and XX hours per night. Beginning XXXX and ending XXXX. **NOTE Verify MassHealth eligibility prior to using PCA services.** "
C. If the consumer's eligibility includes enrollment in a Senior Care Options (SCO) or Program for All Inclusive Care for the Elderly (PACE) program, the prior authorization request will be denied as personal care services are available through the SCO or PACE, with the following external text message: "*Date* MassHealth has denied your prior authorization request for PCA services because personal care services are available to you through SCO (or PACE)." (*state which one*)
D. If a consumer enrolls in SCO or PACE during a prior authorization period, the prior authorization does not need to be terminated, but PCA, PCM Agency and FI services will not be reimbursable under the MassHealth PCA Program.
E. Medically necessary PCA services authorized by the PAU are based on day/evening hours and minutes per week and night hours and minutes per night.

VI. <u>Prior Authorizations with Missing Procedure Codes or Modifiers:</u>
Occasionally, the PAU may receive a prior authorization request with a missing procedure code(s) or modifier (for example, a missing TV line).

A. Upon receiving a prior authorization request with a missing procedure code or modifier, the PAU will:
   1) Contact the PCM Agency designee and ask him/her to resubmit the prior authorization with the appropriate procedure codes or modifiers.
   2) Void the originally submitted prior authorization.

VII. Prior Authorizations with Errors

A. When PCM Agency submits a prior authorization with a math error (in the minutes calculated in the evaluation or in the units submitted in the prior authorization request)

1) Upon identifying the math error in the prior authorization request, the PAU will correct the error and adjust the prior authorization request and specify the reason for the modification with the following external message text:
    a) "*Date* MassHealth has modified your request for PCA services due to a submission error (specify: calculation error, date errors, etc) by the PCM Agency. Total PCA hours approved XX hours and XX minutes per week day/evening and XX hours per night. Beginning XXXX and ending XXXX. Total Holiday Time XX hours and XX minutes."

B. When PAU makes a math error in adjudicating the prior authorization

1) Upon identifying a math error made by the PAU, the PCM Agency or FI must e-mail the PAU at PCAinfo@umassmed.edu and include the following:
    a) CORRECTION in the subject line of the e-mail
    b) Prior authorization #
    c) Lines/units to be corrected
2) The PAU Clinical Reviewer will review the correction request, modify the prior authorization as appropriate, and enter the correction with the following external message text:
    a) "*Date* MassHealth has modified your prior authorization for PCA services due to a MassHealth calculation error. Total PCA hours approved XX hours and XX minutes per week day/evening and XX hours per night. Beginning XXXX and ending XXXX. Total Holiday Time XX hours and XX minutes."

C. When PAU makes an error in expiration dates

1) Upon identifying an expiration date error made by the PAU, the PCM Agency or FI must e-mail the PAU at PCAinfo@umassmed.edu and include the following:
    a) CORRECTION in the subject line of the e-mail
    b) Prior authorization #
    c) Dates to be corrected
2) The PAU Clinical Reviewer will review the correction request, modify the prior authorization as appropriate, and enter the correction with the following external message text:
    a) "*Date* MassHealth has modified your prior authorization for PCA services due to a MassHealth error inputting expiration dates. Total PCA hours approved XX hours and XX minutes per week day/evening and XX hours per night. Beginning XXXX and

ending XXXX. Total Holiday Time XX hours and XX minutes. The MassHealth error only affected the expiration date of your PCA services and not the number of hours/week. This is not an appealable action."

D. <u>When PAU makes an error in the message text</u>

1) Upon identifying a message text error made by the PAU, the PCM Agency or FI must e-mail the PAU at PCAinfo@umassmed.edu and include the following:
    a) CORRECTION in the subject line of the e-mail
    b) Prior authorization #
    c) Message to be corrected
2) The PAU Clinical Reviewer will review the correction request, modify the prior authorization as appropriate, and enter the correction with the following external message text:
    a) "*Date* MassHealth has modified your prior authorization for PCA services due to a MassHealth error when entering the message text. Corrected message is as follows, total PCA hours approved XX hours and XX minutes per week day/evening and XX hours per night. Beginning XXXX and ending XXXX. Total Holiday Time XX hours and XX minutes. The MassHealth error does not affect your PCA services and hours per week. This is not an appealable action."
    b) When correcting an error in the current prior authorization that results in a reduction of PCA hours for the consumer, the PAU will add 14 calendar days to the date of adjudication to allow for the consumer's receipt of the notice and appeal rights, as well as for the FI to process PCA activity forms.
    c) When correcting an error in the current prior authorization that results in an increase of PCA hours for the consumer, the correction will be effective as of the start date of the prior authorization, or the start date of the adjustment, whichever is appropriate.

VIII. <u>Cancellations:</u> In the event that a PCM Agency submits an adjustment request to the PAU by adding an additional line with the identical code or modifier that is on the current prior authorization, the PAU will cancel such line to avoid any billing or claims issues for the FI.

A. Upon determining that a PCM Agency has submitted, as described above, an adjustment request by adding an additional line to a current prior authorization, the PAU Clinical Reviewer will cancel the newly added line in MMIS and include the following external message text:
    1) "*Date* MassHealth has cancelled your request for an adjustment of PCA services due to a procedure error by your PCM Agency. MassHealth has informed your PCM Agency to submit a new adjustment request per current policy."
B. The PAU Clinical Reviewer will contact the PCM Agency and notify the specified contact person and ask them to submit a new prior authorization per the Adjustment Operating Standard and inform them that the recently added line will be cancelled to avoid any billing or claims issues for the FI.

IX. PAU/PCM Communications

A. When PAU Denies a Prior Authorization Request: When the PAU Clinical Reviewer determines that a prior authorization request is not supported by medical necessity and intends to deny the request, PAU staff will contact the designated PCM staff to facilitate case discussion and collaboration prior to adjudicating the prior authorization request.

1) Upon determining that the request for day/evening PCA services or night (midnight to 6:00 AM) PCA services is not supported by medical necessity and as a result will be denied, the PAU Clinical Reviewer or their supervisor will call the PCM designee that submitted the request and discuss with them:
    a) The disposition of the case,
    b) The reason for the determination, and
    c) Ask if there is additional information the PCM Agency wants to provide to substantiate their request.
    d) If the PCM Agency has additional medical documentation to submit to justify the request, such documentation must be submitted to the PAU via POSC (as an attachment to the existing PA) within 4 days from the date the PAU spoke with the PCM Agency.
        i. If there is no response within 4 business days, the PAU will adjudicate the prior authorization based on the original documentation submitted.

2) Upon completion of the conversation or receipt of any additional documentation from the PCM Agency, the PCA PAU clinical reviewer shall:
    a) Review the additional information and its bearing on the original "denial" determination;
    b) If necessary, change the initial determination or issue a denial for the request.
    c) If the decision is to deny the request, clearly specify the reason for denial in the prior authorization notice, and utilize the appropriate denial code.

B. When PAU significantly modifies a request for a current consumer:
The PAU staff will contact the PCM Agency designee to facilitate discussion and collaboration prior to "significantly" modifying the prior authorization request under the following circumstances:

a) The consumer is medically stable (meaning the consumer's chronic condition(s) and any associated medical condition(s) are stable, have not deteriorated since the start of the previous prior authorization, and there is no evidence that indicates further medical intervention is

warranted at the time the new prior authorization request is under review by MassHealth); and

b) The consumer has been receiving PCA services for an extended period (3 or more years) of time; and

c) The PAU has determined that the prior authorization request must be "significantly" modified (i.e. the prior authorization is being modified by more than 20% of the PCA hours requested).

1) Upon determining that the request for PCA services is not supported by medical necessity and as a result a prior authorization request that meets the criteria above will be significantly modified, the PAU clinical reviewer or their supervisor will call the PCM Agency designee that submitted the request and discuss with them:
    a) The disposition of the case,
    b) The reason for the determination, and
    c) Ask if there is additional information the PCM Agency wants to provide to substantiate their request.
    d) If PCM Agency has additional medical documentation to submit to justify the request, such documentation must be submitted to the PAU via POSC (as an attachment to the existing prior authorization) within 4 days from the date the PAU spoke with the PCM Agency.
        i. If there is no response within 4 days, the PAU will adjudicate the prior authorization based on the original documentation submitted.

2) Upon completion of this conversation, the PCA PAU Clinical Reviewer shall:
    a) Review the additional information and its bearing on the original "modification" determination;
    b) If necessary, change the initial determination and adjudicate the prior authorization based on the above information.
    c) If the decision is to modify the request, clearly specify the reason for modification in the prior authorization notice and utilize the appropriate reason code.

3) If an adjustment request results in modification of hours less than what was previously authorized, the PCA PAU Clinical Reviewer will contact the PCM Agency designee that submitted the request and discuss with them:
    a) The disposition of the case,
    b) The reason for the determination, and
    c) Ask if there is additional information the PCM Agency wants to provide to substantiate their request.
    d) If PCM has additional medical documentation to submit to justify the request, such documentation must be submitted to

the PAU via POSC (as an attachment to the existing prior authorization) within 4 days from the date the PAU spoke with the PCM Agency.

i) If there is no response within 4 days, the PAU will adjudicate the prior authorization based on the original documentation submitted.

4) If a modification results in the denial of an entire ADL or IADL, the PAU Clinical Reviewer will contact the PCM Agency designee that submitted the request and discuss with them:
    a) The disposition of the case,
    b) The reason for the determination, and
    c) Ask if there is additional information the PCM Agency wants to provide to substantiate their request.
    d) If PCM Agency has additional medical documentation to submit to justify the request, such documentation must be submitted to the PAU via POSC (as an attachment to the existing prior authorization) within 4 days from the date the PAU spoke with the PCM Agency.
        i) If there is no response within 4 days, the PAU will adjudicate the prior authorization based on the original documentation submitted.

X. **<u>Deferrals:</u> If a PCM Agency submits a prior authorization request that does not conform with all submission requirements (See MassHealth PCA regulations at 130 CMR 422.422 (C)(3) and (D), and the *MassHealth's Standard Documentation to Include with a Prior Authorization Request for PCA Services*), the PAU will defer the request back to the PCM Agency in order to provide the PCM Agency the opportunity to submit the missing documentation as soon as possible.**

A. If upon receiving a prior authorization request, the PAU Clinical Reviewer identifies that specific required documentation is missing, the PAU will defer the prior authorization by changing the prior authorization from "In Review" status to "Deferred" status.

B. Through MMIS, the Clinical Reviewer will specify their consultant ID, reason code and which documentation is missing, and request that the PCM Agency submit the missing documentation as an attachment to the existing prior authorization via the POSC.

C. The PCM Agency will obtain the specifics regarding the missing documentation via the POSC by reviewing the Deferred List and choosing the relevant prior authorization. (To obtain the Deferred List on the POSC, go to the *Prior Authorization Search* screen and choose *Deferred* in the Status drop-down list, then click *Search*. All prior authorizations deferred for the PCM Agency will appear in the *Prior Authorization Search Results* at the bottom of the screen.)

D. The PCM Agency will submit the missing documentation via the POSC by choosing the appropriate prior authorization # from the Deferred List and opening the *Attachment* tab. The PCM can then upload the missing documentation through the *New Item* function.

E. Upon receipt of the missing documentation from the PCM Agency via the POSC, the PAU will process the prior authorization as usual.
   1) If the PCM Agency submits the requested documentation within 4 calendar days of the date the PAU requests the missing documentation (deferral date), the prior authorization will be adjudicated within the original 21 calendar day Cornelius date (i.e. within 21 days from the date the PAU receives the prior authorization request via the POSC).
   2) If the PCM Agency submits the required documentation 5 calendar days or more after the PAU requests the missing documentation (deferral date), per regulation, the decision will be delayed by the time elapsing between the 4 days and when the PAU receives the missing documentation. These elapsed days will be added to the original Cornelius date to ensure allowable time to review, per the following example:

a) Prior authorization is received at PAU on 1/31/11 and Cornelius date is 2/21/11. PA is deferred on 2/2/11. If the PCM Agency submits the required documentation on 2/10/11 (8 days after the PAU requested the documentation), the Cornelius date now becomes 2/25/11 (8 days minus 4 days = 4 additional days added onto Cornelius date).

F. If the PAU does not receive the missing documentation within 21 days of the original prior authorization request received by the PAU, the Clinical Reviewer will adjudicate the prior authorization request based on the available documentation provided by the PCM Agency.

G. PCM Agencies are strongly encouraged to submit the missing documentation within 4 days to ensure no interruption of services.

H. If the PCM Agency does not have additional documentation to submit, the PCM Agency will contact the PAU by sending an email to PCAinfo@umassmed.edu with "DEFERRAL – Tracking # XXXXXXX" in the email subject line, and state that the PCM Agency does not have additional information to submit.

XI. <u>Terminating PCA Services (including Closed Cases)</u>: When a consumer who has an open prior authorization intends to no longer use PCA services or is deemed clinically not eligible for the PCA program during the prior authorization period, the PCM Agency must communicate with the PAU to proceed with terminating the prior authorization and closing the case. This is a change in Section 2.2 G (10) of the PCM Agency Contract, which currently requires the PCM Agency to solely notify the FI of closed cases. Examples or circumstances under which a PCA prior authorization should be terminated include, but are not limited to: deceased (including deceased SCO members), no longer clinically eligible, AFC/GAFC, admitted to a nursing facility and no longer will use PCA services, moving out of area/out of state, member is DDS eligible and is moving to a 24/7 staffed group home.

A. When a consumer has an open prior authorization (not part of a re-evaluation process), the PCM Agency must submit a NEW prior authorization request to the PAU in order to terminate PCA services, and include the following information:
   1) In the **Provider Comments** Section of the POSC, enter **TERMINATION**
   2) The completed and signed* MassHealth PCA Adjustment Form; PCM Agency must include the reason for termination in the comments section of this form **(*MD/NP signature required only when PCM Agency determines that the consumer is deemed clinically no longer eligible for PCA services**)
      a) <u>The MassHealth PCA Adjustment Form is required for consumers who are deemed clinically no longer eligible for PCA services.</u>

      <u>OR</u>
   3) A cover letter, for all other terminations, including:
      a) Reason for the adjustment (termination) request including the clinical rationale for termination of PCA services.
      b) Prior authorization# of the active prior authorization to be terminated.
   4) If the consumer intends to no longer use PCA services, the consumer (via the PCM Agency) or the PCM Agency must provide a written notification stating so, which the PCM Agency must then submit to the PAU with the cover letter.
   5) In the NEW prior authorization request, the PCM Agency must enter the total units that had been authorized for each line of the current prior authorization, as well as include dates of service that reflect the original start date and the new expiration date of the current prior authorization.
   6) **NOTE:** If the PCM Agency has submitted a Bureau of Special Investigations (BSI) referrals to MassHealth or BSI, the case cannot be terminated for reasons of fraud, unless otherwise specified by MassHealth. PCA fraud must be reported to the MassHealth PCM Agency Contract Manager.

B. PAU downloads termination prior authorization request and distributes to the appropriate Clinical Reviewer.

C. Clinical Reviewer processes the request in accordance with information provided in Section XI (A).

D. PAU voids the new prior authorization request submitted by the PCM Agency and enters the following message as a Provider Comment on the voided prior authorization:
   1) "*Date* Please see PA XXXXXXX for termination on POSC."

E. When terminating the current prior authorization in MMIS, PAU will add 14 calendar days to the date of adjudication to allow for the consumer's receipt of the denial notice and appeal rights, as well as for the FI to process PCA activity forms. The new expiration date of the prior authorization will therefore be 14 calendar days from the date PAU adjusts the current prior authorization.
   1) In those cases where the reason for termination is due to death of consumer, the new expiration date will be the date PAU receives the request to terminate PCA services.

F. PAU terminates current prior authorization in MMIS by changing the expiration date of the prior authorization as stated in (E), and prior authorization notice is forwarded to consumer along with appeal rights, and to the PCM Agency and FI with the following external text message:
   1) "*Date* MassHealth has terminated your PCA services per request of your PCM Agency and has modified the end date of your current PCA prior authorization. Your PCA services will end on XXXX."

G. PAU updates the internal text of the prior authorizatino with the following message:
   1) "*Date* Please see Tracking # XXXXXXX for supporting documentation."

H. The PCM Agency must notify the FI when a request to terminate PCA services is submitted to MassHealth and must also notify the FI when they are made aware that a consumer is deceased, or when a consumer is admitted or discharged to/from an inpatient facility for short or long-term stays.

XII. Calculating Units: When submitting or authorizing PCA prior authorization requests, the responsible entity must calculate units for all procedure codes, ensuring that all PCA hours and minutes are converted into appropriate units. Refer to Transmittal Letter PCA-13, issued October 2002, for further examples.

A. Units for T1019: The PCM Agency must convert the hours and minutes being requested to 15 minute units. For calculation purposes, day/evening units and night units should be calculated separately and then combined for submission on the POSC.

