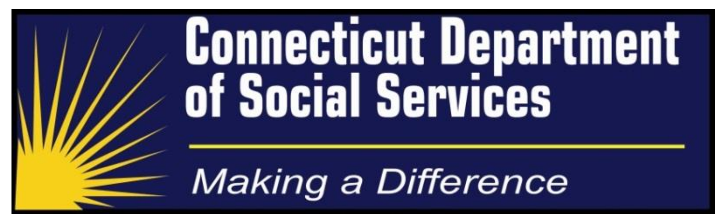
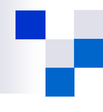
Home Health Services Prior Authorization Documentation Requirements

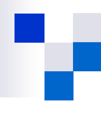
December 5, 2018





Objectives

- Review the HUSKY Health program's Prior Authorization (PA) documentation requirements for home health services
- Gain an understanding of the basic documentation that must be submitted with a PA request to avoid having it pended for additional information
- Reduce administrative burden associated with the PA process
- Improve provider satisfaction with the PA process

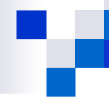


PA Introduction

- All HUSKY Health members are eligible to receive healthcare services or goods from Connecticut Medical Assistance Program (CMAP) enrolled providers
- ***Only CMAP enrolled providers will be reimbursed*** for services or goods provided to HUSKY Health members
- All referrals for home health services must come from an enrolled CMAP provider
- Determinations are made on a case-by-case, person-centered clinical assessment of the member and his/her clinical needs

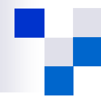
Coverage of Home Health Services

- Home health services are a covered benefit for all eligible HUSKY Health program members
- PA of all home health care services for members in the following waiver programs must go through the appropriate Access Agency or Department of Social Services (DSS) waiver program case manager:
  1. Money Follows the Person (MFP)
  2. Connecticut Home Care Program for the Elders (CHCPE)
  3. Acquired Brain Injury (ABI)
  4. Personal Care Assistant (PCA)
  5. Autism



PA Request Submission

- All home health services requests must be submitted through the Community Health Network of Connecticut, Inc. (CHNCT) *Medical Authorization Portal* (Clear Coverage™)
- All behavioral health home health service requests must be submitted through the Beacon Health Services Authorization Portal
- There are some exceptions made for requests due to retro eligibility and requests for modifications to existing authorizations
- Retrospective and modification requests must be faxed in using the Outpatient Prior Authorization Request Form

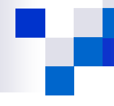


PA Request Submission (cont.)

- If you do not have a *Medical Authorization Portal* user account, or would like to add users to an existing account, contact CHNCT support for more information:
  - Email: clearcoveragehelpdesk@chnct.org
  - Phone: 1.877.606.5172 for Technical Portal support
- The portal allows providers to backdate the prior authorization request up to five (5) calendar days to accommodate for member retroactive enrollment and holidays

Person-Centered Care Planning

- Providing the member with needed information, education, and support required to make fully informed decisions about their care options and to actively participate in their self-care and care planning
- Supporting the member and their designated representative(s) in working together with non-medical, behavioral health, and medical providers and care manager(s) to obtain necessary supports and services; and
- Reflecting care coordination under the direction of and in partnership with the member and their representative(s); that is consistent with their personal preferences, choices, and strengths; and that is implemented in the most integrated setting



Person-Centeredness in the PA Review Process

- All aspects of a person's medical and behavioral health needs are taken into consideration when determining medical necessity for a good or service
- While clinical reviewers use medical criteria, guidelines, and policies to determine medical necessity, these are guidelines and not an absolute
- The member may have a co-morbid medical condition or psychosocial situation that impacts their medical needs
- These situations are reviewed and taken into consideration when determining medical necessity

Requirements for the Provision of Home Health Services

- Requests are reviewed in accordance with clinical criteria, guidelines, or medical policies
- Coverage determination is based upon a clinical review of submitted case-specific information with consideration for a person-centered approach
- Payment is based on the member having active coverage and benefits, and the policies in effect at the time of service
- All determinations are made on the basis of medical necessity
- Determinations must be in compliance with the definition of Medical Necessity, Regulation 17b-259b(a)

Definition of Medical Necessity

- Section 17b-259b(a)
- "Medical Necessity" (or "Medically Necessary") means those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition; including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are:

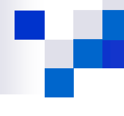
  (1) Consistent with generally-accepted standards of medical practice that are defined as standards based on:

  (A) Credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community

  (B) Recommendations of a physician-specialty society

  (C) The views of physicians practicing in relevant clinical areas

  (D) Any other relevant factors



Definition of Medical Necessity (cont.)

