

Overview of the Home Health Services Prior Authorization Process

June 13, 2019





Objectives

- Understand the HUSKY Health program's person-centered Prior Authorization (PA) process for home health services
- Gain a working knowledge of the documentation requirements for both initial and re-authorization requests
- Reduce provider administrative burden and 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 healthcare services or goods provided to HUSKY Health members
- All referrals for home health services must come from either an ordering/prescribing/referring (OPR) or CMAP provider
- Determinations are made on a case-by-case, person-centered clinical assessment of the member and their clinical needs

Definition of Person-Centeredness

- All aspects of a person's medical needs are taken into consideration when determining medical necessity for a healthcare good or service
- While clinical reviewers use medical criteria, guidelines, and policies to determine medical necessity, these are guidelines and not an absolute





Person-Centeredness in PA

- The member may have a comorbid medical condition or psychosocial situation that impacts their medical needs
- These situations are reviewed and taken into consideration when determining medical necessity
- Because every individual is unique, a person-centered approach is necessary to determine medical necessity for any requested good or service



PA Determinations

All determinations are made on the basis of medical necessity and 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 which are defined as:
 - (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 their medical condition

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

Face-to-Face Requirements

- As required by federal law, effective for home health services ordered on or after July 1, 2017, a face-to-face visit and physician certification will be required for home health services
- The Centers for Medicare and Medicaid Services (CMS) requires that individuals receiving home health services must have a face-to-face visit with the ordering physician either 90 days before or 30 days after the start of the services
- Documentation of the face-to-face encounter must be maintained in the member's records at the home health agency
- The face-to-face encounter is not a requirement for PA purposes
- Please refer to [Provider Bulletin 2017-02](#) ***New Face-to-Face Requirements for Initial Orders of Home Health Services***



Home Health Services Requiring PA

Access the Home Health Benefit Grid


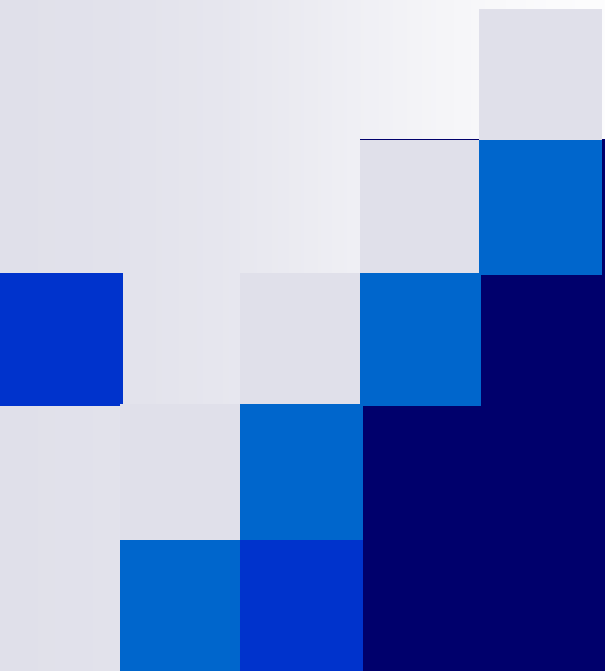
- The home health benefit grid is available on the HUSKY Health website to help you determine what home care services require PA
- Go to www.ct.gov/husky, click “**For Providers,**” “**Medical Management,**” “**Benefit Grids,**” then “**Home Health Grid**”