1) **Day Evening units:** In order to calculate day/evening units, the responsible entity will:
    a) Determine day/evening minutes being requested or approved.
    b) Determine day/evening hours per week by dividing by 60 (mathematical conversion from minutes to hours).
    c) If hours per week is not equal to an exact 15 minute increment (0 min, 15 min, 30 min, or 45 min), **round hours per week up to the next 15 minute increment**.
    d) Determine units per week by multiplying rounded day/evening hours per week by 4 (mathematical conversion from hours to 15 minute increments).
    e) Determine total day/evening units by multiplying units per week by total weeks in time period being requested.
        i) A traditional year has 52.14 weeks
        ii) A leap year has 52.28 weeks
    f) If calculated units are not equal to a whole integer (1,2,3…), round up to the next whole unit.
    g) PCA day/evening hours are authorized **per week**. For example, 32 hours and 15 minutes day/evening PCA services per week.
2) **Night units:** In order to calculate night units (midnight to 6:00 AM), the responsible entity will:
    a) Determine total minutes per night being requested or approved.
    b) Determine hours per night by dividing by 60 (mathematical conversion from minutes to hours).
    c) If hours per night are not equal to a whole integer (0,1,2,3…) **round up to the next whole hour**. Note: If hours per night are greater than 0 but less than 2 hours, round up to 2 hours.
    d) Determine units per night by multiplying by 4 (mathematical conversion from hours to 15 minute increments).
    e) Determine total night units by multiplying units per night by total nights per year in time period being requested or approved.
        i) A traditional year has 365 nights.
        ii) A leap year has 366 nights.
    f) PCA night hours are authorized **per night.** For example, 2 hours per night.

3) In order to calculate total units per time period being requested or approved, add day/evening units and night units.
4) If the prior authorization request is for a time period with varying units per week over the duration of the prior authorization, day/evening units and night units should be calculated for each component of the time period and then combined for the total duration of the prior authorization request. For example, if over a 52.14 week time period, the request includes a certain number of minutes for 40 weeks and a different number of minutes for 12.14 weeks, calculate the units for each time period and then combine the units for the total PA period.

B. Calculating Units for T1019 TV (HOLIDAY): When submitting a prior authorization request, the PCM Agency must calculate units for PCA premium pay during holidays. For purposes of the PCA program, applicable holidays are Christmas day, New Year's day, 4th of July and Thanksgiving. These units are for premium pay and should not be deducted from T1019 units.

1) To determine hours per day being requested or approved, divide hours per week by 7 (mathematical conversion from weeks to days).
2) To determine hours per time period, multiply hours per day by number of holidays in prior authorization time period.
    a) For one year prior authorizations, there are 4 holidays
    b) For less than one year prior authorizations, determine which applicable holidays occur during that time period
3) If hours per prior authorization time period do not equal an exact 15 minute increment, round hours per prior authorization time period up to the next 15 minute increment.
4) To determine the number of units per time period, multiply by 4 (mathematical conversion from hours to 15 minute increments).
5) Enter number of T1019 TV units on a separate line on the POSC.

C. Calculating Units for Prior Authorizations in Different Settings: When submitting prior authorization requests for services in different settings (i.e. day habilitation, adult day health, school/college and home/vacation), the PCM Agency must submit separate evaluation forms to support the PCA services requested in each setting.

1) When submitting a prior authorization request for services in different settings, the PCM Agency must complete and submit a separate evaluation form for each setting to support the PCA services requested.
2) The PCM Agency must ensure that the total units and dates on the prior authorization request reflect the sum of all calculated units on each evaluation and the time period in each setting, and clearly detail the

hours/week of day/evening PCA services, hours per night of PCA services, and relevant holiday time being requested.

3) NOTE: Holiday time should be based on when the consumer is home all day, and not in a day program or school setting.

D. Calculating Units for Greater than 1 Year Duration Prior Authorizations:

When the PAU determines that a consumer is eligible for and authorizes a prior authorization for greater than one year as consistent with standard XV, PAU staff must calculate units for the prior authorization period for all procedure codes, ensuring that all PCA hours and minutes are converted into appropriate units.

1) **Units for T1019: Units should be calculated for each 1 year or partial year of the prior authorization as described in Operating Standard XII.A and combined.**
    a) To determine the total number of units in a greater than 1 year prior authorization, add the total number of units in each year or partial year for total number of units for the prior authorization period (e.g. Year 1 + Year 2, or Year 1 + 6 months).
    b) Note: If one of the prior authorization years is a leap year, the number of units will differ for each year.
2) **Units for T1019 TV: Holiday units should be calculated for each 1 year or partial year of the prior authorization as described in Operating Standard XII.B and combined.**
    a) To determine the total number of holiday units in a greater than 1 year prior authorization, add the total number of units in each year or partial year for total number of units for the prior authorization period (e.g. Year 1 + Year 2, or Year 1 + 6 months). For partial years, determine which holidays occur within the time period prior to calculating.
    b) Note: Leap year will not affect holiday units; therefore, Year 1 and Year 2 should have the same number of units, regardless of number of days in a year.

XIII. <u>Letters/Notices</u>: The PAU will ensure that the external message text (6000 message) in prior authorization decision letters/notices generated by MMIS is clear, accurate, understandable for the consumer, PCM Agency, and FI, and that the message accurately reflects Clinical Reviewer's authorization as well as the number of units for T1019, T1019 TV and T1019 TU, as applicable.

A. Upon making a prior authorization decision, the PAU will create clear, legible external message text for the MMIS letter/notice, ensuring the following details are included:
    1) The MassHealth decision (i.e. MassHealth has approved/modified/ denied)
    2) The reason for any modification or denial, including the regulation cite used to modify or deny the request.
    3) The specific ADLs or IADLs modified, if any, and for how many minutes each.
    4) The total day/evening PCA hours/minutes authorized per week
        i. Authorization must be detailed in total hours and total minutes, such as 42 hours and 15 minutes per week, and not utilize decimals.
    5) The night-time PCA hours authorized per night.
    6) The start and end dates of the prior authorization.
    7) The total holiday time (in hours/minutes) authorized during the prior authorization period.
    8) Jury duty or overtime, if authorized.

B. For initial or re-evaluation prior authorization requests, the PAU will authorize the prior authorization request in MMIS, and ensure that the prior authorization notice forwarded to the consumer , PCM Agency and FI includes the date of decision and the following external message text:
    1) Approvals: "*Date* MassHealth has approved your prior authorization request for PCA services. Total PCA hours approved XX hours and XX minutes per week day/evening and XX hours per night. Beginning XXXX and ending XXXX. Total Holiday Time XX hours and XX minutes."
    2) Modifications: "*Date* MassHealth has modified your prior authorization request for PCA services. Your PCM Agency requested XX hours and XX minutes per week (per night). MassHealth is authorizing XX hours and XX minutes per week day/evening and XX hours per night. Beginning XXXX and ending XXXX. Total Holiday Time XX hours and XX minutes." Modifications made to (ADLs/IADLs).
    3) Denials: "*Date* MassHealth has denied your prior authorization request for PCA services. Prior authorization request denied due to XXXX."
    4) Approvals/Denials: "*Date* MassHealth has approved (or modified) your prior authorization request for day/evening PCA services and denied your prior authorization request for night-time hours. Total PCA hours approved XX hours and XX minutes per week day/evening. Beginning XXXX and ending XXXX. Total Holiday Time XX hours and XX minutes. Night services denied due to XXXX."

C. For extension, adjustment, jury duty, overtime, correction or termination prior authorization requests, the PAU will adjudicate the prior authorization request and create the external message text in accordance with the respective PCA Operating Standards.

XIV. <u>Authorizing PAs Greater Than 1 Year Duration:</u> Consistent with proposed changes to MassHealth regulations 130 CMR 422.422 (D)(2), the PAU may, at its discretion, grant prior authorization beyond the usual one-year period for services following a reevaluation in cases meeting specific criteria. Consumers must be age 22 years and older, and meet the criteria described in (B) below to qualify for a PA of greater than one year duration. MassHealth makes the final determination as to the duration of the PA.

A. When submitting a prior authorization request following a re-evaluation, the PCM Agency may request prior authorizations of greater than one year duration in the Provider Comments section of the prior authorization by indicating the requesting duration of the prior authorization (Example: requesting 33 hours per week of PCA services from 5/1/11 to 4/30/13). **NOTE: The PCM Agency is not required to make this request for the PAU to authorize a prior authorization for more than one year duration.**
    1) **If requesting prior authorization for greater than one year duration, the PCM Agency must only include the total units and dates for the duration of 1 year in its PA request.**
    2) **PCM Agencies are asked to discuss this matter with the consumer prior to submission of the prior authorization. Some consumers who meet the criteria in (B) below may still wish to have a prior authorization of one year duration or less, and the PCM Agency and MassHealth will honor this request.**

B. Upon receiving a prior authorization request, the PAU Clinical Reviewer will review the request and authorize a prior authorization of greater than one year duration if the following criteria are met:
    1) The consumer is 22 years of age of older; and
    2) The evaluation is not an initial evaluation; and
    3) The consumer's chronic condition(s) and any associated medical condition(s) are stable, have not deteriorated since the start of the previous prior authorization, and there is no evidence that indicates further medical intervention is warranted at the time the new prior authorization request is under review.
    4) NOTE: The PAU will authorize a prior authorization of greater than one year duration even if the PCM Agency has not requested it and there is no documentation that the consumer wants only prior authorization for one year or less.

C. If the PAU Clinical Reviewer determines a prior authorization of greater than one year duration is appropriate, the PAU Clinical Reviewer will modify the prior authorization request to adjust the units and dates requested, and generate a prior authorization notice to the consumer PCM Agency, and FI with the following external text message:
    1) "*Date* MassHealth approves/modifies your prior authorization request for PCA services. Total PCA hours approved XX hours and XX minutes per

week day/evening and XX hours per night. Beginning XXXX and ending XXXX. Total Holiday Time XX hours and XX minutes."

XV. <u>No Change Forms:</u> To streamline the prior authorization submission process for those consumers who have had no change in the number of PCA hours, the PCM Agency may use the MassHealth Re-evaluation Form (No Change).

A. When submitting a prior authorization request for PCA services where the consumer's prior authorization is due to expire, and the prior authorization request is for the same number of PCA hours per week and per night that MassHealth had authorized at the start date of the current prior authorization, the PCM Agency may utilize the MassHealth Re-evaluation Form (No Change).
   1) PCM Agencies should not utilize the No Change process for those consumers who are medically unstable, utilizing continuous skilled nursing services, or newly receiving skilled nursing visits.

B. When submitting a No Change prior authorization request, the PCM Agency must include:
   1) The completed *MassHealth Application to Request Prior Authorization for PCA Services*
   2) The completed and signed *MassHealth Re-Evaluation for PCA Services "NO CHANGE"* form
   3) For consumers who receive less than 24/7 residential supports funded by the Department of Developmental Services (DDS), the DDS PCA Referral forms as required by the DDS/EOHHS ISA.
   4) For consumers who receive residential supports (including 24/7) funded by a state agency other than DDS, a copy of the vendor contract.

C. The PCM Agency should not submit the full *MassHealth Re-Evaluation for PCA Services* form. If this form is submitted, the PAU will review the request as a standard reevaluation request and not as a "No Change" request.

D. The PAU Clinical Reviewer will review and authorize the "No Change" request based on the documentation provided by the PCM Agency and not on the evaluation form submitted the year prior, in accordance with the *No Change Clinical Review Process Guidelines* (Appendix I).

E. Unless otherwise requested by the PCM Agency and consumer, the PAU will authorize all "no change" prior authorization requests for greater than one year duration, in accordance with Operating Standard XIV: Authorizing Prior Authorizations Greater Than 1 Year Duration.

XVI. **<u>Overlapping Prior Authorizations:</u> Consumers must have only one active PCA prior authorization per time period or for specific dates of service. Under no circumstances should a consumer have PCA prior authorizations that overlap dates, as this causes confusion related to appropriate services to be provided, as well as billing and claim issues.**

A. Upon receiving a prior authorization request, the PAU Clinical Reviewer will review any current PCA prior authorizations for the consumer, including dates of service, and ensure that authorization of the new PA request will not result in overlapping prior authorizations.

B. If the prior authorization request would result in an overlap of service dates, the PAU Clinical Reviewer will contact the PCM Agency designee to discuss the request and inform and determine what dates of service should be modified (either the end date of the current prior authorization, or the start date of the new request).

C. Upon determining which prior authorization(s) will be modified, the PAU Clinical Reviewer will adjudicate the new prior authorization request and authorize the PCA services determined to be medically necessary.

D. If the FI or PCM Agency determines that a consumer has been issued two prior authorizations with overlapping dates of service, the FI or PCM Agency must notify the PAU via PCAinfo@umassmed.edu.

XVII. <u>Appeals/Hearings:</u> When a consumer disagrees with a PAU decision on a prior authorization request, the consumer has the right to request a fair hearing on the decision in accordance with Board of Hearings (BOH) regulations at 130 CMR 610.000 by submitting the Fair Hearing Request Form that is provided with the consumer's MMIS prior authorization notice to the BOH in the timeframes specified in the BOH regulations. The PAU must implement aid pending in accordance with BOH regulations, as well as implement the BOH final decision, as appropriate.

A. "Aid Pending": 130 CMR 610.036 Continuation of Benefits Pending Appeal. When the appealable action involves the reduction, suspension, termination, or restriction of assistance, such assistance will be continued until the Board of Hearings decides the appeal or, where applicable, the rehearing decision is rendered if the Board of Hearings receives the initial request for the fair hearing before the implementation date of the appealable action.

When a consumer appeals a decision by MassHealth to modify, reduce or deny a request for PCA services, and the consumer is authorized to receive PCA services at the time of MassHealth's decision, MassHealth must continue to provide PCA services at the amount authorized prior to the modification/denial if:

- The BOH receives the initial request for a fair hearing before the implementation date of the appealable action; or
- The appealable action was implemented before a timely request for a hearing and the BOH receives the request for a fair hearing within 10 days of the MassHealth/PAU mailing of the notice of appealable action.
- **Note:** Aid pending remains in place until such time as the BOH renders a written decision to MassHealth or the hearing request is withdrawn or dismissed.

1) Upon notification from the BOH that an appeal has been filed, the PAU Appeals Unit will inquire as to when the request for the fair hearing was received by BOH.
    a) If the appealable action was implemented before a timely request for a hearing, and the BOH received the request for the hearing within 10 days of the mailing of the PAU/MassHealth decision notice, or if the BOH received the fair hearing request prior to the implementation date of the appealable action, the PAU Appeals Reviewer will implement "aid pending."
    b) The PAU Appeals Reviewer will modify the appealed prior authorization to reflect the previous level of PCA services if the previous level of PCA services is greater than the appealed prior authorization decision, and generate a prior authorization notice to the consumer, PCM Agency and FI with the following external text message:

i) "*Date* MassHealth is modifying the appealed prior authorization for PCA services to implement aid pending per Board of Hearings regulations at 130 CMR 610.036 until such time as a written decision is rendered by the Board of Hearings. Approve XX hours and XX minutes per week day/evening and XX hours per night. Increase in Holiday Time included: XX hours and XX minutes (covers XXXX holidays). Beginning XXXX and ending XXXX. Total dates of service beginning XXXX and ending XXXX. Implementation of aid pending is not an appealable action with the Board of Hearings."

c) Note: "Aid pending" for adjustment requests will only be implemented in cases where the PAU receives a request for an adjustment in PCA hours that results in a decision by the PAU to authorize less than the previous number of PCA hours and the conditions in XVII (A) are met. The effective date of the "aid pending" for an adjustment will be the date the adjustment request was received by the PAU.

B. Adjustment & Re-Evaluation Requests: If a prior authorization is pending appeal with the BOH or pending a decision from the BOH, and the PCM Agency submits either an adjustment or re-evaluation request, the PAU Clinical Reviewer will review the request to ensure a decision should not be made prior to the hearing date.

1) When a prior authorization is pending appeal or decision from the BOH, and the PCM Agency submits an adjustment request to the PAU:
   a) If there is new information not previously submitted to the PAU, such as a documented change in the medical condition or living situation of the consumer, the PAU Clinical Reviewer will review the request based on medical necessity.
      i) If the PAU decision results in an amount equal to or more than the number of PCA hours authorized (including as "aid pending"), the PAU will adjudicate the adjustment request and implement its decision effective the date the adjustment request was received.
   b) If there is no new information provided and the decision may result in less PCA hours than what is authorized (including "aid pending") the PAU Clinical Reviewer will delay the review of the prior authorization and defer the request back to the PCM Agency, in accordance with Operating Standard X: Deferrals, and specify that the PAU is awaiting results of the BOH decision prior to adjudicating the prior authorization request.
2) When a prior authorization is pending appeal or decision from the Board of Hearings, the prior authorization is due to re-evaluation) to the PAU:
   a) If the new prior authorization (re-evaluation) request is for equal to or greater than the prior authorization amount (including "aid pending"), the PAU Clinical Reviewer will review the request.

i) If the PAU Clinical Reviewer determines the number of medically necessary PCA hours to be less than the appealed prior authorization amount (including "aid pending"), the PAU Clinical Reviewer will delay the review of the prior authorization and will defer the request back to the PCM Agency, in accordance with Operating Standard X: Deferrals, and specify that the PAU is awaiting results of the BOH decision prior to adjudicating the prior authorization request.

