Home Care Authorization Overview

March 24, 2022

12:30-1:30 p.m.

Presented by HPP Utilization Management

Health Partners Plans HPP

Home Care Agenda

- Prior authorization requirements
- Home care documentation
- Home care coverage criteria
- Verbal orders (Medicare/Medicaid)
- Order requirements (Medicare/Medicaid)
- Recertifications
- Maintenance therapy
- References
- Questions

Prior Authorization Requirements

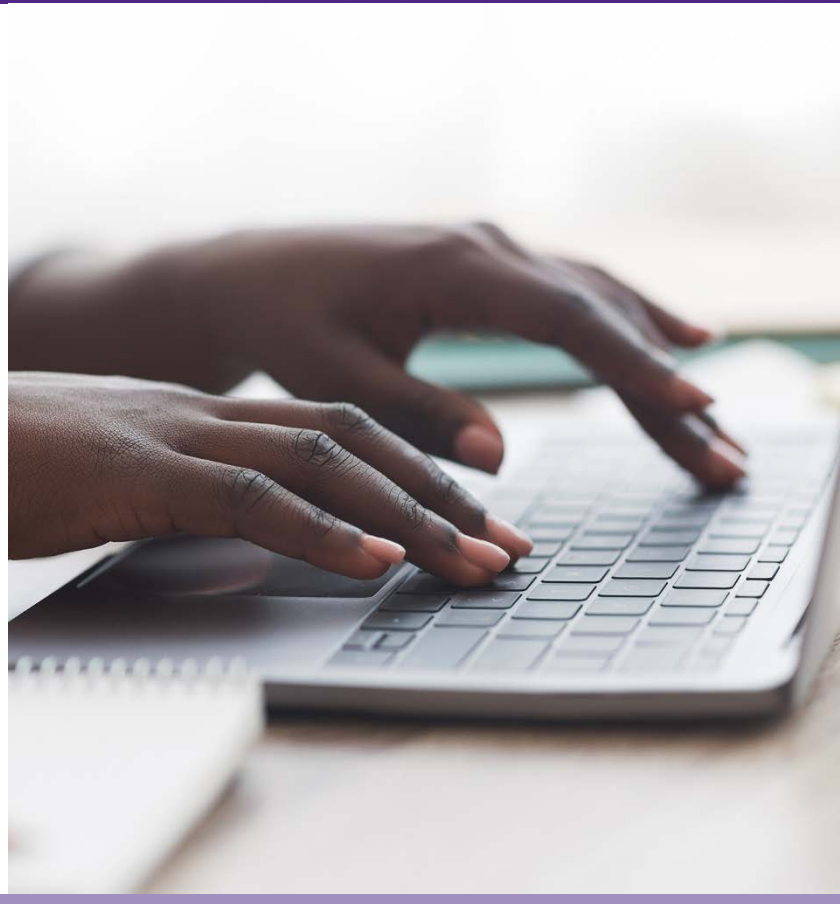
Home health agencies are encouraged to use the Provider Portal to submit all prior authorization requests.

Providers have 5 business days from **initial** start of care to submit requests in order to be timely.
All ongoing home care requests are **expected to be submitted before services are rendered**.

HPP makes every attempt to provide determinations as quickly as possible when all required documentation is received timely.
Medicare has 14 days to render a determination for all standard pre-service requests.
Medicaid has 2 business days to render a determination for all standard pre-service requests.

Home Care Documentation

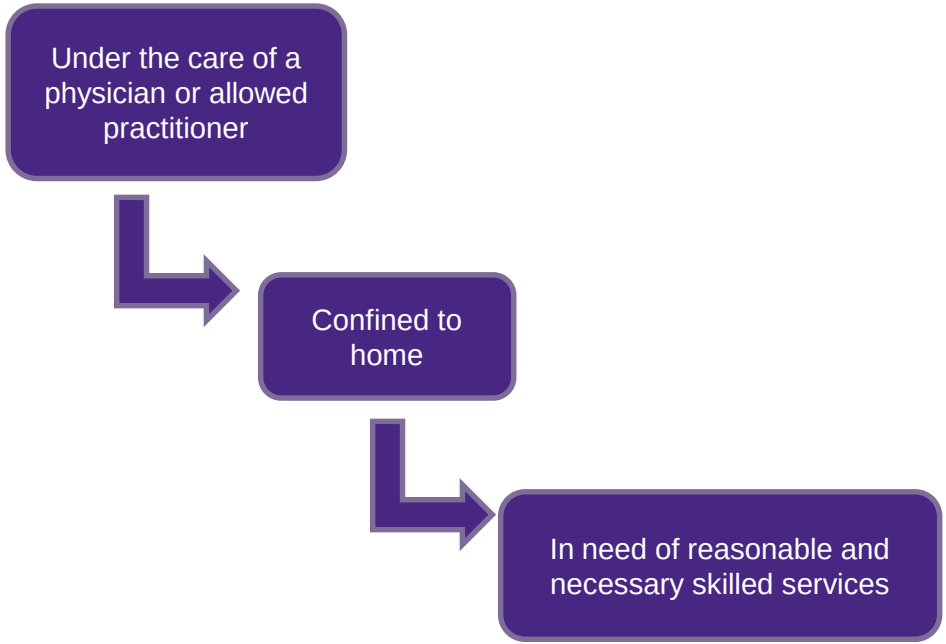
- Orders
  - Signed and dated (verbal) orders that include services/dates/frequency
- Referrals
  - Signed and dated for the HC evaluation and or start of care following a hospital or post acute discharge.
- Clinical summary/discharge summary from the inpatient stay
- Visit notes (ongoing requests)
  - Wound care notes
  - Therapy notes
- Plan of care (485)
  - Signed and dated by the overseeing provider in 30 days of the start of care (SOC) and certification period