(2) Clinically appropriate in terms of type, frequency, timing, site, extent and duration, and considered effective for the individual's illness, injury or disease

(3) Not primarily for the convenience of the individual, the individual's healthcare provider, or other healthcare providers

(4) Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury, or disease

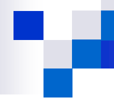
(5) Based on an assessment of the individual and his/her medical condition

All final determinations of medical necessity must be based upon this statutory definition

Types of Home Health Services

- Skilled Nursing Visits (SN)
- Extended or Complex Nursing (CN)
- Medication Administration Visits (MA)
- Home Health Aide (HHA)
- HHA Medication Administration
- HHA Medication Prompting
- Personal Automated Medication Boxes
- Physical Therapy (PT)
- Speech Therapy (ST)
- Occupational Therapy (OT)
- Start of Care/Resumption of Care (SOC)

Documentation Requirements by Service Type



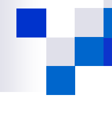
Required Documentation: SN Visits

Initial Request:

- Comprehensive start of care nursing assessment
- Completed and signed 485 form, if available. Otherwise, a verbal order from the physician overseeing the plan of care and ordering the services
- Schedule of days/visits/hours the licensed nurse will be going to the home and the skilled interventions to be provided during that time (can be in the assessment)

Reauthorization Request:

- Current comprehensive nursing recertification assessment
- Current 485 signed by the ordering physician. If current 485 is not yet signed, a verbal order for the services to be provided during the requested dates of service
- Previous 1-2 weeks of nursing notes. Must include recent wound measurements if services are for wound care



Required Documentation: CN Services

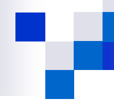
Initial Request:

- Comprehensive start of care nursing assessment
- Completed and signed 485 form, if available. Otherwise, a verbal order from the physician overseeing the plan of care and ordering the services
- Written plan of care that includes schedule of days/hours the licensed nurse will be going to the home and the continuous and skilled interventions/assessments to be provided during that time (can be in the assessment)

Reauthorization Request:

- Current comprehensive nursing recertification assessment
- Current 485 signed by the ordering physician. If current 485 is not yet signed, a verbal order for the services to be provided during the requested dates of service
- Previous two weeks of nursing narrative notes

Extended nursing services are not a covered benefit under HUSKY B



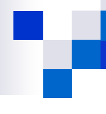
Required Documentation: MA Visits

Initial Request:

- Start of care nursing assessment
- Completed and signed 485 form, if available. Otherwise, a verbal order from the physician overseeing the plan of care and ordering the services
- Written plan of care that includes the physical, functional, or developmental barrier leading to medication non-compliance, and the schedule of planned visits i.e. *BID 7 days a week* (can be in the assessment)

Reauthorization Request:

- Current comprehensive nursing recertification assessment
- Current 485 signed by the ordering physician. If current 485 is not yet signed, a verbal order for the services to be provided during the requested dates of service
- Previous 1-2 weeks of nursing notes. Must include recent test for success, education, and progress toward goals for self-administration



Required Documentation: HHA Visits

Initial Request:

- A start of care nursing assessment
- A completed and signed 485 form, if available. Otherwise, a verbal order from the physician overseeing the plan of care and ordering the HHA services, followed by faxing the signed 485 when complete
- The ***15-minute breakdown*** of the hands-on personal care/activities of daily living (ADL) tasks expected to be provided to the member as well as the specified days and hours

Reauthorization Request:

- A current 60-day certification nursing assessment and written plan of care
- An updated 485 form signed by the physician ordering and overseeing the plan of care
- The ***15-minute breakdown*** of hands-on personal care/ADL tasks expected to be provided to the member as well as the specified days and hours