1. The PAU Appeals Reviewer will extend the appealed prior authorization until such time as the BOH renders a decision.

ii) If the PAU Clinical Reviewer determines the number of medically necessary PCA hours to be equal to or greater than the current prior authorization amount (including "aid pending"), the PAU will adjudicate the prior authorization and send notice to the consumer, FI, and PCM Agency, in accordance with Operating Standard XIII: Letters/Notices.

b) If the new prior authorization (re-evaluation) request is for less than the appealed prior authorization amount (including "aid pending"), the PAU Clinical Reviewer will not review the new prior authorization, and the prior authorization will remain in "In Review" status, until after the BOH has rendered a decision on the current prior authorization.

i) The PAU Appeals Reviewer will extend the appealed prior authorization until such time as the BOH renders a decision.

C. Pre-Hearing Agreements: Prior to the BOH appeal, the PAU may review the prior authorization documentation and/or new clinical information, discuss the case with the consumer and agree to a change in the previous prior authorization decision, resulting in a withdrawal of the appeal.

1) Following a pre-hearing agreement and withdrawal of an appeal, the PAU Appeals Reviewer will generate a prior authorization notice to the consumer, PCM Agency and FI with the following external text message:

a) "*Date* Appeal # XXXX, Per pre-hearing agreement with consumer dated XX/XX/XX, approve XX hours and XX minutes of day/evening PCA services per week and XX hours of PCA services per night, beginning XXXX and ending XXXX. Modifications restored XXXX. Total Holiday Time XX. Withdrawal of an appeal prior to the appeal date finalizes the appeal process. This is not an appealable action."

b) If the pre-hearing agreement results in a decrease in hours for the consumer, the effective start date of the adjusted prior authorization should be on a Sunday, and at least 14 calendar days after the pre-hearing agreement date.

c) If the pre-hearing agreement results in an increase in hours for the consumer, the effective start date of the adjusted prior authorization should be retroactive to the start date of the prior authorization (per

Fair Hearing Regulations 130 CMR 610.071) and effective from the start date through the period covered by the prior authorization request.

D. Change in Prior Authorization Decision & Withdrawal at BOH Appeal: During the BOH hearing, the PAU Appeals Reviewer may review new documentation/clinical information, or consider new information presented during oral testimony by the consumer/appeal representative, that results in the PAU Appeals Reviewer changing the prior authorization decision and the consumer withdrawing the appeal.

1) Following an agreement during the hearing between the BOH, PAU Appeals Reviewer and the consumer, and resulting in withdrawal of the appeal, the PAU Appeals Reviewer will generate a prior authorization notice to the consumer, the PCM Agency, and the FI, with the following, external text message:
    a) "*Date* Appeal # XXXX, Hearing date XX/XX/XX, consumer withdrew at the appeal. Approved XX hours and XX minutes of day/evening PCA services per week and XX hours of PCA services per night, beginning XXXX and ending XXXX. Modifications restored XXXX. Total Holiday Time XX hours and XX minutes. Withdrawal of an appeal during the appeal process finalizes the appeal. This is not an appealable action."

E. Hearing Decisions: Following the BOH decision on a PCA appeal, the PAU must implement the BOH's hearing decision and adjust the consumer's prior authorization for PCA services, as appropriate, and send notice to the consumer, PCM Agency and FI.

1) Upon receipt of a written hearing decision from the BOH, the PAU Appeals Reviewer will review the decision to determine if the consumer's PCA prior authorization needs to be adjusted to implement the BOH decision, and to determine the effective date of the BOH decision.
2) If the PCA prior authorization does not require adjustment due to the BOH decision, and the amount granted for aid pending needs to remain in place, the PAU Appeals Reviewer will generate a prior authorization notice to the consumer, PCM Agency and FI with the following external text message:
    a) "*Date* Per Board of Hearings decision dated XX, appeal # XX, PCA services currently authorized will remain in place. XX hours and XX minutes per week day/evening and XX hours per night, beginning XXXX and ending XXXX. Total Holiday Time XX hours and XX minutes. Board of Hearings decisions are not an appealable action to the Board of Hearings."
3) If the PCA prior authorization requires adjustment due to the BOH decision, the PAU Appeals Reviewer will adjust the appropriate prior authorization line items, units, and/or dates on the prior authorization,

and generate a prior authorization notice to the consumer, PCM Agency and FI with the following external text message:

a) "*Date* Per Board of Hearings decision dated XX, appeal # XX, PCA services authorized for XX hours and XX minutes per week day/evening and XX hours per night, beginning XXXX and ending XXX. Total Holiday Time XX hours and XX minutes. Board of Hearings decisions are not an appealable action to the Board of Hearings."

b) Unless otherwise stated in the BOH written decision, if the BOH decision results in a decrease in hours for the consumer, the effective start date of the adjusted prior authorization should be on a Sunday, and at least 14 calendar days after the BOH decision date.

c) If the BOH decision results in an increase in hours for the consumer, the effective state date of the adjusted prior authorization should be retroactive to the start date of the prior authorization (per Fair Hearing Regulation 130 CMR 610.071) and effective from the start date through the period covered by the prior authorization request.

4) The PAU staff (operational) will upload the decision to the appropriate prior authorization in MMIS for future reference.

NOTE: PCM Agencies should continue their re-evaluation process as usual, regardless of the timing of scheduled hearings or hearing decisions.

XVIII. <u>Identifying Duplication of Services:</u> MassHealth pays for medically necessary services in accordance with 130 CMR 450.204. When submitting or authorizing PCA prior authorization requests, the PCM Agency or PAU must make every effort to ensure PCA services are medically necessary and are not requested or authorized for times that the member is participating in other MassHealth programs as described in 130 CMR 422.412 (D) (E), or that the PCA services being requested are not otherwise provided through another service provider or payer.

A. PCM Agencies must ensure all necessary documentation is completed and submitted with the PCA prior authorization request.

1) The PCM Agency must submit necessary documentation to allow the PAU to ensure there is no duplication of services. The PCM Agency must submit the *MassHealth Application for PCA Services (PCA-1)* form, and the completed and signed *MassHealth Evaluation for PCA Services (PCA-2)* form.
    a) Both forms must be fully completed.
    b) "Yes" or "No" responses must be recorded for check boxes within **Section IV: In-Home Services** and **Section V: Out-of-Home Activities** of the PCA-1 form.
        i. If the response is "yes," additional information must be provided.
    c) The application must denote other services the consumer is receiving including the service type, agency providing the service and contact information, level of service and frequency of service.
2) It is the PCM Agency responsibility to:
    a) Inquire with the consumer regarding other services received
    b) If other services are identified, utilize that information when conducting the PCA evaluation
    c) Provide documentation on the PCA evaluation that demonstrates there is no duplication of services for the consumer
    d) Include additional documentation with the PCA prior authorization request, as appropriate. The *Standard Documentation to Include with a Prior Authorization Request for Personal Care Attendant (PCA) Services* document outlines when additional documentation is required and what documentation must be submitted to support the consumer's medical necessity for PCA services. The updated list of standard documentation is available at www.mass.gov/masshealthpubs.
3) **Note:** Refer to Operating Standard XV: No Change Forms for documentation requirements for this streamlined prior authorization submission process.

B. PAU Clinical Reviewers must review evaluations and attached documentation to ensure there are no duplicative services being requested in the PCA prior authorization request.

1) If upon reviewing a PCA prior authorization request, the PAU Clinical Reviewer identifies possible duplication of services due to incomplete or missing information within the evaluation or supporting documentation, the PAU Clinical Reviewer will defer the prior authorization request consistent with Operating Standard X: Deferrals.
2) If the documentation submitted by the PCM Agency clearly documents duplication of services, the PAU will modify the prior authorization request and provide the reason for the modification in the message text of the prior authorization notice.

XIX. <u>Reporting Surrogate Changes:</u> Consistent with MassHealth regulations 130 CMR 422.422 (B)(5) regarding Surrogates, the PCM Agency must provide the MassHealth agency and the FI with the name, address, and phone number of the consumer's surrogate, and report any changes in surrogate information.

A. The PCM Agency must conduct a written assessment of the consumer's capacity to manage PCA services independently. A full assessment must be conducted before submitting an initial prior authorization request to MassHealth, and the assessment must be reviewed and modified, as appropriate, at the time of consumer's re-evaluation; if the consumer's medical/cognitive/ emotional condition changes in a way that affects the consumer's ability to manage PCA services; or if the FI or MassHealth requests the assessment to be reviewed.
    1) A full assessment is not required if the consumer has a legal guardian or is a minor. All consumers who are minors or who have legal guardians must have a surrogate.

B. When a PCM Agency assessment determines that a consumer requires a surrogate to manage some or all of the PCA tasks, or if the consumer has a court-appointed legal guardian or is a minor child, and the consumer or legal guardian cannot identify a surrogate, the PCM Agency will assist the consumer or legal guardian in selecting a surrogate.

C. The PCM Agency must complete all appropriate surrogate information on Page 5 of the *MassHealth Evaluation for PCA Services* form and Section II of the *MassHealth PCA Re-evaluation (No Change)* form when submitting a prior authorization request.

D. The PCM Agency must maintain the surrogate's name, address, telephone number and relationship to the consumer in the consumer's record and forward a copy of the information to the FI, and forward any updates to the FI should a consumer's surrogate information change.

E. The PCM Agency must notify the PAU of any surrogate changes listed below that occur during a prior authorization year by e-mailing the PAU at PCAinfo@umassmed.edu (enter SURROGATE CHANGE in the subject line), with a copy to the FI. The e-mail must include:
    1) Consumer Name
    2) Current Prior Authorization #
    3) Surrogate Name
    4) Surrogate Address
    5) Surrogate Telephone Number
    6) Surrogate Relationship to the consumer

F. PAU staff (operational) will document the Surrogate Change and surrogate related information in the Provider Comments section in MMIS. A letter/notice will <u>not</u> be generated.

G. **NOTE:** If the Surrogate information is not fully completed in either of the PCA evaluation forms (i.e. boxes are left unchecked or information is missing), the PAU will defer the prior authorization request, in accordance with Standard X: Deferrals.

XX. <u>Circumstances Under Which PAU Conducts Home Visits:</u> As part of the PAU scope of work, PAU Clinical Reviewers may conduct home visits independently or with PCM Agencies.

A. PAU Initiates Home Visit: The PAU Clinical Reviewer may initiate a home visit as a means of gathering additional information to make a determination on medically necessary PCA services or to observe the PCM Agency evaluation process.

1) Situations where a home visit to gather additional information that will benefit the PAU's medical necessity review:
    a) Consumer has a high volume of appeals on PCA services.
    b) Consumer has significant residential supports from other agencies.
    c) PCM Agency has requested a significant increase in hours without a documented change in the consumer's medical condition or living situation.
    d) Calls/complaints from the consumer or external parties (political, legal, other state agencies) regarding the level of services being authorized or utilized.
2) Situations that may require observation of the PCM Agency evaluation process:
    a) PAU Clinical Reviewer new hire training/orientation.
    b) PAU Clinical Reviewer annual training curriculum.
3) Trends/patterns in prior authorization requests for a specific PCM Agency.
4) PAU will collaborate with MassHealth and the PCM Agency to coordinate home visits so that all parties are aware of the intent of the home visit. Under no circumstances will there be an interruption of services for the consumer.

B. PCM Agency Initiated Requests For PAU To Conduct Home Visits: The PCM Agency may initiate a request for the PAU to complete a home visit as a means to better understand the PAU rationale for decisions.

1) Cases with repeated modifications year after year (repeated prior authorization requests that are continually modified).
2) Complex cases in which the determination of medical necessity has been difficult.
3) Calls/complaints from the consumer or external parties (political, legal, state agency) regarding level of services being authorized or utilized.
4) Situations where there are questions related to the appropriateness of PCA services versus skilled nursing service.
5) PAU will collaborate with MassHealth and the PCM Agency to coordinate home visits so that all parties are aware of the intent of the home visit. Under no circumstances will there be an interruption of services for the consumer.

XXI. <u>Passive Range Of Motion (PROM) Requests:</u> As part of the initial evaluation, re-evaluations, and adjustments, PCM Agencies may request time for passive range of motion (PROM) assistance when it is medically necessary (see 130 CMR 422.402, 130 CMR 422.410(A)(5), and 130 CMR 450.204). PCM agencies must include documentation to support medical necessity in the PCA evaluation and the PAU will evaluate the request on a case by case basis.

A. <u>When a PCM Agency initiates a request(s) for time for PROM:</u> PCM Agencies may submit documentation supporting PCA time for PROM when requesting prior authorization for PCA services as part of the consumer's initial evaluation, re-evaluation, or as an adjustment to an existing prior authorization.

1) The documentation for time for PROM, as with all ADLs, must include documentation to support the medical necessity of the request in accordance with 130 CMR 422.416 and the *List of Standard Documentation to Include with a Prior Authorization Request for PCA Services*.
2) To request PCA time for PROM, the PCM Agency must complete the Passive Range of Motion section on the *MassHealth Evaluation for Personal Care Attendant (PCA) Services,* or, if requesting an adjustment, enter "PROM" as an ADL on the *MassHealth PCA Prior Authorization Adjustment* form, and include the following information, specifying Upper Extremities (UE) and/or Lower Extremities (LE), as applicable:
   a) PCA time (min: number of minutes for UE's and number of minutes for LE's.): as determined through the PCM Agency evaluation.
   b) Frequency (number of times per day and number of days per week): as determined through the PCM Agency evaluation.
   c) Total minutes per week: as calculated by multiplying PCA time in minutes by frequency per day or week.
3) Comments regarding the PROM assistance must be noted as part of the evaluation. Comments specific to PCA PROM assistance will include, as applicable, considerations listed for PROM in the *Time For Task Guidelines for the MassHealth PCA Program*. **Please refer to the *Time For Task Guidelines for the MassHealth PCA Program* prior to completing any evaluation for current guidance.** As a reminder, these considerations include, as applicable, the following:
   a) Functional ability (A member may have partial range of motion (as documented in the evaluation); however, PROM PCA assistance and time may only be requested for the range of motion that is dependent.)
   b) Severity of symptoms/diagnosis
   c) Contractures/spasms
   d) Level of pain (including, as necessary, information about the use of PROM to alleviate pain and/or tightness)
   e) Height and weight
   f) Age

g) Other therapy services provided
h) Skin integrity
i) Additional medical equipment (e.g., G-tube, urological equipment, oxygen tank)
j) Effects of mental status and/or level of member's cooperation with activity

4) Additional considerations that are relevant to PCA PROM assistance should either be addressed along with the Comments noted in 3) above or should be included in other sections of the evaluation. These considerations include:
   a) ADL ability: If the evaluation documents ADL abilities that could be interpreted as inconsistent with the medical necessity for PCA PROM assistance, clinical rationale for PCA PROM assistance should be included in the comments section of the evaluation for PROM.

   The PCM Agency may attach additional sheets of paper to the *MassHealth Evaluation for Personal Care Attendant (PCA) Services,* or the *PCA Prior Authorization Adjustment* form as necessary to provide justification for the medical necessity for PCA PROM assistance.

B. **The PAU will determine medical necessity of PCA PROM assistance based on all documentation submitted (as noted in A. 1)-5) above). Based on this determination, the PAU will approve, modify or deny the prior authorization request for PCA PROM assistance.**

XXII. <u>PCA Prior Authorization Requests for Consumers Who Receive Residential Supports</u>: Some PCA consumers may receive residential supports provided by a vendor who is under contract with another state agency, such as the Department of Developmental Services (DDS), Massachusetts Rehabilitation Commission (MRC), Department of Mental Health (DMH), or Department of Children and Families (DCF). Residential supports may be provided on a 24 hour/7 day per week basis, or may be provided less than 24/7. Residential supports may include assistance with activities of daily living or instrumental activities of daily living, and it is therefore critical that the PCM Agency obtain documentation from the vendor or the state agency that describes the services provided under the residential supports contract. This information is needed in order for the PAU to determine medical necessity in accordance with 130 CMR 450.204(A)(2).

When a PCM Agency receives a referral for a consumer who is receiving residential supports, the PCM Agency should first inquire as to which state agency is funding the provision of residential supports. This operational standard describes what documentation the PCM Agency must submit when requesting prior authorization for PCA services for consumers who receive residential supports, based on which state agency is funding the residential supports.

To streamline documentation required when a consumer receives residential supports, MassHealth has worked with DDS to develop forms that DDS and PCM Agencies must use when PCA services are being requested. The standards below describe which forms must be used, and when the forms need to be used. Copies of the forms are included in Appendix II of these operating standards.