HUSKY Health Program Benefit Grids

Ambulatory Surgical Clinic Grid - Revised on 6/14/17	Lab Grid - Revised on 8/22/17
BHP Grid - Revised on 9/2/15	Limited Eligibility Grid - Revised on 1/8/18
Chiropractor Grid - Revised on 7/19/17	Medical Clinic Grid - Revised on 6/14/17
Chronic Disease Hospital and Long Term Care Grid - Revised on 6/14/17	Naturopath Grid - Revised on 6/14/17
DHP Grid - Revised on 6/20/14	Outpatient Hospital Grid - Revised on 7/18/17
Dialysis Clinic Grid - Revised on 6/14/17	Physician Grid - Revised on 7/12/17
DME Grid - Revised on 3/1/18	Podiatry Grid - Revised on 6/14/17
Family Planning Clinic Grid - Revised on 7/12/17	Radiology Grid - Revised on 6/14/17
Home Health Grid - Revised on 6/14/17	Rehab Clinic Grid - Revised on 7/18/17
Hospice Grid - Revised on 6/20/14	Transportation Grid - Revised on 1/8/18
HUSKY Plus Grid - Revised on 3/1/18	Therapy Grid - Revised on 7/18/17
Inpatient Hospital Grid - Revised on 6/14/17	Vision Grid - Revised on 1/12/18

http://www.huskyhealthct.org/providers/provider_postings/benefits_grids/Home_Health_Grid.pdf



How to Submit a PA Request

Methods for Submission

- All home health services requests must be submitted through the Community Health Network of Connecticut, Inc. (CHNCT) *Medical Authorization Portal* (Clear Coverage™)
- 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](#)

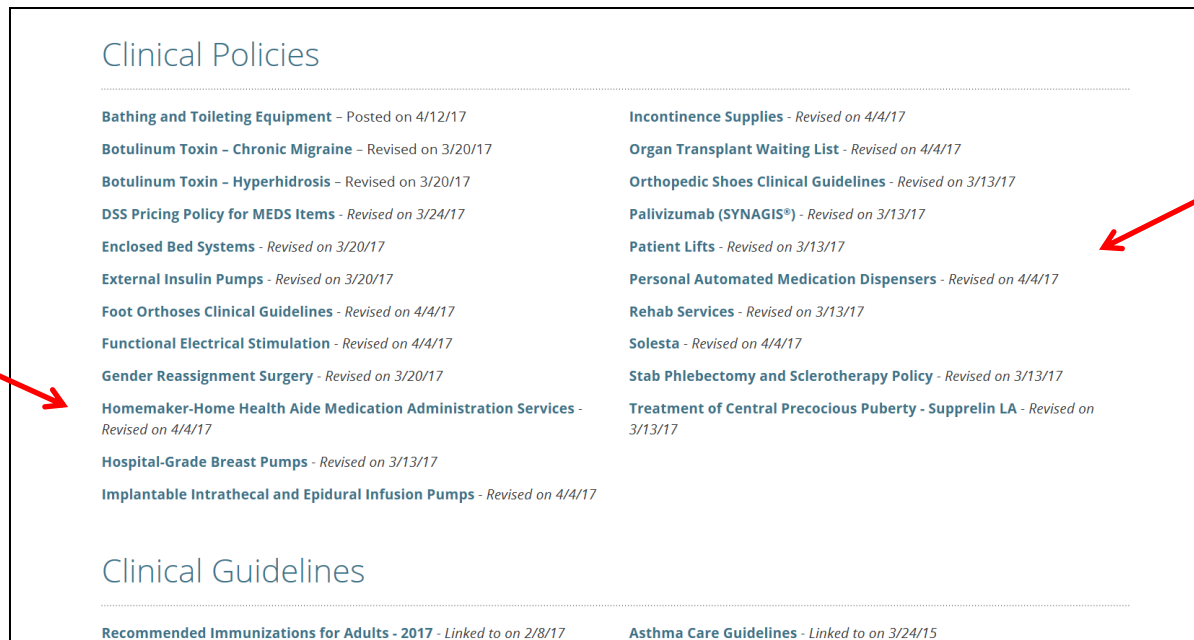
Basic Requirements for Requests

You must submit:

- A current CMS-485 signed by the physician
- If the current 485 is not signed then a verbal order is required for the specific services being requested, signed by the registered nurse (RN)
- Clinical documentation supporting the medical necessity of the requested home health services

Required Clinical Information

To reference Clinical Policies, visit www.ct.gov/husky, click “**For Providers**,” “**Medical Management**,” then “**Policies, Procedures, & Guidelines**” if submitting PA for Home Health Aide Medication Administration (MA) or use of a Personal Automated Medication Dispenser:



Clinical Policies

Bathing and Toileting Equipment - Posted on 4/12/17	Incontinence Supplies - Revised on 4/4/17
Botulinum Toxin - Chronic Migraine - Revised on 3/20/17	Organ Transplant Waiting List - Revised on 4/4/17
Botulinum Toxin - Hyperhidrosis - Revised on 3/20/17	Orthopedic Shoes Clinical Guidelines - Revised on 3/13/17
DSS Pricing Policy for MEDS Items - Revised on 3/24/17	Palivizumab (SYNAGIS®) - Revised on 3/13/17
Enclosed Bed Systems - Revised on 3/20/17	Patient Lifts - Revised on 3/13/17
External Insulin Pumps - Revised on 3/20/17	Personal Automated Medication Dispensers - Revised on 4/4/17
Foot Orthoses Clinical Guidelines - Revised on 4/4/17	Rehab Services - Revised on 3/13/17
Functional Electrical Stimulation - Revised on 4/4/17	Solesta - Revised on 4/4/17
Gender Reassignment Surgery - Revised on 3/20/17	Stab Phlebectomy and Sclerotherapy Policy - Revised on 3/13/17
Homemaker-Home Health Aide Medication Administration Services - Revised on 4/4/17	Treatment of Central Precocious Puberty - Supprelin LA - Revised on 3/13/17
Hospital-Grade Breast Pumps - Revised on 3/13/17	
Implantable Intrathecal and Epidural Infusion Pumps - Revised on 4/4/17	

Clinical Guidelines

Recommended Immunizations for Adults - 2017 - Linked to on 2/8/17	Asthma Care Guidelines - Linked to on 3/24/15
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http://www.huskyhealthct.org/providers/policies_procedures.html

When to Submit PA Requests

- All initial requests for services must be submitted no later than two (2) business days of the date of the start of care (SOC) assessment
- All re-authorization requests must be submitted prior to the end date on the previous PA
- Failure to comply in either instance may result in non-coverage of some of the services



For all PA Requests

CHNCT reserves the right to request additional clinical information in order to make a person-centered medical necessity determination



Submitting Initial PA Requests

Skilled Nursing or Complex Nursing

- Start of care (SOC) 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)
- CHNCT reserves the right to request additional clinical information in order to make a person-centered medical necessity determination

Medication Administration

- SOC 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 planned visits i.e. *BID 7 days a week*

Home Health Aide

- SOC 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 and hours the aide will be going to the home and the 15-minute breakdown of activities of daily living (ADL) tasks expected to be provided



Submitting Reauthorization PA Requests



Skilled Nursing or Complex Nursing

- Current comprehensive nursing recertification assessment
- Current 485 signed by the ordering doctor. 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

Start of Care Assessments

- The SOC visit for home health services must be billed under the HCPCS code T1001
- PA must be obtained for the second and any subsequent SOC visits being provided to a member in the same calendar year
- PA requests for additional SOC visits must be submitted through the web portal within two (2) business days of the date of the visit
- An explanation of the need for the additional SOC visit as well as the assessment itself must be included

Resumption of Care Assessments

- When a resumption of care (ROC) visit occurs, a new assessment must be created to supplement the current plan of care
- All ROC visits must be billed under the HCPCS code T1001
- PA must be obtained if HCPCS code T1001 will be billed for the same member in the same calendar year
- PA requests for ROC visits must be submitted through the web portal within two (2) business days of the date of the visit
- The ROC nursing assessment/evaluation itself must be submitted for review



Medication Administration

- Current comprehensive nursing recertification assessment
- Current 485 signed by the ordering doctor. 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

Home Health Aide

- Current comprehensive nursing recertification assessment
- Current 485 signed by the ordering doctor. If current 485 is not yet signed, a verbal order for the services to be provided during the requested dates of service
- Schedule of days and hours the aide will be in the home and the 15-minute breakdown of continued ADL tasks to be provided



Submitting Modification Requests

Modification Requests

- A modification is a request to make a change to an existing authorization
- These requests **MUST** be submitted by fax (no web portal)
- All requests for increase in services or to add a third nursing visit in the same week must be submitted via a completed Outpatient Prior Authorization Request Form
- All service increases and third nursing visits must include an updated 485 or a verbal supplemental order
- All third nursing visits must include a clear explanation of the need for the visit along with a copy of the nursing narrative note from the additional visit

Modification Requests (cont.)

