Instructions for completion of the Request and Justification for Skilled Nursing Visits and Home Health Aide Services Form.

When completing this form, please be sure to fill out each section in its entirety. If a particular item does not apply to a member, then indicate not applicable. If a member doesn't have the particular item, such as a caregiver, then indicate none. If the answer to a particular item is not known, then indicate unknown.

Failure to complete any section will result in delays in processing and reviewing the prior authorization request.

I. General Information
Personal Information
Member's Name: List the member's full name including middle initial or name if known
Member's MassHealth ID Number : List the member's 12 digit MassHealth identification number that appears on their MassHealth card
Telephone Number: Enter Member's phone number (home or cell) with area code
Other Insurance Information: MassHealth is the payer of last resort. The provider should use diligent efforts to obtain coverage from other insurance sources. List the Private Insurance Carrier, Policyholder's name, Policy number, and Group number for all other insurances the person is covered by including Medicare. Include why the requested service is not covered by any of the other insurances that the person is covered by and whether or not the insurance has changed
Household Information: List the primary caregivers and their relationship to the member. For people continuing in services identify any changes in the member that would require additional training for the primary caregivers. Describe the specific changes and the training that is needed. List any other members in the household that receive skilled nursing or home health aide services. List none if there is no one. List the number of hours per calendar week the other household member is receiving and the name of the home health agency involved. Include the MassHealth ID number for any members that your agency provides their skilled nursing or home health aide services. If your agency is not providing the home health agency services to other members in household you do not need to list the MassHealth member ID numbers.

II. Patient Assessment and Summary

List the member's date of birth, weight and height.

Primary Medical Diagnosis:

List the medical diagnosis related to the reason for home health services.

Secondary Medical Diagnosis:

List another medical diagnosis related to the reason for home health services if applicable. If there is not a secondary diagnosis, then list none.

Primary Reason for Skilled Nursing Visit:

Briefly describe the reason that the agency will be providing skilled nursing services to the member.

Write a brief narrative that describes the following:

- The member's current medical status and medical history
- The member's current ability to perform self-care related to health conditions (i.e. wound care), injections, etc.
- The member's ability to perform activities of daily living.
- Include an updated summary of the past prior-authorization period, if applicable.
    - Document any change in the member's medical status
    - inpatient and/or outpatient hospital visits,
    - Frequency of illnesses,
    - Changes in plan of care, and
    - Calls or visits to the member's physician.

If additional space is required, please attach additional documents.

III. Home Health Aide Services

Section III only needs to be completed if home health aide services are requested. Fill in the appropriate boxes that indicate the level of functioning for each of the domain areas: cognitive, bathing, dressing, toileting, ambulation, grooming, eating and range of motion exercises. If there is other relevant functional information, then indicate that in the space available below the functional domains.

IV. Health-Related Services Currently Provided to the Member

Document the other services used by the member in this section by indicating yes if they use that service and no if they do not. If they use a service, then indicate the frequency of use of the service and who the payer is. The health related services include physical therapy, occupational therapy, speech/language therapy, intermittent skilled nursing visits, home health aide, personal care attendant, Adult Day Health, Adult Foster Care, Hospice, palliative care, Day Habilitation, MassHealth waiver services, and other.

V. Services provided by another agency

List services (including respite and case management) that are provided by other sources If applicable.

Indicate the frequency of service and the name and telephone number of the case manager. If you do not have case manager/service coordinator information, please obtain this information from the agency providing other services.

Other agencies can include the Massachusetts Commission for the Blind, the Department of Public Health, the Department of Children and Families, the Department of Education, the Department of Mental Health, the Department of Developmental Services, and Early Intervention program.

VI. Request for Skilled Nursing Visits and Home Health Aide Visits

Indicate the service(s) requested either skilled nursing visits, home health aide visits, or both. Include the start and end dates, number of visits during that time frame and the frequency of visits during that period for each service as applicable.

If this is a renewal of an existing PA, then include the number of the previous prior authorization and the expiration date. Also include the number of authorized visits of skilled nursing visits, home health aide visits, or both for the previous PA.

VII. Names and Signatures

Home Health Agency name: put the full name of the home health agency submitting the prior authorization in this section.

Home Health Agency address and phone number: put the full address of the agency and the agency's telephone number in this section.

Nurse from Home Health Agency: Include the name, work address, and work phone number of the agency nurse completing the form. The nurse completing the form signs the form on the appropriate line with the date of the signature.

Physician name: Put the full name of the physician ordering the home health services here. Include the physician's office telephone number.