A. PA requests for Consumers who are DDS eligible and receiving DDS-funded residential supports:

1) Consumers who are DDS eligible and receive 24/7 DDS-funded residential supports are not eligible to receive MassHealth PCA services.
    a) The PCM Agency should therefore not request prior authorization for PCA services for these consumers.
    b) MassHealth has entered into an Interagency Service Agreement (ISA) with DDS for these consumers, and DDS is responsible for the provision of all ADLs and IADLs.
2) Consumers who are DDS eligible and receive less than 24/7 DDS-funded residential supports may be eligible to receive PCA services, provided there is no duplication of services.
    a) PCM Agencies must obtain the following forms from DDS and submit to the PAU along with the prior authorization request.
        i) *DDS PCA Referral Form* (Appendix III), completed and signed by the DDS Service Coordinator, DDS Area Director and PCM Agency.

ii) *DDS PCA Contract Summary Form* (Appendix IV), completed and signed by DDS Area Director and the DDS ISA contracts Officer.

b) These forms must be complete, signed and made available to the PCM Agency RN to review as part of the evaluation for PCA services.

c) Services funded through DDS and their residential providers must be identified and documented in the *MassHealth Application to Request Prior Authorization for PCA Services* and considered in the evaluation for PCA services. The PCM Agency RN must ensure the time requested for PCA services is not duplicative of the services funded through the DDS.

B. PA requests for consumers who are Developmentally Disabled (DD), but NOT DDS eligible, including "Rolland" class members receiving DDS/ MRC residential supports.

1) Rolland DD individuals who move into 24/7, DDS/MRC funded and operated residential settings, and who are not eligible for DDS services, can request prior authorization for PCA services, provided there is no duplication of services.

a) Although not DDS eligible, Rolland DD individuals are assigned a DDS Service Coordinator (SC) to coordinate the provision of residential and day supports.

b) Rolland DD individuals who are transitioning from a nursing facility to the community receive care coordination through UMMS Transitional Case Management (TransCM) during the first year of the consumer's transition to the community.

c) TransCM is responsible for coordinating and authorizing all MassHealth community long term care services during this period. If the consumer requires PCA services, TransCM will conduct the PCA initial evaluation and will notify the consumer and the PCM Agency of its decision.

i) To determine medical necessity for PCA services, MassHealth, UMMS, and DDS have developed the *Personal Care Attendant Contract Summary Form - for DD (Not DDS Eligible) Rolland Class Members Receiving DDS 24/7 Residential Supports* (Appendix V).

d) Prior to the Rolland DD consumer's transition from a facility to a 24/7 DDS operated residence, the DDS Service Coordinator (SC) must complete the *Personal Care Attendant Contract Summary Form for DD (Not DDS Eligible) Rolland Class Members Receiving 24/7 Residential Supports* (Appendix V). Upon approval from DDS, the DDS SC will submit the completed form to TransCM to be included in the initial evaluation for PCA services.

2) Prior to expiration of the PCA prior authorization and disenrollment from TransCM (one year post facility transition), the PCM Agency will conduct a PCA re-evaluation.
    a) PCM Agency must obtain the following form and information from the funding state agency (if not already received) [1] and submit to the PAU as required documentation, along with the prior authorization request for PCA services.
        i) *PCA Contract Summary Form For DD (Not DDS Eligible) Rolland Class Members Receiving DDS 24/7 Residential Supports* - completed and signed by all of the noted parties.
        ii) If not indicated in the contract summary, a list of services provided by the residential services provider and provider's staffing schedule.
    b) PCM Agency must ensure that required forms are complete, signed, and made available to the PCM Agency RN for review as part of the evaluation for PCA Services.
    c) PCM Agency must document all services funded through DDS or the state agency in the *MassHealth Application to Request Prior Authorization for PCA Services* and consider these services in the evaluation for PCA services.
    d) The PCM Agency RN must ensure the time being requested for PCA services is not duplicative of the services funded through the state agency and consideration of such must be documented in the evaluation for PCA services.
    e) PCM Agency must consider the following, at a minimum:
        i) IADLs, such as laundry, food shopping, housekeeping, etc., are included as responsibilities in 24/7 contracts, and PCA time may not be allowed for these tasks because they would duplicate services provided by the residential services provider.
        ii) Medication assistance and assistance with medical appointments are generally the responsibility of the residential services provider and PCA time may not allowed for these tasks.
        iii) PCA overnight services will not be approved in cases where there is awake, staffing coverage in the residential contract, except in cases where there is a medical need, such as a two

[1] *PCA Contract Summary Form For DD (Not DDS Eligible) Rolland Class Members Receiving DDS 24/7 Residential Supports*
    a) Signed by the DDS Service Coordinator, and approved and signed by the DDS Area Director and DDS Central Office staff.
    b) DDS Central Office staff sends the form directly to TransCM for initial requests for PCA services, and to PCM Agency (for re-evaluations and adjustments) one year post facility transition after the first year of PCA services).

person lift is required and only one overnight staff is available.

3) PCM Agency will submit the completed and signed *Personal Care Attendant Contract Summary Form for DD Individuals* as required documentation with the prior authorization request.
    a) If the *Personal Care Attendant Contract Summary Form for DD Individuals* is not submitted, the PAU will not be able to determine medical necessity and may defer, or ultimately deny if not received, the prior authorization request.
4) PAU receives the prior authorization request and required documentation and will:
    a) Review to determine if there is any evidence of duplication of services and authorize the prior authorization accordingly.
    b) Defer the prior authorization if any required documentation is missing, including the *Personal Care Attendant Contract Summary Form for DD Individuals,* in accordance with Operating Standard X: Deferrals.

C. Prior authorization requests for PCA services for consumers who are receiving residential supports funded by DMH or MRC. MassHealth is in the process of working with MRC and DMH to develop forms that are similar to those used by DDS for MRC and DMH consumers who are receiving residential supports. In the interim, until such forms are developed, PCM Agencies and PAU must follow this standard for these consumers.

1) Residential supports provided by residential services providers under contract with DMH or MRC may be provided on a 24/7 week basis, or may be provided less than 24/7. These contracts may require the residential services provider to provide support to consumers that includes assistance with ADLs and IADLs. The PCM Agency must obtain documentation from the residential services provider or the state agency that describes the services provided under the residential supports contract. DMH or MRC consumers receiving residential supports may be eligible to receive PCA services, provided there is no duplication of services.
2) PCM Agency must identify the funding agency and obtain the following information and documents, with appropriate signatures, either from that agency or the provider responsible for providing contracted services to the consumer. The following must be submitted to the PAU along with the prior authorization request for PCA services:
    a) Signed copy of the state agency's contract with the provider providing services to the consumer requesting PCA services.
    b) If not indicated in the contract summary, a list of services provided by the state agency's provider and provider's staffing schedule.

3) PCM Agency must ensure that required forms are complete, signed, and made available to the PCM Agency RN for review as part of the evaluation for PCA Services.
4) PCM Agency must document all services funded through the state agency in the *MassHealth Application to Request Prior Authorization for PCA Services* and consider these services in the evaluation for PCA services.
5) The PCM Agency RN must ensure the time being requested for PCA services is not duplicative of the services funded through the state agency and consideration of such must be documented in the evaluation for PCA services.
6) PCM Agency must consider the following, at a minimum:
    a) IADLs, such as laundry, food shopping, housekeeping, etc., are included as responsibilities in 24/7 residential services contracts, and PCA time may not be allowed for these tasks because they would duplicate services provided by the residential services provider.
    b) Medication assistance and assistance with medical appointments are generally the responsibility of the residential services provider and PCA time may not allowed for these tasks.
    c) PCA overnight services will not be approved in cases where there is awake, staffing coverage in the residential contract, except in cases where there is a medical need, such as a two person lift is required and only one overnight staff is available.
7) PCM Agency will submit the completed and signed contract documentation as required documentation with the prior authorization request.
    a) If the contract documentation is not submitted, the PAU will not be able to determine medical necessity and may defer, or ultimately deny if not received, the prior authorization request.
8) PAU receives the prior authorization request and required documentation and will:
    a) Review to determine if there is any evidence of duplication of services and authorize the prior authorization accordingly.
    b) Defer the prior authorization if any required documentation is missing, including the contract documentation, in accordance with Operating Standard X: Deferrals.

XXIII. <u>Special Kids Special Care & PCA Services</u>: The Department of Children and Families (DCF) and MassHealth cosponsor a program, Special Kids Special Care (SKSC) to enroll certain children in foster care who have special health-care needs into Neighborhood Health Plan (NHP), a health plan that contracts with MassHealth. NHP authorizes a full range of medically necessary services to be delivered in the child's foster home or other appropriate settings. For children in SKSC, a nurse practitioner from NHP works with the DCF case manager, the DCF family resource worker, the foster family, and the primary-care physician to develop an individualized medical-care plan, arrange for the child to obtain the necessary care and services, and monitor the child's health care needs 24 hours a day, including medically necessary home-health services, durable medical equipment, and medical supplies. PCM Agencies and PAU Clinical Reviewers must consider all home health services authorized through SKSC to ensure there is no duplication of services with the PCA services requested or authorized.

A. Prior to conducting an evaluation for a child in SKSC, the PCM Agency will:
   1) Confirm that the child is in SKSC via the Provider Online Service Center. Please refer to the *MMIS Job Aid: Verify Member Eligibility for Special Kids Special Care Program* (Appendix VI).
   2) Obtain a copy of the child's authorization to release information and submit to the contact at NHP (Priscilla Meriot at 1-888-897-8947 or Priscilla_Meriot@NHP.org)
   3) Obtain and review the DCF Individual Care Plan from NHP, as required in the *Standard Documentation to Include with a Prior Authorization Request for Personal Care Attendant (PCA) Services*.
      a) The DCF Individual Care Plan lists all services being utilized (including continuous skilled nursing), who is providing each service, schedule of when the services are being provided, and name and contact information for the nurse practitioner approving the service and providing case management for the child if needed.

B. As part of the evaluation process for a child in SKSC, and prior to submitting the prior authorization request and required documentation, the PCM Agency will:
   1) Identify the schedule of services currently provided to the consumer/child and document this information in "Section IV: In Home Services" on page 2 of the *MassHealth Application to Request Prior Authorization for PCA Services.*
   2) Ensure that the PCA services requested do not duplicate services provided through SKSC.

C. Upon receipt of a prior authorization request for a child in foster care, identified as "Dept. Of Children and Families (DCF) foster care" on page 1 of the *MassHealth Application to Require Prior Authorization for PCA Services,* the PAU Clinical Reviewer will:

1) Review the most recent enrollment list for SKSC received from the PAU Associate Director to determine if the consumer/child is enrolled.
2) If the consumer/child is enrolled in SKSC, ensure there is not any duplication of services when determining the medically necessary amount of PCA services to authorize.
    a) The PAU Clinical Reviewer must review the DCF individual Care Plan and schedule of services documented in "Section IV: In Home Services" on page 2 of the *MassHealth Application to Request Prior Authorization for PCA Services"* to confirm when services are provided to the consumer/child.
    b) PCA services requested during the times in which continuous skilled nursing (CSN) services are scheduled in the home are considered to be duplicate and should not be authorized.

XXIV. <u>Authorizing Prior Authorizations for Less Than 1 Year Duration</u>: The PAU may, at its discretion, grant prior authorization for less than the usual one-year period. MassHealth is responsible for determining the length of the prior authorization, in accordance with 130 CMR 422.417(A).

A. Upon receiving a prior authorization request for PCA services for a consumer, the PAU Clinical Reviewer will review the request and may authorize a prior authorization of less than one year duration (6 month period) if the consumer's chronic condition(s) and any associated medical condition(s) may result in a functional improvement or decline (as assessed based on diagnosis and supporting documentation) and impact the ability to perform ADL's.

B. If the PAU Clinical Reviewer determines a prior authorization of less than one year duration is appropriate, the PAU Clinical Reviewer will modify the prior authorization request to adjust the units and dates requested, and generate a prior authorization notice to the consumer, PCM Agency, and FI, with the following external text message:
   1) "*Date* MassHealth approves/modifies your prior authorization request for PCA services. Total PCA hours approved XX hours and XX minutes per week day/evening and XX hours per night. Beginning XXXX and ending XXXX. Total Holiday Time XX hours and XX minutes."

C. Prior to expiration of the prior authorization, the PCM Agency may submit a re-evaluation and prior authorization request if the PCM Agency assesses the consumer to need ongoing assistance with ADL's.
   1) A new application and full evaluation must be submitted at this time.
   2) An extension will not be granted to extend the previous prior authorization to the full year duration in lieu of a re-evaluation.

XXV. <u>Voided Prior Authorizations:</u> In addition to the void processes followed in Operating Standard I: Extensions and Operating Standard III: Adjustments, the PAU may void prior authorization requests when documentation (PCA application, PCA evaluation, etc) for another consumer is inadvertently attached to another consumer's prior authorization request.

A. Upon determining that a PCM Agency inadvertently submitted documentation for another consumer to a different consumer's prior authorization request, the PAU Clinical Reviewer will void the prior authorization request and request submission of a new prior authorization.
    1) **NOTE:** Voided prior authorization does not generate a notice or right to appeal letter to the consumer.

B. The PAU Clinical Reviewer will contact the PCM Agency and notify the specified contact person and ask them to submit a new prior authorization and inform them that the recently submitted prior authorization request will be voided due to the inadvertent attachment of another consumer's documentation.

C. The PCM Agency will e-mail the PAU at PCAinfo@umassmed.edu to notify them that a new prior authorization request has been submitted, and will include the following:
    1) VOIDED PA – INADVERTENT DOCUMENTATION in the subject line of the e-mail
    2) Tracking #XXXXXXX (of the new prior authorization request)

D. The PAU Clinical Reviewer will prioritize the request so that a gap in service does not occur.

E. If the original prior authorization request was an expedited request, the PCM Agency and PAU will operate in accordance with Operating Standard IV: Expedited Requests.

XXVI. <u>Pediatric PCA Evaluation and PAU Clinical Review:</u> At the time of the initial evaluation, re-evaluation, or adjustment for Pediatric PCA services, a PCM Agency Nurse Evaluator is responsible for evaluating the disabling, functional ability of the child and the medical necessity for PCA services (see definition of disability of children per Office of Social Security, 130 CMR 450.204, 130 CMR 422.402, 130 CMR 422.412). The PCM Agency Nurse Evaluator uses his/her assessment skills and clinical judgment and educates the parent or legal guardian regarding what services are appropriate to include in the PCA evaluation request. It is appropriate to request time for PCA services when a child has a chronic, permanent disabling condition resulting in hands-on ADL care needs and services due to functional limitations. The *Schematics of Age Ranges at which Non-Disabled Children Master Functional Items* (50% percentile) is the adopted pediatric developmental tool to assist the PCM Agency Nurse Evaluator and PAU Clinical Reviewer in determining if the child's functional ability is within the age range for the mastery of functional skills for non-disabled children. The PCM Agency must include documentation to support medical necessity in the PCA evaluation. The PAU Clinical Reviewer will review all supporting documentation for medical necessity on an individual basis. If medical necessity is established based on the PCA evaluation documentation, an approval or modification will be considered. If medical necessity is not established, a denial will be considered.

A. When a PCM Agency initiates a pediatric PCA evaluation request, the PCM Agency must consider the following as part of the evaluation and documentation process:

1) Parent(s), legal guardian(s) or designee(s) are responsible for providing oversight and care for children and directing the PCA services (see MassHealth Regulations 130 CMR 422.412 (A) and 130 CMR 422.412 (F)).
    a. The MassHealth Regulations address non-covered services (130 CMR 422.412 (C)) which include assistance provided in the form of cueing, prompting, supervision, guiding, and/or coaching.
    b. A parent or "designee" (i.e. sibling, aunt, uncle, etc.) is required to be the second person when two people are required to perform a task (i.e. if a child has spastic tone due to cerebral palsy, a second person may be required for transfers).
        i. Special consideration may be given for MD transportation if a second person is required to assist with medical and/or behavioral needs. Documentation must be consistent and clear to support this request.
    c. Special consideration may be given to behavioral needs that demonstrate a safety risk for the child or others (i.e. removing a child from a dangerous situation), but documentation must support

the request. Please Note: PCA time is not allowed when requested for purposes of restraint.

d. Special consideration may be given for IADL's if the documentation supports the reason(s) the parent(s) or legal guardian(s) cannot perform the task(s) or if the task(s) is/are above and beyond what would be expected of a non-disabled child of the same age.

2) The PCM Agency Nurse Evaluator evaluates ***non-skilled care*** and assesses if the task can be safely performed for the child by the PCA. The following tasks are examples that may be considered non-skilled services and can be requested if assessed to be safely performed for the child by the PCA:
   a) Gastrostomy tube (G-tube) feedings
   b) G-tube site care (as part of bathing)
   c) Oral suctioning
3) The PCM Agency Nurse Evaluator identifies if skilled care services are required for the consumer. ***Skilled care services are not appropriate services to be completed by a PCA and generally should not be requested.*** Skilled care services are considered to be high risk and unsafe tasks to be performed by a PCA and therefore, should be performed by a skilled clinician, parent, legal guardian or designee. These services require individuals with training in specialized skills, clinical assessment, and judgment to promote safe and effective care for consumers whose conditions may be complex. The following tasks are examples of skilled care services that are generally performed by trained healthcare professionals:
   a) Feeding a child with a high aspiration risk
   b) Medication administration
   c) Oxygen administration
   d) Tracheal care and suctioning
   e) Chest physical therapy (Chest PT)
   f) Cough assist therapy
   g) Chest vest therapy
   h) Nebulizer treatments
   i) Complex Wound Care
   j) Catheterizations
   k) Peripherally Inserted Central Catheter (PICC) line and central line dressing changes
   l) Total Parenteral Nutrition (TPN)
   m) Intravenous (IV) therapy and IV medication administration

n) Administration of peritoneal dialysis medication and fluids
o) Adjustment of ventilator settings and controls
p) Applied Behavior Analysis (ABA) Behavioral Therapy
q) Wilbarger Brushing Therapy

4) The PCM Agency may include separate evaluations. If requesting different hours for weeks when the consumer attends school and weeks when the consumer is out of school, the PCM Agency must include separate evaluations as part of the pediatric PCA PA submission request.
5) The documentation for ADL service requests must include documentation to support the medical necessity of the request in accordance with 130 CMR 422.416 and the *List of Standard Documentation to Include with a Prior Authorization for PCA Services.* If more PCA hours are requested the following year for a PCA re-evaluation, documentation must be provided to support the need for the additional time requested.