- All requests for an increase to complex nursing or Home Health Aide (HHA) services must include documentation as to the change in the member's condition necessitating the change
- It is necessary to wait two (2) business days from the time the approval notification is received before submitting claims against a PA that has been modified

Outpatient PA Request Form

- Visit www.ct.gov/husky, click “**For Providers,**” “**Medical Management,**” “**Forms,**” then “**Outpatient Prior Authorization Request Form**”

Provider Forms


Find all forms available for provider use below. Some forms may also be found in related sections of the provider website.

Forms

- [Advanced Imaging Prior Authorization Request Form](#)
- [Escalation Referral Form](#)
For help locating a specialist, other provider, or community resources for your HUSKY patients. Please fax to [203.265.3197](tel:203.265.3197) or e-mail to reachforescalation@chnct.org
- [Eteplirsen Prior Authorization Form](#)
- [Genetic Testing Prior Authorization Form](#)
- [ICM Referral Form](#)
- [Inpatient Acute Rehabilitation & Chronic Disease Hospital \(CDH\) Request Form](#)
For all inpatient admissions requests to Acute Rehabilitation and Chronic Disease Hospital; complete and fax the form to [203.774.0551](tel:203.774.0551).
- [Inpatient Chemotherapy Request Form](#)
For all elective inpatient chemotherapy admissions requests, please complete and fax the form to [203.265.3994](tel:203.265.3994).
- [Inpatient Surgery/Procedure Request Form](#)
For all elective inpatient admissions requests, such as preoperative day admissions, elective inpatient surgeries, and elective medical procedures; complete and fax the form to [203.265.3994](tel:203.265.3994).
- [KYMRIA™ \(tisagenlecleucel\) Prior Authorization Form](#)
- [LUXTURN™ \(voretigene neparvovec-rzyl\) Prior Authorization Form](#)
- [Non-invasive Prenatal Testing for Fetal Aneuploidy Prior Authorization Request Form](#)
- [Outpatient Prior Authorization Request Form](#)
Authorization requests for home care must be submitted through the Medical Authorization Portal. Outpatient hospital-based therapy may be requested via fax to [203.265.3994](tel:203.265.3994).
- [Palivizumab \(Synagis®\) Request Form](#)
For use by clinics and private practices.
- [Palivizumab \(Synagis®\) Outpatient Hospital Request Form](#)
For information on the coverage guidelines and procedures for requesting authorization for Palivizumab (Synagis®), please refer to the clinical policy located on our [Policies, Procedures & Guidelines page](#).
- [Spinraza™ \(nusinersen\) Prior Authorization Request Form](#)
For information on the coverage guidelines and procedures for requesting authorization for Spinraza™ (nusinersen) please refer to the clinical policy located on our [Policies, Procedures & Guidelines page](#).
- [Wheeled Mobility Device Guidelines](#)
 - [Wheeled Mobility Letter of Medical Necessity Form](#) (PDF version)
 - [Wheeled Mobility Letter of Medical Necessity Form](#) (MS Word version)
 - [Accessibility Survey](#)
- [Whole Exome Sequencing and Whole Genome Sequencing Prior Authorization Request Form](#)
- [YESCARTA® \(axicabtagene ciloleucel\) Prior Authorization Request Form](#)

Outpatient PA Request Form

- Full instructions on Page 2 of form
- All boxes must be completed in order for your request to be considered for coverage
- Include a face sheet to indicate retrospective eligibility or modification request



Outpatient Prior Authorization Form

This form may be filled out by typing in the field, or printing and writing in the fields. Please fax completed form to CHNCT at 1.203.265.3994. Please call CHNCT's provider line at 1.800.440.5071 with any questions.