Medicare HC Coverage Criteria

Certification or Recertification

- Certifies/recertifies member's eligibility and orders home health.
- Plan of care (485) is established and periodically reviewed by a physician or allowed practitioner.
- Face to face encounter -90 days prior or within 30 days after SOC (start of care).
  - The certifying physician or allowed practitioner must also document the date of the encounter.
- Clinical medical necessity



Medicaid HC Coverage Criteria

Certification or Recertification

- Certifies/recertifies member's eligibility and orders home health.
- Plan of care (485) is established and periodically reviewed by a physician or allowed practitioner
- Clinical medical necessity

Verbal Orders

ALL LINES OF BUSINESS

- The orders must be signed and dated with the date of receipt.
- All verbal orders must have the name of the ordering/certifying practitioner along with the name and credential of the person taking the verbal order documented clearly.
- Verbal orders may be signed by a registered nurse, supervisor or qualified therapist (i.e., physical therapist, speech-language pathologist, occupational therapist or medical social worker).
- For services furnished based on a physician or allowed practitioners (MD, DO, NP, PA, CNS) orders, the orders may be accepted and put in writing by personnel authorized to do so by applicable State and Federal laws and regulations.
- Verbal orders must be countersigned and dated by the physician or allowed practitioner (NP, PA, CNS) as soon as possible but no later than 30 days.

Order Requirements

- Signed orders are required by Health Partners Plans for all Home Healthcare service requests.
- The plan of care will be clearly signed and dated within 30 days of the Start of Care (SOC) and be submitted to HPP.
- Orders/certification is for the same services related to the diagnosis.
- New orders are required for new services or a change in diagnosis and management.
- This following constitutes a valid order:
  - Obtained from a physician (MD,DO) or allowed practitioner (NP, PA, CNS).
  - Hospitalist referral, prescription, discharge instructions, plan of care/485, letter of medical necessity, electronic referral etc.
    - A referral does not remove the requirement for the POC (485).
  - Written orders must have the date, time and credentials of the certifying practitioner.

Medicaid Order Exceptions

- Orders **will not** be accepted by the following:
  - Certified Nurse Midwives (CNMs)
  - Certified Registered Nurse Practitioners (CRNPs)
  - Clinical Nurse Specialists (CNSs)
  - Physician Assistants (PAs)
  - Podiatrists

Recertification For Continued Services

Recertification				
Require supporting documentation including signed and dated orders/certifications, post hospital face-to-face visit notes, clinical to support the request.	The recertification visit can be done during the prior certification period.	Required at least every 60 days when there is a need for continuous home health care after an initial 60-day certification.	Medicare/Medicaid does not limit the number of continuous 60-day recertifications for beneficiaries who continue to be eligible for the home health benefit.	Home care providers must be acting upon the plan of care certified by the overseeing physician or allowed practitioner.

Maintenance Therapy

- Maintenance therapy is used to prevent or slow further deterioration such that care is required to be performed by a qualified therapist or licensed provider/skilled services.
  - The home care provider will submit a summary of the comprehensive assessment by a qualified therapist or skilled nurse.
  - The orders must state “Maintenance Therapy” when not for purposes of restorative care or treatment. This can be for a new SOC or part of the 60-day recertification.
  - Clinical necessity can warrant a member to return to restorative services at any time during maintenance therapy.
- Goal:
  - The goals of a maintenance program would be to maintain the patient’s current functional status or to prevent or slow further deterioration.
  - Maintenance therapy addresses management of individuals:
    - Functional impairment, has a chronic or progressive illness, without the expectation for improvement.

References

- Medicare Benefit Policy Manual Chapter 7-Home Health Services 11.6.2020
- Center for Medicare and Medicaid Service https://www.cms.gov/
- Department of health and human services (DHS)
- Provider Manual https://www.healthpartnersplans.com

Contact Information

- Ancillary Services
  - Phone number 215-967-4690 or 1-866-500-4571
- Home Care (fax numbers)
  - Medicare: 267-515-6633
  - Medicaid: 215-967-4491
- Provider Services Helpline 1-888-991-9023 (M-F, 9am to 5:30 p.m.)
- Member Relations
  - Medicaid: 1-800-553-0784 (TTY 1-877-454-8477)
  - Medicare: 1-866-901-8000 (TTY 1-877-454-8477)
  - CHIP: 1-888-888-1211 (TTY 1-877-454-8477)

Questions?

Thank you for attending!