APPENDICES

I. No Change Clinical Review Process Guidelines

I. The PAU Clinical Reviewer reviews the required documentation: "No Change" form and the Mass Health Application, and if applicable, the DDS Referral form or State Contract.

II. Upon review, the PAU Clinical Reviewer identifies that the required documents are included and there are no case concerns or calculation issues identified.

1) Approve the "No Change" prior authorization.
2) If there are calculation issues, modify the request to correct the errors.

III. Upon review, the PAU Clinical Reviewer identifies one or more case concerns, including but not limited to:

(1) Required documents not included (i.e. MH application for PCA services).
   (a) Defer the prior authorization and request that the PCM Agency submit the required documentation.

(2) Incomplete documentation, omissions, or inconsistencies in the "No Change" documentation.
   (a) Defer the prior authorization and request that the PCM Agency submit more completed documentation.

(3) On Section I of the "No Change" form, if answered "yes" for adjustment in PCA hours since the last prior authorization. Requested hours on the "No Change" form should be the same as the approved hours at the start date of the previous year's prior authorization.
   (a) Defer the PA and request that the PCM Agency submit the full PCA evaluation.

(4) Documentation of functional improvements on Section III comments of the "No Change" form.
   (a) Contact the PCM Agency for additional information and modify the prior authorization if needed.

(5) Documentation that the consumer is medically unstable, utilizing continuous skilled nursing services, or newly receiving skilled nursing visits.
   (a) Defer the prior authorization and request that the PCM Agency submit the full PCA evaluation and 485 (if appropriate).

(6) Documentation that the consumer is receiving new state agency programs or other new support services. Documentation provided does not address duplication of services.
   (a) Defer the prior authorization and request the contract summary of other supporting documentation to rule out duplication in services.

II. PROM Consensus Statements

For the purposes of medical necessity for Passive Range of Motion within the context of the MassHealth PCA program	
Definition of PROM (130 CMR 422.402)	Passive Range of Motion (PROM) is movement applied to a joint or extremity by another person solely for the purpose of maintaining or improving the distance and direction through which a joint can move. It is not a strengthening exercise. MassHealth does not approve PCA services for exercise or active ROM. In the PCA program, PROM is considered an activity of daily living (ADL).
Definition of Medical Necessity (130 CMR 450.204)	All PROM must meet medical necessity regulations. A service is "medically necessary" if: (1) it is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity; and (2) there is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service, that is more conservative or less costly to the MassHealth agency. Services that are less costly to the MassHealth agency include, but are not limited to, health care reasonably known by the provider, or identified by the MassHealth agency pursuant to a prior-authorization request, to be available to the member through sources described in 130 CMR 450.317(C), 503.007, or 517.007. (B) Medically necessary services must be of a quality that meets professionally recognized standards of health care, and must be substantiated by records including evidence of such medical necessity and quality. A provider must make those records, including medical records, available to the MassHealth agency upon request. (See 42 U.S.C. 1396a(a)(30) and 42 CFR 440.230 and 440.260.)

For the purposes of medical necessity for Passive Range of Motion within the context of the MassHealth PCA program	
Characteristics of PROM	PROM is a specific series of movements done to an extremity by another person. PROM is applied solely for the purpose of maintaining or improving the distance or direction through which a joint can move; or to alleviate pain or reduce severe spasms/cramping. PROM is any ranging movements that require the hands-on performance of the ranging by another person.
Continuum of active to passive range of motion	MassHealth does not approve PCA activity time for exercise or active ROM. Passive Range of Motion (PROM) is the motion done by another person through the dependent portion of the range of motion. If a consumer has the ability to do some of their range of motion but is dependent for the full range of motion, PROM may be requested for the portion of the range that is dependent, given that it is documented.
Skilled versus unskilled service	PROM is sometimes conducted by skilled PTs/OTs/nurses. If PROM is conducted by skilled OT/PT (specific days per week) in conjunction with a therapeutic treatment program for a specific condition (like spasticity), then frequency of the task should be documented and adjusted in the request. PROM is not considered a skilled activity within the context of the MassHealth PCA Program. Consumers (or surrogates) may direct PCAs to perform PROM, when it is considered an unskilled ADL activity.
Training needs of PCAs doing PROM	PROM, as an unskilled ADL activity, may be performed by PCAs. PCAs should be trained by the consumer or surrogate to perform PROM.
Whether a person can do their own Range of Motion	A consumer can do his/her own range of motion (ROM) if and when he/she or the surrogate has the knowledge and understanding of their range of motion in appropriate joints/extremity. When a consumer has the strength and endurance to do their PROM unassisted, then there is no medical necessity for a PCA to perform PROM. PROM may be requested for the joints/extremities that the consumer has limited or no ability to perform his/her own ROM on.
Documentation	The OT's functional status assessment, completed as part of the initial PCA evaluation, should document the current

	range of motion restrictions. PROM should be documented on initial evaluation by the RN (need/medical necessity, time and frequency); as part of this initial evaluation, the RN should consider the OT's functional status assessment. On re-evaluations, the RN must document any ongoing PROM (need/medical necessity, time and frequency).

III. DDS PCA Referral Form

Complete both pages of this form for Department of Developmental Services (DDS) adult consumers who receive less than 24 hours per day of DDS-funded Residential Services, and are applying for PCA Services (initial, adjustment requests, new service arrangements, and reevaluation). This form may not be used for DDS Consumers who receive 24 hours per day of DDS-funded Residential Services, including Waiver Participants who receive Residential Habilitation Services under the HCBS Waiver. If complete information is not provided, MassHealth will defer acting on the prior authorization request. DDS must complete Sections 1-4. The PCM agency must complete Section 5.

Section 1

Consumer Name: Date

DOB: MassHealth #:

Address:

Phone: Residential Provider (If applicable)

Service Coordinator: Area Office:

Who would you like MassHealth to contact if they have any questions about this application?

Name: Phone:

Relationship to applicant:

List here other potential sources of funding for PCA services that DDS has explored: _____

Section 2

1. This application is for (check all that apply):

☐ Initial Evaluation
☐ Reevaluation Date current PCA approval expires:
☐ New Service Arrangement - consumer will receive less than 24 hr/day DDS-funded supports in their home and DDS is planning to use both PCA and DDS residential supports.
☐ Adjustment to increase/decrease PCA hours Is this a temporary adjustment? ☐ Yes ☐ No
If yes: duration of adjustment:

The Consumer (check one):
☐ Receives no DDS-funded Residential Services:
- **Complete and send this form directly to PCM Agency**

☐ Receives fewer than 24 hour per day DDS-funded Residential Services:
- **Complete and send this form and the DDS Contract Summary Page directly to the DDS Central Office**

NOTE: Effective July 1, 2006, DDS Consumers who receive 24-hour per day Residential Services and are requesting PCA Services must contact the DDS Area Office. MassHealth will not process PCA applications for DDS Consumers receiving 24 hours per day of DDS-funded Residential Services.

3. If Reevaluation, complete Section 3 below.

Section 3

1. Has the Consumer's medical or functional status changed since the last PCA evaluation? Yes☐ No☐
   Describe:

2. Have the Consumer's DDS Residential Services changed since the last PCA evaluation? Yes☐ No☐
   (Contractual funding, type of residence, number of staff, staffing patterns/ratios)

   Describe:

Section 4

DDS SIGN-OFF

The information is accurate to the best of my knowledge:

_____ Date _____
DDS Service Coordinator Signature

DDS Service Coordinator Print Name

_____ Date _____
DDS Area Director Signature

DDS Area Director Print Name

PCM AGENCY SIGN-OFF

☐ I have conducted a **PCA reevaluation** for a Consumer who receives less than 24 hours per day of DDS-funded Residential Services, **(Send the request for prior authorization, this signed PCA Referral Form, and the signed DDS Contract Summary Page to MassHealth.**

☐ I am requesting an **adjustment** (increase or decrease) in PCA hours for a Consumer who receives less than 24 hours per day of DDS-funded Residential Services,. **(Send the request for prior authorization and required documentation for adjustment, along with this signed PCA Referral Form and the signed DDS Contract Summary Page to MassHealth and notify the DDS Service Coordinator.)**

☐ I have conducted an **initial** evaluation for a DDS Consumer who receives less than 24 hours per day of DDS-funded Residential Services **(Send the request for prior authorization, this signed PCA Referral Form, and the signed DDS Contract Summary Page to MassHealth.)**

_____ Date _____
PCM Agency Signature

_____ Date _____
PCM Agency Print Name

IV. DDS PCA Contract Summary Form

This document must be completed by DDS staff and signed by the DDS ISA Contract Officer when submitting any request for PCA Services to the PCM agency for an adult consumer who receives less than 24-hour per day DDS-funded Residential Services. This document summarizes the DDS contract information and, if completed fully, will assist MassHealth in processing the prior authorization request. Incomplete documentation of DDS services may result in an interruption or denial of PCA Services. This form can also be used for a New Service Arrangement where a contract does not yet exist.

A. INFORMATION

Person filling out form: Title:

Area Office: Phone:

Consumer name: MassHealth # :

DOB:

Current Address:

Planned address: (if moving)

B. DAY PROGRAM INFORMATION

Does Consumer attend a day program? ☐ **Y** ☐ **N** If Y, complete the following information:

Type of Service: ☐ Day Habilitation ☐ Adult Day Health
☐ Comm. Based day Support ☐ Employ. Supports

Provider: Address:

Contact name: Phone:

Days and Hours attending:

C. RESIDENTIAL SERVICES INFORMATION

Provider:

Contact person: Phone:

Annual contract amount (for individual only): Total hours per week:

Are there any temporary funds associated with this individual? ☐ **Y** ☐ **N**

Explain:

Are there other DDS consumers in the consumer's home? ☐ **Y** ☐ **N** How many?

Do any of them receive PCA supports? ☐ Currently ☐ Planned

Consumer lives: ☐ Alone
☐ With other individuals: number and relationship:

Program narrative: (This is a general description of the program as a whole)
Please include a summary of DDS funded provider staff responsibilities (what tasks are required during their time in the home), physical description of the residence (physical accessibility of site), any notable distinctions about the Residential Services being provided, e.g., staffing includes day program coverage. Be specific.

DDS Provider Staffing Schedule and Ratios: (add extra lines, if needed) – DO NOT INCLUDE ANY PCA COVERAGE IN THESE SCHEDULES.

	Morning Hours/Ratio	Afternoon/Eve Hours/Ratio	Overnight Hours/Ratio
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

Individual narrative: Provide a description of supports provided by DDS-funded provider staff during the times listed above for the individual only who is applying for PCA supports. Be as specific as possible.

I approve this summary.

DDS ISA Contracts Officer Signature: Date:

Area Director Name:

Area Director signature: _____ Date:

Submitted to PCM agency (date):

V. Personal Care Attendant Contract Summary Form – for DD (Not DDS Eligible) Rolland Class Members Receiving DDS 24/7 Residential Supports

ROLLAND DD PCA APPLICATION INSTRUCTIONS

The attached ***Personal Care Attendant (PCA) Contract Summary Form for DD Individuals*** must be used for all Rolland DD individuals who move into 24 hour, DDS funded, residential settings, and who are not eligible for DDS services and are requesting prior authorization for PCA services. This form is meant to inform UMASS Transitional Case Management (TCM) and Personal Care Management (PCM) Agencies of the services within the DDS contract, and to ensure there is no duplication of services with the PCA services authorized. This form must also be used for PCA re-evaluations and any request for adjustments to the PCA prior authorization.

When the Service Coordinator (SC) becomes aware that a Rolland DD individual is ready to move into a 24 hr DDS funded residence, and the individual will require PCA services to meet his/her needs, the SC must fill out this form completely. The SC must then send the completed form to the DDS Area Director for approval, who will send it directly to Anne Marie Stanton at DDS Central Office. This is the same process for re-evaluations.

This must be done via email, and an electronic, signed copy will be returned to the SC so the SC may continue the application process either with TCM for the initial application, or the PCM agency for a PCA re-evaluation.

This form, signed by DDS Central Office, must then be sent to TCM (for initial applications) or to the PCM Agency (for re-evaluations) and be submitted as part of the prior authorization request, or TCM or the Prior Authorization Unit will not be able to determine medical necessity or process the PA. Please be aware that IADLs, such as laundry, food shopping, housekeeping, etc., are included as responsibilities in 24 hour contracts, and PCA time will not be allowed for these tasks. Also, medication administration is the responsibility of the contract provider, and PCA time will also not be allowed for this task. Overnight coverage will not be allowed in cases where there is awake staffing covered in the contract, except in cases where there is a need, such as a two person lift is required (and only one overnight staff is available).

This application form should be filled out completely, and any questions can be directed to Anne Marie Stanton at 617-624-7784, or Anne.Marie.Stanton@state.ma.us.

PERSONAL CARE ATTENDANT CONTRACT SUMMARY FORM - FOR DD (NOT DDS ELIGIBLE) ROLLAND CLASS MEMBERS RECEIVING DDS 24/7 RESIDENTIAL SUPPORTS

This document must be completed by DDS staff and signed by the DDS Central Office designee when submitting any request for MassHealth PCA Services to the PCM agency or TCM for a DD Rolland class member who receives 24-hour per day DDS Residential Services, but who is ineligible for DDS services. This document summarizes the residential contract information and, if completed fully, will assist MassHealth in processing the prior authorization request. Incomplete documentation of contract services may result in an interruption or denial of PCA Services. This form can also be used for a New Service Arrangement where a contract does not yet exist. DDS residential contracts are assumed to include assistance with medical appointments and management, medication administration, and IADLs. Time will not be allowed for these services with infrequent exceptions.

Applicant's Name: **SSN:**

Address: **MassHealth ID:**

DDS Area Office: **Person Completing Form / Title:**

Phone: **Date submitted:**

Planned/Current DDS Residential Provider:

This is an: initial evaluation ☐ re-evaluation ☐ adjustment request ☐ (choose only one)

1. **Describe the medical needs initiating the evaluation for PCA services:**

2. **Check below <u>each</u> ADL area where the individual will require physical assistance:**

   a. ☐ Mobility/Transfers **b. ☐ Bathing/Grooming** **c. ☐ Dressing/Undressing**
   d. ☐ Range of Motion **e. ☐ Eating** **f. ☐ Toileting**

3. **Why are the current DDS contract resources not adequate to meet these needs? (please include staffing patterns, including overnights, and be as detailed as possible)**

   Are PCA night services (midnight to 6 am) needed? Yes No

   If yes, explain why

4. **Number of individuals living in this DDS home?**

5. **Are there currently MassHealth PCA hours approved for this individual? (if no, enter 0)**

6. **If applicable, date of current PCA PA expiration: (MO) (D) (YR)**

<u>Approvals:</u>

DDS Area Director: **DDS Regional Director:**

DDS Central Office signature and date:

VI. MMIS Job Aid: Verify Member Eligibility for Special Kids Special Care Program

This job aid describes how to:

- Verify a member's eligibility using the Provider Online Service Center, as it relates to **"Special Kids Special Care (SKSC) Program".**

Access Verify Member Eligibility

From the Provider Online Service Center home page:

1. Click **Manage Members.**
2. Click **Eligibility.**
3. Click **Verify Member Eligibility**. The **Check Member Eligibility** panel is displayed.

Enter Member and Provider Information

On the **Check Member Eligibility** panel:

1. Select the Provider from the drop-down list.
2. Enter the **Member ID**.
3. In the **From Date of Service** and **To Date of Service fields**, enter the date range for the search.
    a. **Note:** Both fields automatically default to the current date, but you can modify either field as desired. Maximum date span allowable for a search is 31 days.
4. Click **Submit.**

NOTE: There are four ways to perform an eligibility verification transaction for a member. You can enter the 12-digit Member ID **OR** the Member's SSN **OR** the Member's Other Agency ID (DCF and DYS) **OR** the Member's first name, last name, DOB and gender. Should the system return a "Member Not Found" error message in the search results, you may wish to perform a second search using a different search method.

Confirm Member Information

On the **Member Information** tab:

1. Confirm the member's information including:
    a. Member Name, Member ID.
    b. Provider ID, Date of Service, Local Office Code.
2. Once you have confirmed the member's information, click the **Eligibility** tab.