Required Documentation: HHA Medication Administration Visits

Initial Request:

- A start of care nursing assessment
- A completed and signed 485 form, if available. Otherwise, a verbal order from the physician overseeing the plan of care and ordering the HHA-medication administration services
- An assessment completed by a Registered Nurse (RN) documenting that medication administration can be accurately and safely performed by the trained HHA

Reauthorization Request:

- A current 60-day certification nursing assessment and written plan of care
- An updated 485 form signed by the physician ordering and overseeing the plan of care
- Previous two weeks of medication administration notes and most recent nursing supervisory notes

Required Documentation: HHA Medication Prompting Visits

Initial Request:

- A start of care nursing assessment that includes descriptive documentation as to existing barriers to the individual self-administering medications every day as scheduled
- A completed and signed 485 form, if available. Otherwise, a verbal order from the physician overseeing the plan of care
- An assessment completed by an RN documenting that prompting of medications that have been pre-poured by a licensed nurse can be accurately and safely performed by the HHA

Reauthorization Request

- A current 60-day certification nursing assessment and written plan of care
- An updated 485 form signed by the physician ordering and overseeing the plan of care
- Previous two weeks of HHA medication administration documentation and most recent nursing supervisory notes

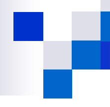
Required Documentation: Personal Automated Medication Box

Initial Request:

- Comprehensive start of care nursing assessment that includes any cognitive and/or functional/sensory impairments; history of medication non-compliance; any adverse incidents related to not taking medications on time and as ordered
- A completed and signed 485 form, if available. Otherwise, a verbal order from the physician overseeing the plan of care
- Documentation from a home visit where observation of successful medication self-administration took place

Reauthorization Request:

- A current 60-day certification nursing assessment that includes documentation supporting success with current plan of care as evidenced by improvement in the individual's compliance with self-administration
- An updated 485 form signed by the physician ordering the medications and overseeing the plan of care



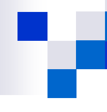
Required Documentation: PT/ST/OT

Initial Request:

- Comprehensive therapist evaluation and written plan of care including the problems, planned modalities, and the short and long term goals for attaining and/or maintaining improvement or preventing decline
- A completed 487/485 form signed by the physician ordering the services

Reauthorization Request:

- Comprehensive therapy re-evaluation
- Current 487/485 form signed by physician ordering the services
- Previous month of therapy notes
- Therapist re-assessment showing progress towards established goals
- Documentation of a home exercise program and/or any maintenance strategies put in place

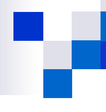


Additional Documentation Requirements

In addition to the standard required documentation for all home health services, CHNCT and Beacon CT reserves the right to request any and all additional clinical or psychosocial information in order to make an informed, person-centered medical necessity determination

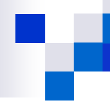
Medical Necessity Determinations

- Once all necessary information is received, requests for home health services are reviewed in accordance with guidelines, medical policies, and the DSS Definition of Medical Necessity
- All medical necessity reviews are conducted utilizing a person-centered approach
- Determinations are based upon a clinical review of submitted case-specific information with consideration being given to relevant psychosocial factors



Determination Notifications

- If a request has been approved, letters are generated within 48 hours of the decision being made
- The home health provider will receive the approval notification via a note in the web portal and an approval letter by fax
- The member will receive the approval letter via mail
- If a request has been denied, letters are generated within 24 hours after the decision has been made
- The written notification will include an outline of the appeal process
- All letters are faxed to the home health provider and mailed to the member within three business days from the date of the decision



Conclusion

- All medical necessity reviews are conducted utilizing a person-centered approach
- Determinations are based upon a clinical review of submitted case-specific information with consideration being given to relevant psychosocial factors
- CHNCT and Beacon CT have standard required documentation for all home health care service types but reserves the right to request any additional information necessary to make a medical necessity determination
- PA requests lacking standard documentation or specifically requested additional clinical or psychosocial information will be pended for up to twenty (20) business days
- Requests pended for additional information that was not received will be denied for lack of sufficient information no later than business day twenty (20)

Questions/Comments