BILLING PROVIDER INFORMATION				MEMBER INFORMATION			
1. Medicaid Billing Number:				7. Member ID Number:			
2. Billing Provider Name:				8. Member Name (Last, First):			
3. Street Address:				9. Street Address:			
4. City, State, Zip:				10. City, State, Zip:			
5a. Contact Name/Telephone Number:				11. Date of Birth (MM/DD/YYYY):			
5b. Contact Fax Number:				12. Sex:			
6. Referring MD/Information: Name, Address, Medicaid ID #, Phone #, and Fax #				13. Primary Diagnosis Code:			
				14. Estimated Delivery Date (DME ONLY) (MM/DD/YYYY):			

15. Authorization Service Requested (Check all that apply):

<input type="checkbox"/> Customized Wheelchair	<input type="checkbox"/> Medical/Surgical Services	Independent Chiropractic	<input type="checkbox"/> Evaluation	<input type="checkbox"/> Initial	<input type="checkbox"/> Re-Auth
<input type="checkbox"/> DME	<input type="checkbox"/> Orthotic & Prosthetic Devices	Home Health		<input type="checkbox"/> Initial	<input type="checkbox"/> Re-Auth
<input type="checkbox"/> Genetic Testing/Lab Services	<input type="checkbox"/> Oxygen	Occupational Therapy		<input type="checkbox"/> Initial	<input type="checkbox"/> Re-Auth
<input type="checkbox"/> Hearing Aids	<input type="checkbox"/> Professional/Surgical Services	Physical Therapy		<input type="checkbox"/> Initial	<input type="checkbox"/> Re-Auth
<input type="checkbox"/> Hospice	<input type="checkbox"/> Vision Care Services	Speech Therapy		<input type="checkbox"/> Initial	<input type="checkbox"/> Re-Auth

16a. HUSKY Plus: Yes No 16b. Birth to Three Provider: Yes No

17. Line Item	Start Date (MM/DD/YYYY)	End Date (MM/DD/YYYY)	18. Place of Service	19. Proc/RCC Code/List	20. Mod 1	21. Mod 2	22. Mod 3	23. Units	24. Total Cost Dollars
1									
2									
3									
4									
5									
6									
7									
8									

25. Clinical Statement: Include a prognosis and rehabilitation potential in the space provided below. A current plan of treatment and progress notes as to the necessity, effectiveness, and goals of service requested must be attached.

Signature of Clinical Practitioner: _____ Date: _____

26. Certification Statement: This is to certify that the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of this patient and that a prescribing practitioner signed order is on file (if applicable). This form and any statement on my letterhead attached hereto has been completed by me, or by my employee and reviewed by me. The foregoing information is true, accurate and complete, and I understand that any falsification, omission, or concealment of material fact may be subject me to civil and criminal liability.

Signature of Billing Provider: _____ Date: _____



After PA Submission

PA Request Review

- Once the request is entered, a pending authorization number will be generated
- The authorization is assigned to a CHNCT clinical reviewer
- If more information is needed, the clinical reviewer will contact the provider to request the information required to review the request and the request will be pended until the necessary information is received

Process Turnaround Time

- All initial requests for home health services are reviewed within two business days from the date the request is received. Reauthorization requests are reviewed within 14 calendar days of the date received
- If more information is needed, the clinical reviewer will contact the provider and the provider is given additional time to submit the requested information
- A decision must be made by the 20th business day from the date of receipt
- If the requested information is not submitted, then this results in a lack of information denial



Denial Notification

- Denial letters are faxed to requesting providers and referring physicians
- Denial letters are mailed to members within three (3) business days from the decision date
- All denial notifications contain information on how to file a member appeal or a provider re-evaluation request

Approval Notification

- Approval letters are generated after the request has been approved within two (2) business days after the decision has been made
- The home health provider will receive the approval notification via a note in the web portal and an approval letter by fax
- The referring physician will receive approval by fax and the member will receive the approval letter by mail





Questions/Comments