Verify Eligibility Status

On the **Dates of Eligibility** panel:

1. Click the date range to view the member's eligibility details.

2. After verifying the member's eligibility status, please see the following **Eligibility Restrictive Messages;**

    a. The EVS screen shows several restrictive messages: the following bold message is a trigger for a member on the SKSC program.

    - ***121 direct all inquiries about eligibility to social service worker***
    - 246 exempt from copay on pharmacy services under 130 CMR 450.130(D)
    - 186 exempt from copy on non-pharmacy services under 130 CMR 450 (D)

3. Next please see under **"List of Managed Care Data (for MCO)",** this gives the MCO name as **NEIGHBORHOOD HEALTH PLAN-A.** **See example below;**

MCO Name	*NPI*	*MCO Phone*	*Date Range*	
NEIGHBORHOOD HEALTH PLAN-A		*(617) 772-5500*	*xx/xx/xxxx*	*xx/xx/xxxx*

4. **Click on NEIGHBORHOOD HEALTH PLAN-A**

    a. **The following message appears:**

    Managed Care Data (for MCO) Details

    Begin Date xx/xx/xxxx **End Date** xx/xx/xxxx

    MCO Name: NEIGHBORHOOD HEALTH PLAN-A

    NPI **MCO Phone** (617) 772-5500

    Restrictive Messages

    10 / 006 NHP Member. For Medical Services Call 1-800-462-5449. For Behavioral Health Services Call 1-800-414-2820

    773 / 500 Special NHP program. Call NHP at 1-888-816-6000 for authorization for all services except family planning, glasses, and most dental. For Behavioral Health Services Call 1-800-414-2820.

5. The code **773/500 Special NHP program** is exclusively for the Special Kids Special Care program.

VII. PEDIATRIC Consensus Statements

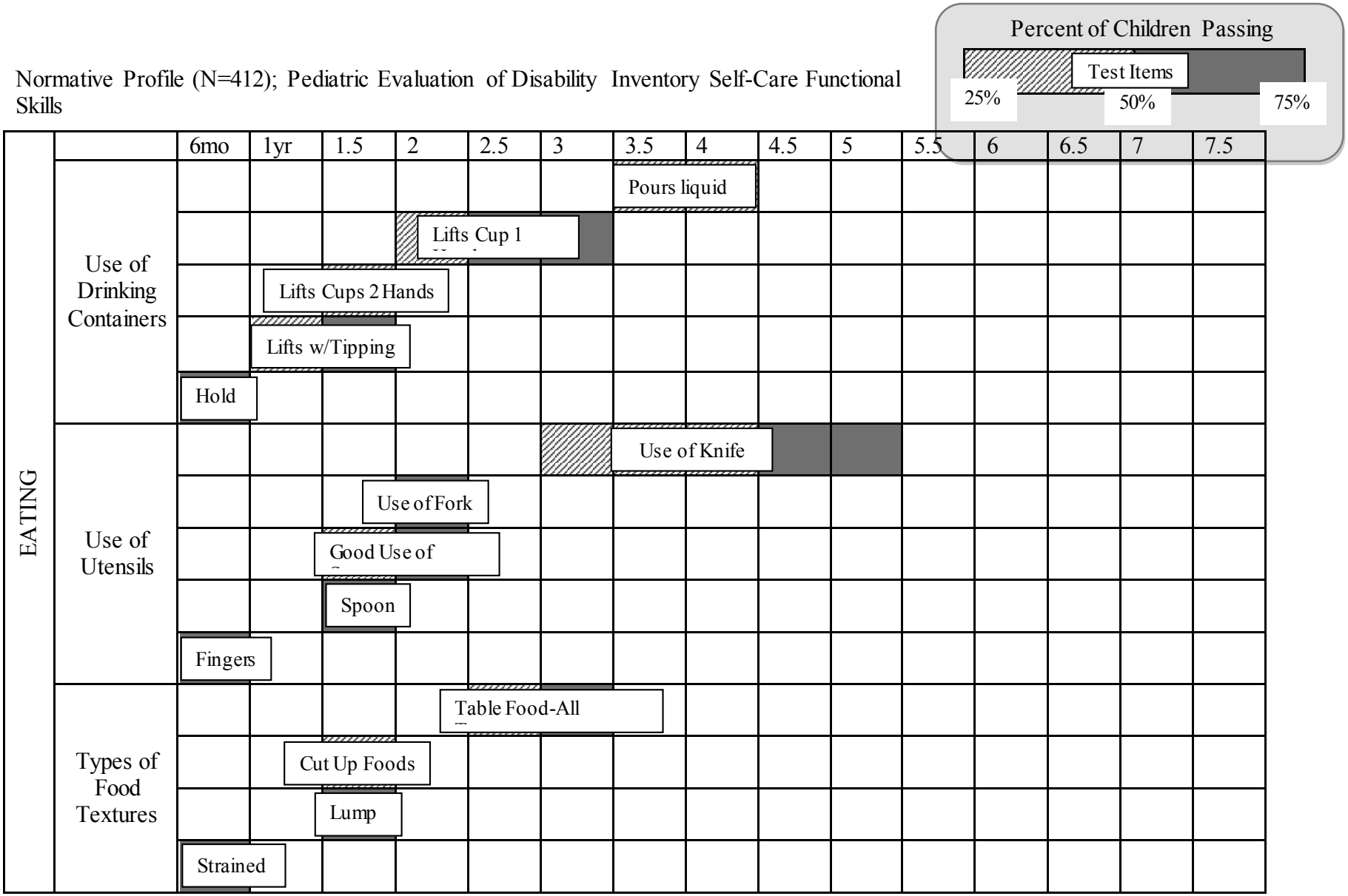
For the purposes of medical necessity for Pediatric Prior Authorization (PA) Reviews within the context of the MassHealth PCA Program	
Definition of Disability in Children (the Office of Social Security Website)	The law defines disability as the inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. Under title XVI, a child under age 18 will be considered disabled if he or she has a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations, and that can be expected to cause death or that has lasted or can be expected to last for a continuous period of not less than 12 months. A medically determinable physical or mental impairment is an impairment that results from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques. A physical or mental impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings, not only be the individual's statement of symptoms.
Definition of Medical Necessity (130 CMR 450.204)	All pediatric PCA requests must meet medical necessity regulations. A service is "medically necessary" if: (1) it is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity; and (2) there is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service, that is more conservative or less costly to the MassHealth agency. Services that are less costly to the MassHealth agency include, but are not limited to, health care reasonably known by the provider, or identified by the MassHealth agency pursuant to a prior-authorization request,

	to be available to the member through sources described in 130 CMR 450.317(C), 503.007, or 517.007. (B) Medically necessary services must be of a quality that meets professionally recognized standards of health care, and must be substantiated by records including evidence of such medical necessity and quality. A provider must make those records, including medical records, available to the MassHealth agency upon request. (See 42 U.S.C. 1396a(a)(30) and 42 CFR 440.230 and 440.260.)
Schematics Pediatric Tool	The Pediatric Workgroup has adopted the Appendix II, Schematics of Age Ranges at which Non-Disabled Children Master Functional Items tool using the 50% percentile for clinical assessment. This tool will be consistently used by the PCM Nurse Evaluators and the PAU Clinical Reviewers.
Skilled versus Unskilled Service	PCA services may be requested for unskilled care. Skilled clinicians, parents, legal guardians or designee are responsible for providing skilled care services that may be considered high risk and affect the safety of the child. These services require individuals with training in specialized skills and clinical assessment.
Parental Responsibility	The Personal Care Program Regulations (130 CMR 422.000) do not specifically address parental responsibility, but do address MassHealth services that are non-covered (130 CMR 422.412): • social services, including, but not limited to, babysitting, respite care, …; • assistance provided in the form of cueing, prompting, supervision, guiding, or coaching; • services provided by family member, as defined in 130 CMR 422.402; or surrogates, as defined in 130 CMR 422.402. Family Member – the spouse of the consumer, the parent of a minor consumer, including an adoptive parent, or any legally responsible relative. Surrogate – the consumer's legal guardian, a family member, or other person as identified in the service agreement, who is responsible for performing certain PCA

	management tasks that the consumer is unable to perform. These tasks must be described in the consumer's service agreement, and must be performed in accordance with MassHealth regulations. These PCA management tasks may include signing and submitting activity forms, firing, supervising, and otherwise directing the PCA as specified in the consumer's service agreement. A consumer's surrogate cannot also be the PCA or an employee or a contractor of either the consumer's fiscal intermediary or the consumer's PCM Agency. The surrogate must live in proximity to the consumer and be readily available to perform the tasks described in the service agreement.
Instrumental Activities of Daily Living (IADL) Request Time	Parent(s) or legal guardian(s) are responsible for completing the IADL's for a child under age 18 (130 CMR 422.410(C)(1)): When a consumer is living with family members, the family members will provide assistance with most IADL's. For example, routine laundry, housekeeping, shopping, meal-preparation, and clean-up performed by the family member will include the related IADL needs of the consumer.
Documentation	The documentation for ADL service requests must include documentation to support the medical necessity of the request in accordance with 130 CMR 422.416 and the *List of Standard Documentation to Include with a Prior Authorization for PCA Services.* If more PCA hours are requested the following year for a PCA re-evaluation, documentation must be provided to support the need for the additional time requested.

VIII. Schematics of Age Ranges at which Non-Disabled Children Master Functional Items[2]

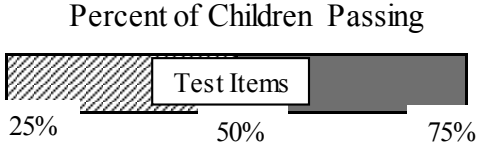
Normative Profile (N=412); Pediatric Evaluation of Disability Inventory Self-Care Functional Skills



Schematics of Age Ranges at which Non-Disabled Children Master Functional Items

[2] Taken from the PEDI: development, standardization and administration manual) authored by Stephen M Haley, NE Medical Center Hospital, PEDI Research Group; 1992 Boston, MA. If anyone is interested in the studies , an article Pediatric Physical Functioning Reference Curves by Stephen Haley, PhD, Maria A Fragala-Pinkham, MS, Peng Sheng Ni, MD, MPH, Alison M. Skrinar, MA, and Edward M. Kaye, MD which describes the data from the samples and how the tool was expanded to include up to age 14.

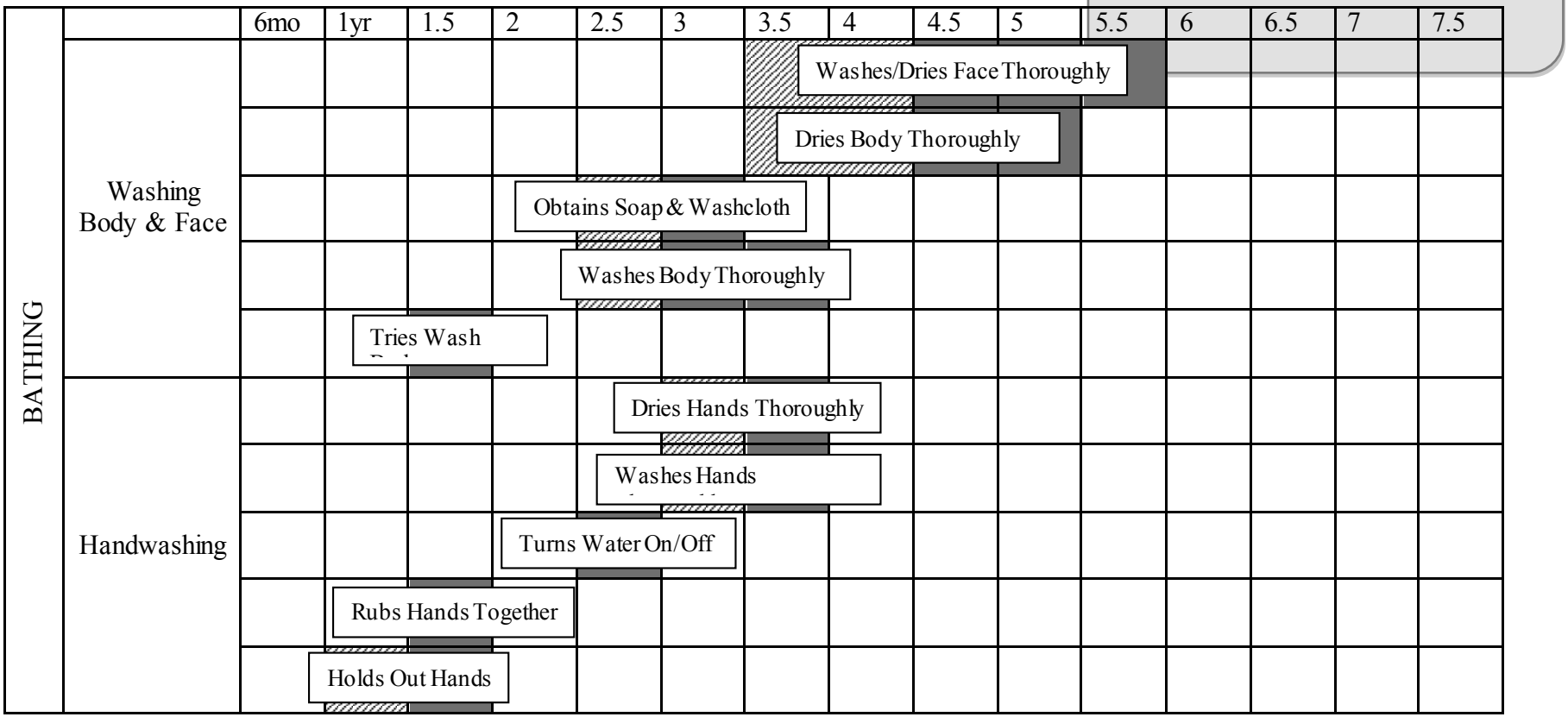
Normative Profile (N=412); Pediatric Evaluation of Disability Inventory Self-Care Functional Skills



		6mo	1yr	1.5	2	2.5	3	3.5	4	4.5	5	5.5	6	6.5	7	7.5
GROOMING	Nose Care									Wipes & Blows on Own						
						Wipes Nose w/o Request										
					Wipes When Requested											
				Tries to Blow												
			Allows													
	Hairbrushing												Manages Tangles/Parts			
					Brushes Hair											
			Brings Comb to Hair													
			Holds Head													
	Toothbrushing								Prepares Toothbrush							
								Thoroughly Brushes Teeth								
				Brushes Teeth Not Thorough												
			Holds Toothbrush													
			Allows Toothbrushing													

Schematics of Age Ranges at which Non-Disabled Children Master Functional Items

Normative Profile (N=412); Pediatric Evaluation of Disability Inventory Self-Care Functional Skills



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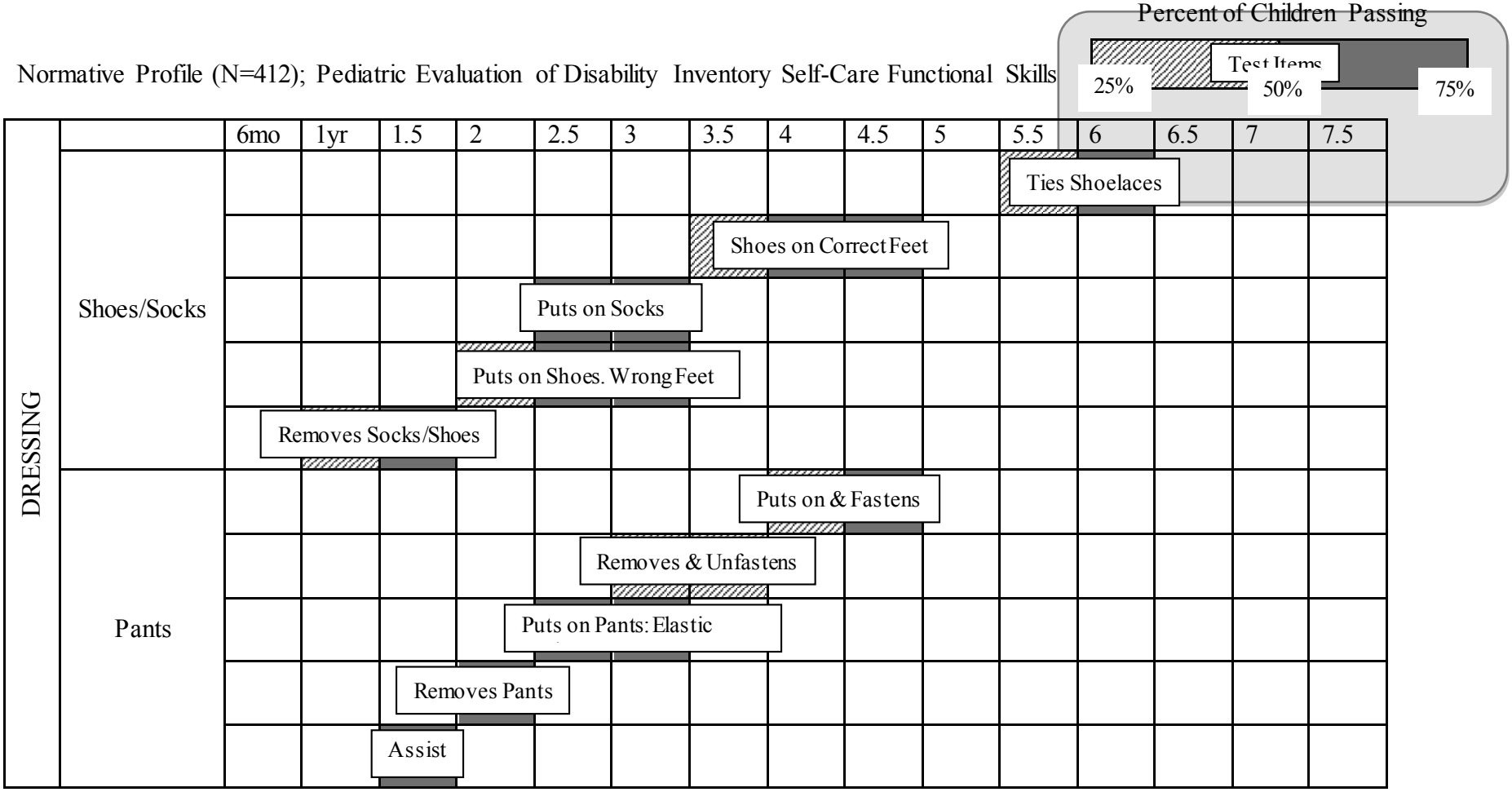

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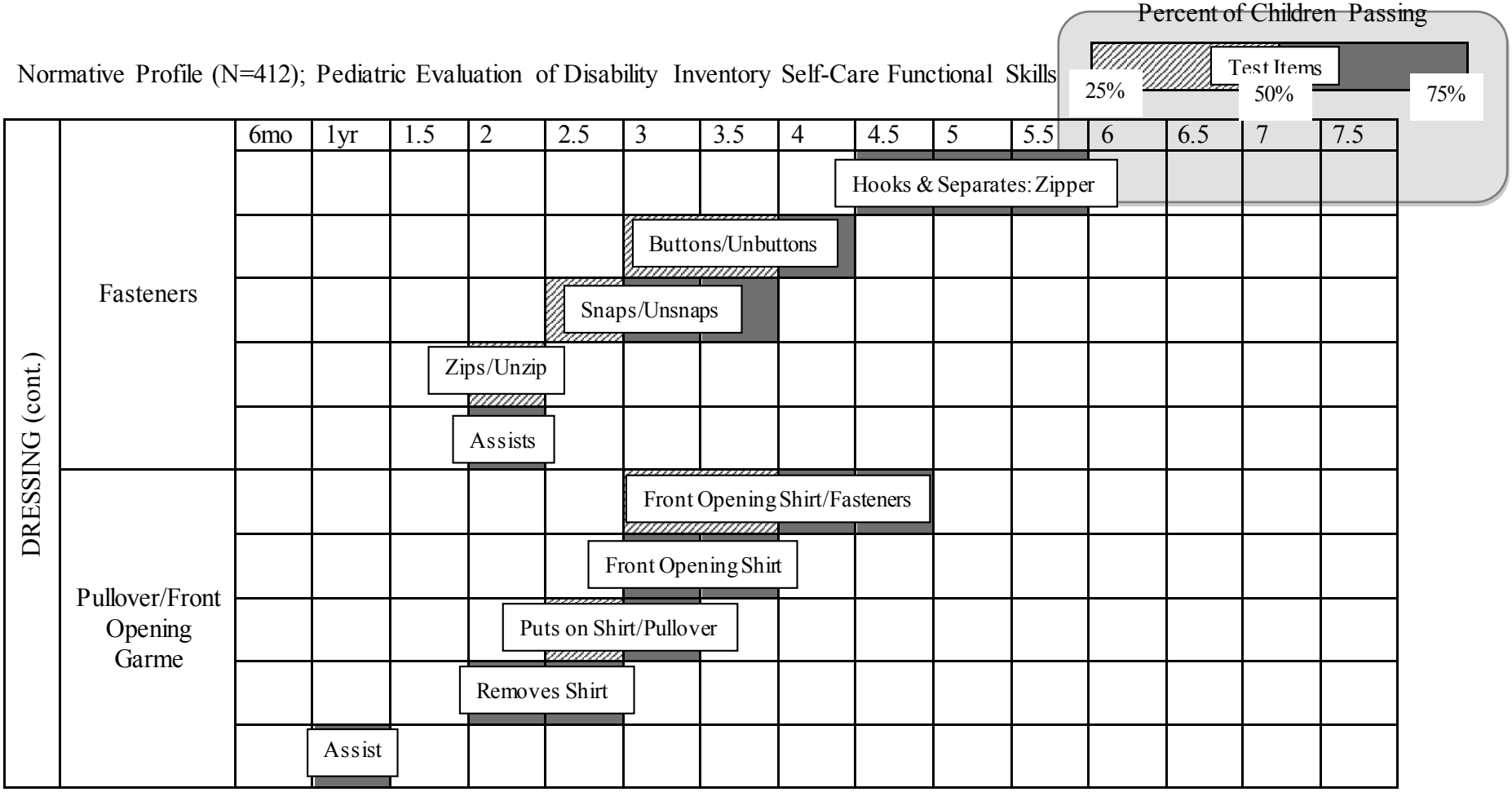

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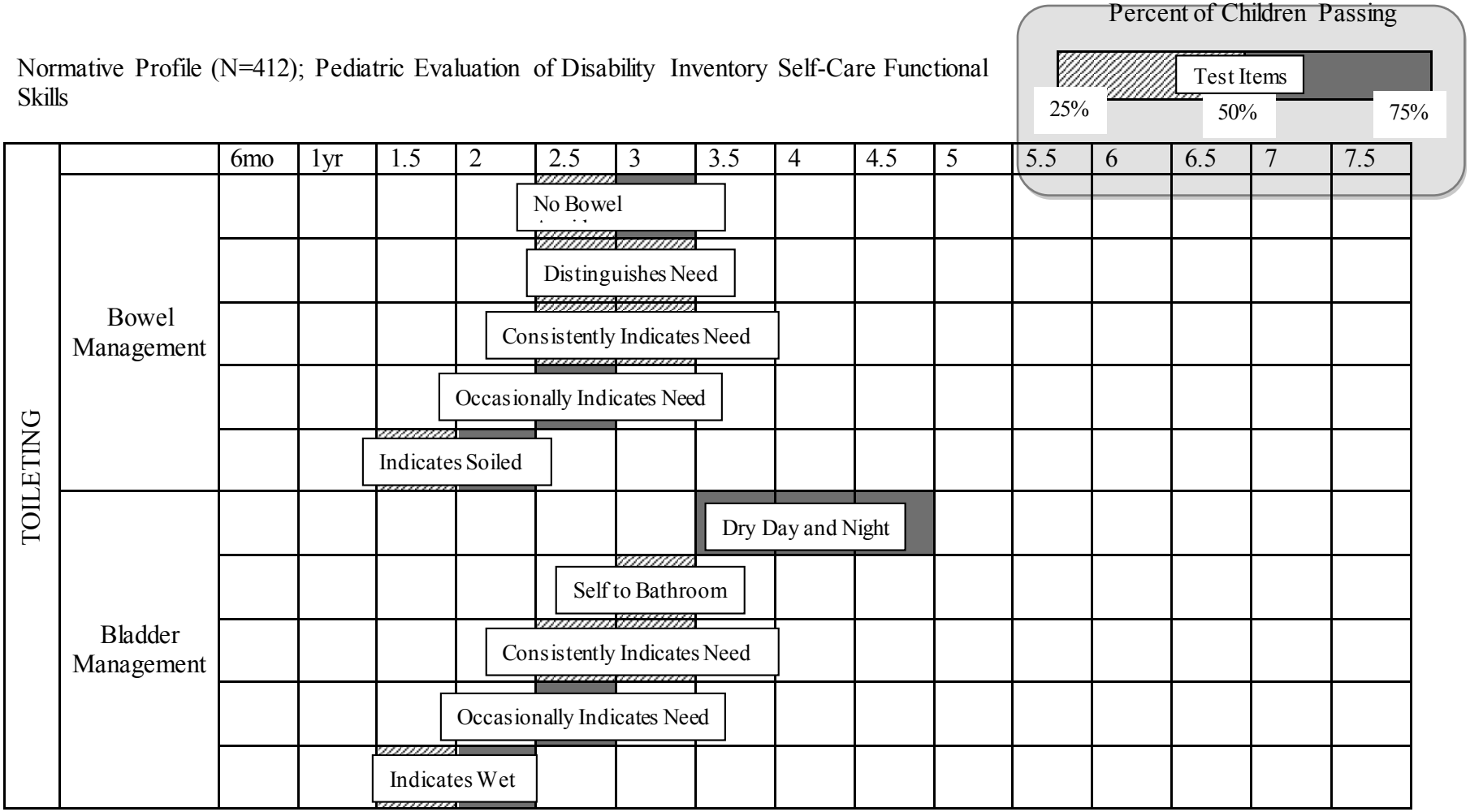

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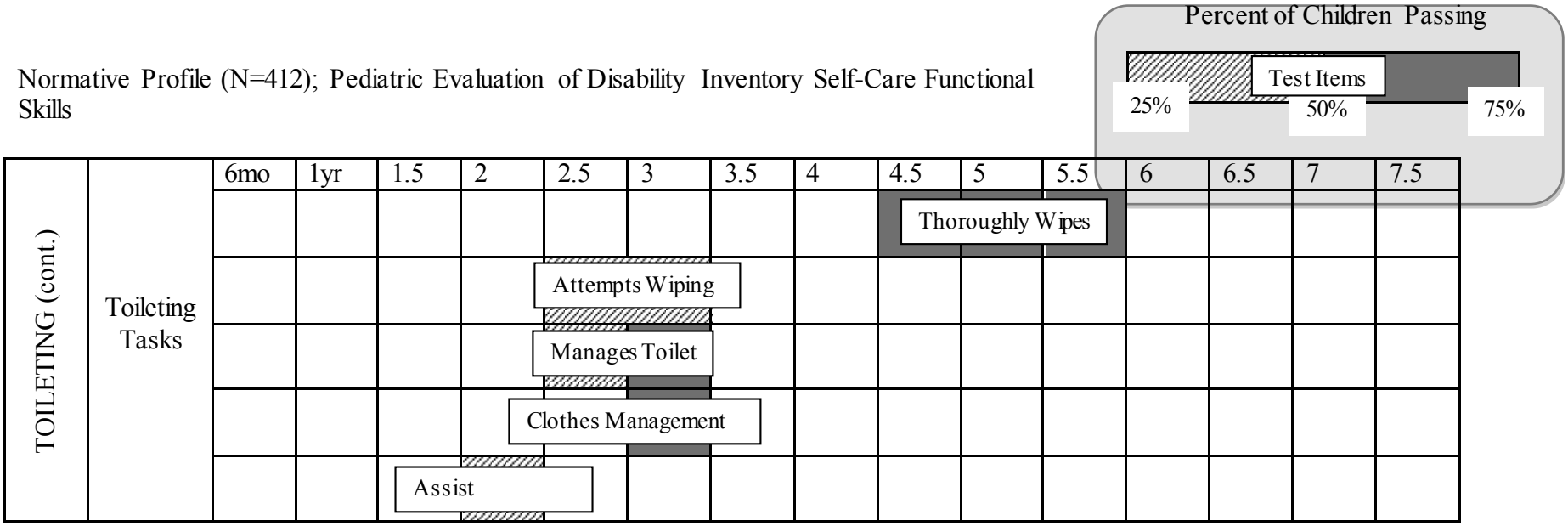

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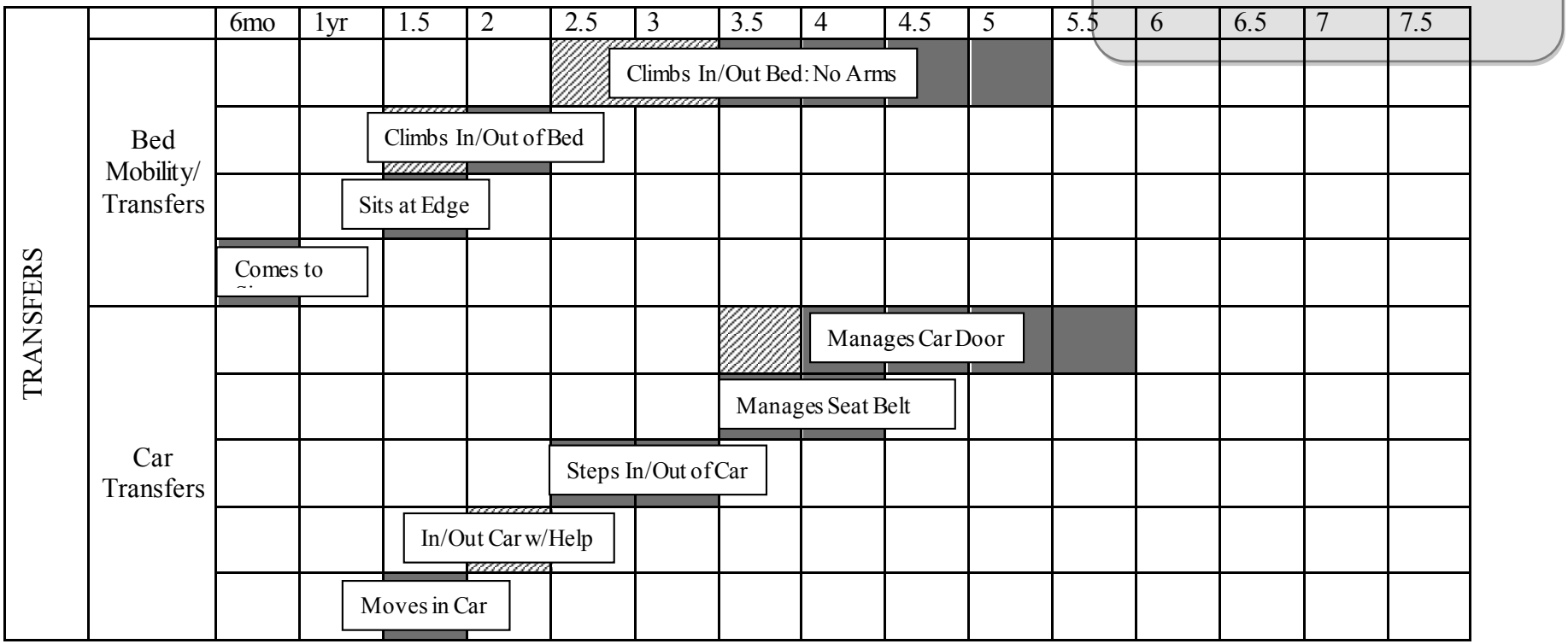

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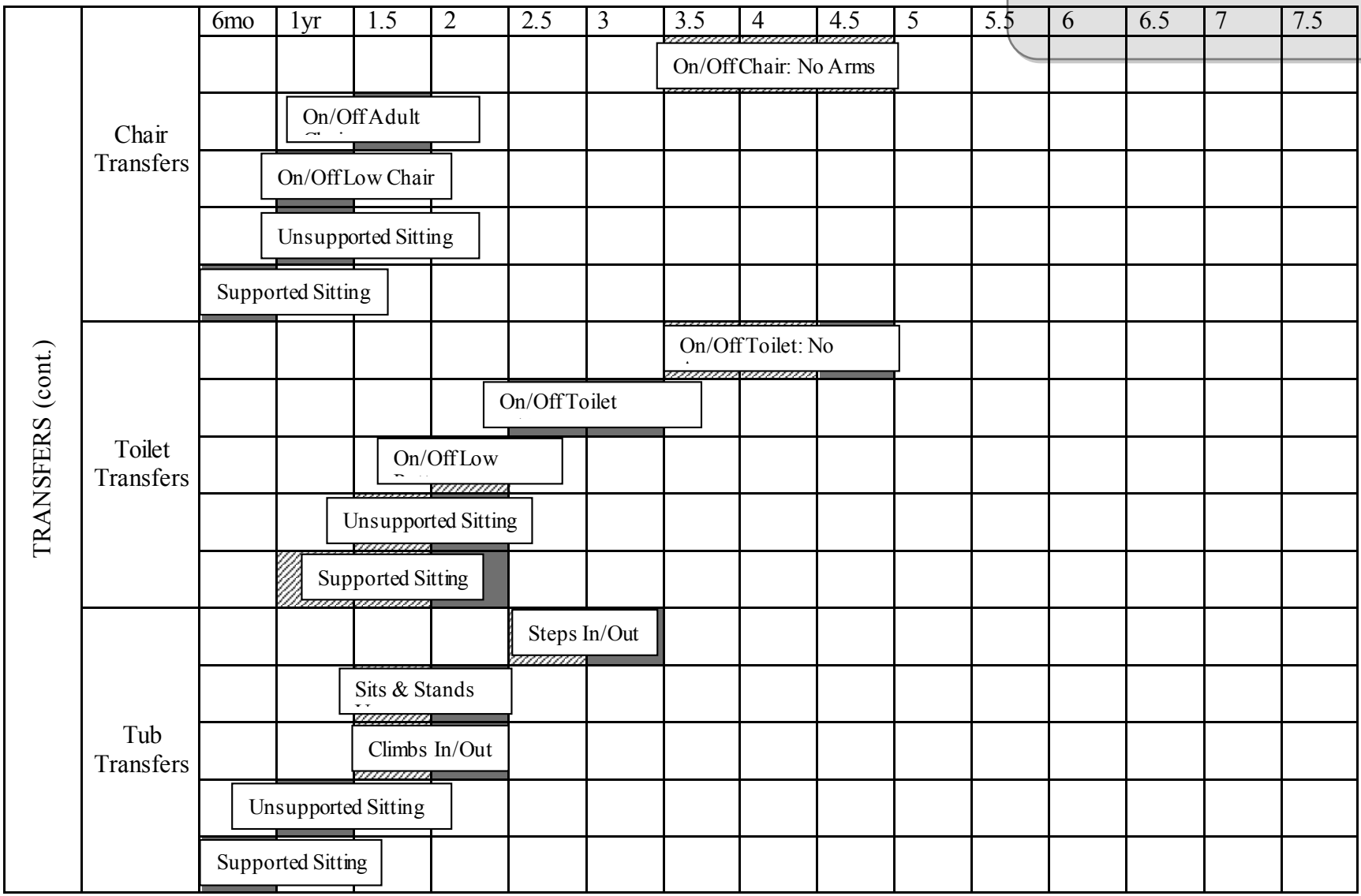

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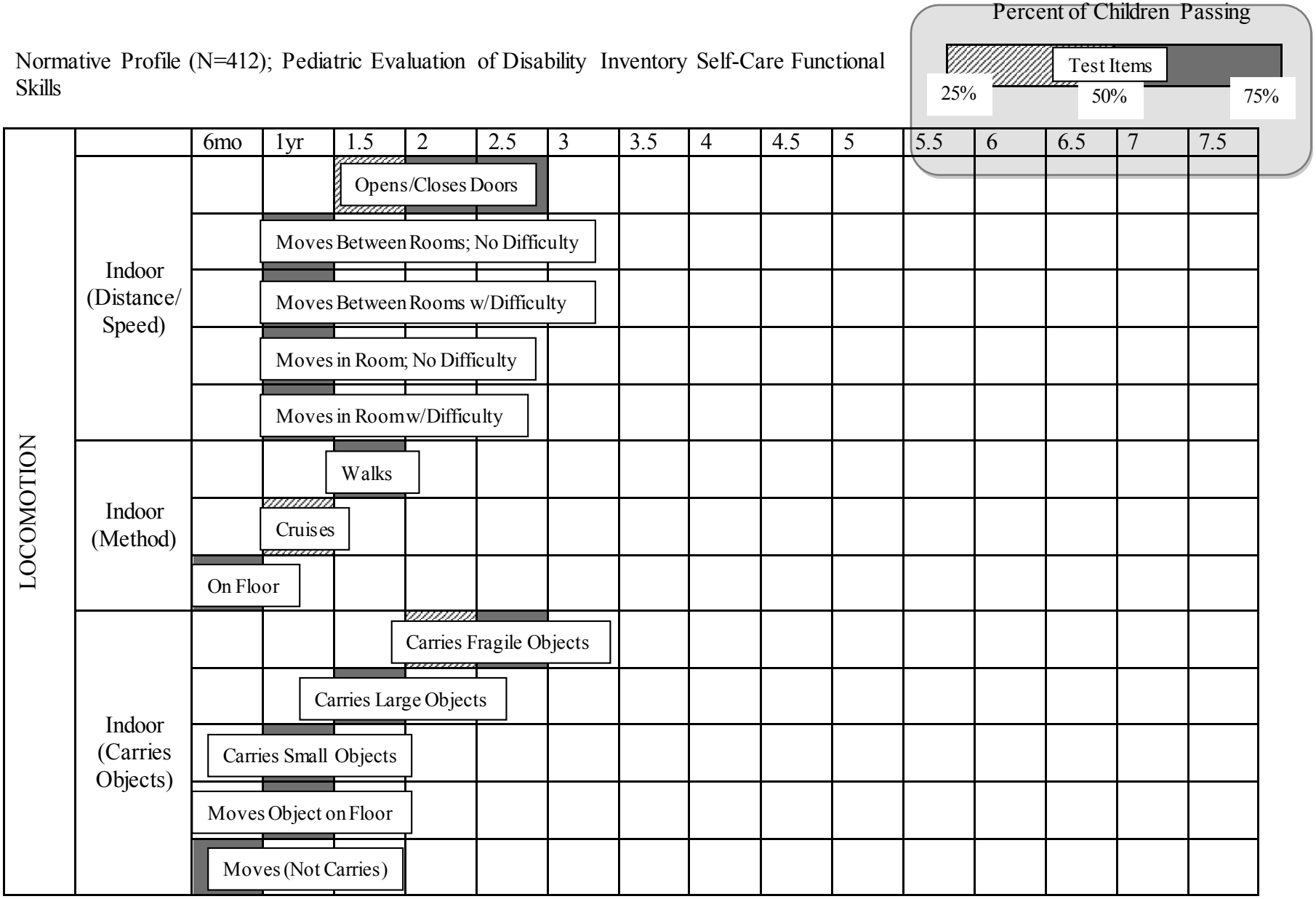

Schematics of Age Ranges at which Non-Disabled Children Master Functional Items

Age Range (yrs) at Which 10/25/50/75/90 Percent of Children Master Self-care Functional Skills Items

	Eating	>10%	>25%	>50%	>75%	>90%
1	Strained foods	>	>	>	>	0.5-1.0
2	Lumpy foods	0.5-1.0	>	1.0-1.5	>	1.5-2.0
3	Cut-up foods	>	1.0-1.5	>	1.5-2.0	3.0-3.5
4	All textures of table foods	1.5-2.0	2.0-2.5	2.5-3.0	3.0-3.5	3.5-4.0
5	Finger feeds	>	>	>	0.5-1.0	1.0-1.5
6	Spoon use	0.5-1.0	>	1.0-1.5	>	1.5-2.0
7	Good spoon use	1.0-1.5	>	1.5-2.0	>	2.0-2.5
8	Fork use	>	>	1.5-2.0	2.0-2.5	2.5-3.0
9	Use of knife	2.0-2.5	2.5-3.0	4.0-4.5	>	5.0-5.5
10	Holds container	>	>	>	>	0.5-1.0
11	Lifts with tipping	>	0.5-1.0	1.0-1.5	>	1.5-2.0
12	Lifts cup 2 hands	>	1.0-1.5	>	1.5-2.0	2.0-2.5
13	Lifts cup 1 hand	1.0-1.5	1.5-2.0	2.0-2.5	>	3.0-3.5
14	Pours Liquid	2.0-2.5	3.0-3.5	>	4.0-4.5	5.0-5.5

Note: Greater-than signs (>) reflect that a greater percentage of children mastered a given item than represented by that column.

Schematics of Age Ranges at which Non-Disabled Children Master Functional Items

Age Range (yrs) at Which 10/25/50/75/90 Percent of Children Master Self-care Functional Skills Items

	Grooming and Bathing	>10%	>25%	>50%	>75%	>90%
15	Allows toothbrushing	>	0.5-1.0	1.0-1.5	>	1.5-2.0
16	Holds toothbrush	>	>	1.0-1.5	>	1.5-2.0
17	Brushes teeth, not thorough	1.0-1.5	>	1.5-2.0	2.0-2.5	2.5-3.0
18	Thoroughly brushes teeth	2.5-3.0	3.0-3.5	4.0-4.5	4.5-5.0	6.0-6.5
19	Prepares toothbrush	3.0-3.5	3.5-4.0	4.0-4.5	4.5-5.0	6.0-6.5
20	Holds head when brushed	>	>	0.5-1.0	1.0-1.5	1.5-2.0
21	Brings comb to hair	0.5-1.0	>	>	1.0-1.5	1.5-2.0
22	Brushes hair	1.0-1.5	>	1.5-2.0	2.5-3.0	3.5-4.0
23	Manages tangles/parts	4.0-4.5	5.5-6.0	6.5-7.0	>	7.0+
24	Allows nose wiped	>	>	0.5-1.0	>	1.5-2.0
25	Tries to blow nose	>	1.0-1.5	>	>	1.5-2.0
26	Wipes when requested	1.0-1.5	>	1.5-2.0	2.0-2.5	2.5-3.0
27	Wipes nose w/no request	1.5-2.0	>	2.0-2.5	3.0-3.5	4.0-4.5
28	Blows and wipes on own	2.5-3.0	3.0-3.5	3.5-4.0	6.0-6.5	6.5-7.0
29	Holds out hands for wash	>	0.5-1.0	1.0-1.5	>	1.5-2.0
30	Rubs hands together	>	1.0-1.5	>	1.5-2.0	2.0-2.5
31	Turns water on/off	1.5-2.0	>	2.0-2.5	2.5-3.0	3.0-3.5
32	Washes hands thoroughly	2.0-2.5	2.5-3.0	3.0-3.5	3.5-4.0	4.0-4.5
33	Washes/dries hands thoroughly	2.0-2.5	2.5-3.0	3.0-3.5	3.5-4.0	4.0-4.5
34	Tries to wash body	>	>	1.0-1.5	>	1.5-2.0
35	Washes body thoroughly	1.5-2.0	2.0-2.5	2.5-3.0	3.5-4.0	4.0-4.5
36	Obtains soap and washcloth	1.5-2.0	2.0-2.5	2.5-3.0	3.0-3.5	4.5-5.0
37	Dries body thoroughly	2.5-3.0	3.0-3.5	4.0-4.5	5.0-5.5	6.0-6.5
38	Washes/dries face thoroughly	2.5-3.0	3.0-3.5	4.0-4.5	5.5-6.0	6.5-6.5

Note: Greater-than signs (>) reflect that a greater percentage of children mastered a given item than represented by that column.

Schematics of Age Ranges at which Non-Disabled Children Master Functional Items

Age Range (yrs) at Which 10/25/50/75/90 Percent of Children Master Self-care Functional Skills Items

	Dressing	>10%	>25%	>50%	>75%	>90%
39	Assists pullover	>	>	0.5-1.0	1.0-1.5	1.5-2.0
40	Removes shirt	1.0-1.5	>	1.5-2.0	>	2.5-3.0
41	Puts on shirt	1.5-2.0	2.0-2.5	2.5-3.0	3.0-3.5	3.5-4.0
42	Front opening shirt	2.0-2.5	>	2.5-3.0	3.5-4.0	4.0-4.5
43	Front opening shirt & fasteners	>	2.5-3.0	3.5-4.0	4.5-5.0	5.5-6.0
44	Assists with fasteners	1.0-1.5	>	1.5-2.0	>	2.0-2.5
45	Zips/unzips	1.0-1.5	1.5-2.0	>	2.0-2.5	4.0-4.5
46	Snaps/unsnaps	1.5-2.0	2.0-2.5	2.5-3.0	3.5-4.0	4.5-5.0
47	Buttons/unbuttons	>	2.5-3.0	3.5-4.0	4.0-4.5	5.0-5.5
48	Hooks & separates zipper	2.5-3.0	>	4.0-4.5	5.5-6.0	6.0-6.5
49	Assists with pants	0.5-1.0	>	1.0-1.5	>	1.5-2.0
50	Removes pants	1.0-1.5	>	1.5-2.0	2.0-2.5	2.5-3.0
51	Puts on pants, elastic waist	1.5-2.0	>	2.0-2.5	>	3.0-3.5
52	Removes & unfastens	2.0-2.5	3.5-3.0	>	3.5-4.0	4.5-5.0
53	Puts on & fastens	2.5-3.0	3.5-4.0	4.0-4.5	4.5-5.0	5.5-6.0
54	Removes socks/shoes	>	0.5-1.0	1.0-1.5	1.5-2.0	2.0-2.5
55	Puts on shoes, wrong feet	1.0-1.5	1.5-2.0	2.0-2.5	>	3.0-3.5
56	Puts on socks	1.5-2.0	>	2.0-2.5	3.0-3.5	3.5-4.0
57	Shoes on correct feet	2.0-2.5	3.0-3.5	3.5-4.0	4.5-5.0	5.5-6.0
58	Ties shoelaces	4.0-4.5	5.0-5.5	5.5-6.0	6.0-6.5	6.5-7.0

Note: Greater-than signs (>) reflect that a greater percentage of children mastered a given item than represented by that column.

Schematics of Age Ranges at which Non-Disabled Children Master Functional Items

Age Range (yrs) at Which 10/25/50/75/90 Percent of Children Master Self-care Functional Skills Items

	Toileting	>10%	>25%	>50%	>75%	>90%
59	Assists with clothing	>	1.5-2.0	>	2.0-2.5	3.0-3.5
60	Attempts wiping	>	2.0-2.5	>	3.0-3.5	3.5-4.0
61	Manage toilet	>	2.0-2.5	2.5-3.0	>	3.0-3.5
62	Clothes management	1.5-2.0	>	2.5-3.0	>	3.0-3.5
63	Thoroughly wipes	3.0-3.5	>	4.0-4.5	5.5-6.0	6.0-6.5
64	Indicates when wet	0.5-1.0	1.0-1.5	1.5-2.0	2.0-2.5	2.5-3.0
65	Occasionally indicates need (bladder)	1.5-2.0	>	2.0-2.5	2.5-3.0	3.0-3.5
66	Consistently indicates need (bladder)	>	2.0-2.5	>	>	3.0-3.5
67	Self to bathroom	2.0-2.5	2.5-3.0	>	>	3.0-3.5
68	Dry day & night	2.0-2.5	>	3.0-3.5	>	4.5-5.0
69	Indicates soiled	0.5-1.0	1.0-1.5	1.5-2.0	>	2.0-2.5
70	Occasionally indicates need (bowel)	1.5-2.0	>	2.0-2.5	2.5-3.0	3.0-3.5
71	Consistently indicates need (bowel)	>	2.0-2.5	>	>	3.0-3.5
72	Distinguishes need	>	2.0-2.5	>	>	3.0-3.5
73	No bowel accidents	2.0-2.5	2.5-3.0	>	3.0-3.5	3.5-4.0

Note: Greater-than signs (>) reflect that a greater percentage of children mastered a given item than represented by that column.

Schematics of Age Ranges at which Non-Disabled Children Master Functional Items

Age Range (yrs) at Which 10/25/50/75/90 Percent of Children Master Mobility Functional Skills Items

	Transfers	>10%	>25%	>50%	>75%	>90%
1	Supported sitting: toilet	>	0.5-1.0	1.5-2.0	>	2.0-2.5
2	Unsupported sitting: toilet	>	1.0-1.5	1.5-2.0	>	2.0-2.5
3	On/off low potty	1.0-1.5	1.5-2.0	>	2.0-2.5	3.0-3.5
4	On/off toilet: arms	1.5-2.0	>	2.0-2.5	>	3.0-3.5
5	On/off toilet: no arms	2.5-3.0	3.0-3.5	4.0-4.5	4.5-5.0	6.0-6.5
6	Supported sitting: chair	>	>	>	>	0.5-1.0
7	Unsupported sitting: chair	>	>	0.5-1.0	>	1.0-1.5
8	On/off low chair	>	>	>	1.0-1.5	1.5-2.0
9	On/off adult chair	>	>	1.0-1.5	1.5-2.0	2.0-2.5
10	On/off chair: no arms	2.0-2.5	3.0-3.5	>	4.5-5.0	5.5-6.0
11	Moves in car	>	>	1.0-1.5	1.5-2.0	2.0-2.5
12	In/out car with little help	>	1.5-2.0	>	2.0-2.5	2.5-3.0
13	Steps in/out car	1.3-2.0	>	2.0-2.5	>	3.0-3.5
14	Manages seat belt	2.0-2.5	>	3.0-3.5	4.0-4.5	4.5-5.0
15	Manages car door	>	3.0-3.5	3.5-4.0	>	5.5-6.0
16	Comes to sit in bed	>	>	>	0.5-1.0	1.0-1.5
17	Sits at bed edge	>	>	1.0-1.5	1.5-2.0	2.0-2.5
18	Climbs in/out bed	>	1.0-1.5	1.5-2.0	>	2.0-2.5
19	Climbs in/out bed: no arms	1.5-2.0	2.0-2.5	3.0-3.5	5.0-5.5	5.5-6.0
20	Supported sit: tub	>	>	>	>	0.5-1.0
21	Unsupported sit: tub	>	>	0.5-1.0	1.0-1.5	1.5-2.0
22	Climbs in/out: tub	>	1.0-1.5	1.5-2.0	2.0-2.5	3.0-3.5
23	Sits & stands up: tub	>	1.0-1.5	1.5-2.0	2.0-2.5	2.5-3.0
24	Steps in/out: tub	>	2.0-2.5	2.5-3.0	3.0-3.5	4.0-4.5

Note: Greater-than signs (>) reflect that a greater percentage of children mastered a given item than represented by that column.