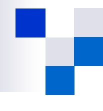
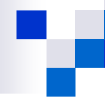
Overview of the Prior Authorization Process for Home Health Aide Services

June 27, 2018



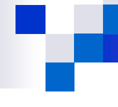
Objectives

- Understand the HUSKY Health program’s Prior Authorization (PA) process for home health aide (HHA) services
- Gain a working knowledge of the documentation and care plan requirements for both initial and re-authorization requests
- Reduce administrative burden associated with the PA process
- Improve provider satisfaction with the PA process



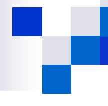
PA Introduction

- 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 HHA Services

- HHA 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 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

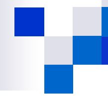


Person-Centered Care Planning

- 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



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:

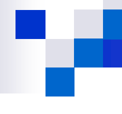
  (1) Consistent with generally-accepted standards of medical practice that are defined as standards based on:

  (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

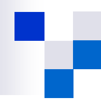
(5) Based on an assessment of the individual and his/her medical condition

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

HHA Definition

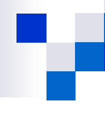
The term “Homemaker-Home Health Aide” is defined by Sec.19-13-D66 of the Regulations of Connecticut State Agencies as:

An unlicensed person who has successfully completed a training and competency evaluation program for the preparation of homemaker-home health aides approved by the Connecticut Department of Public Health (DPH)



HHA Services

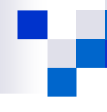
- Non-skilled, hands-on assistance for personal care and activities of daily living (ADLs)
- Typically provided in a member's home
- Administered under the direction of a written person-centered plan of care and supervised by a registered nurse
- The plan of care is both ordered and overseen by the member's attending physician
- Requested and billed with HCPCS Code T1004: "Services of a qualified nursing aide, up to 15 minutes"



HHA Plan of Care

When designated by the supervising primary care nurse, the HHA plan of care may include:

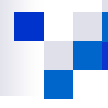
- Assisting the member with personal care ADLs including bathing, oral hygiene, feeding, and dressing
- Assisting the member with exercises, ambulation, transfer activities, and prompting to take medications that are either pre-poured by a nurse or taken independently
- Performing some incidental activities of daily living (IADLs) that directly correspond to a hands-on ADL such as simple meal prep (heating up already prepared food) before feeding or changing sheets during or after bathing



HHA Plan of Care (cont.)

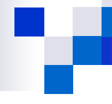
When designated by the supervising primary care nurse, the HHA plan of care should not typically include:

- Homemaker services such as shopping, making meals, doing laundry, or any other housecleaning chores
- Lengthy amounts of time allotted for AM and PM care, feeding, toileting, ambulation, and bed to chair or room to room transfers
- Companion services
- Being in attendance to provide oversight and supervision for member safety



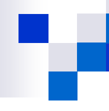
Requesting PA: HHA Services

- All requests for HHA services in excess of 14 hours per week must be submitted through the Community Health Network of Connecticut, Inc. (CHNCT) *Medical Authorization Portal* (Clear Coverage™)
- Requests backdated more than five calendar days due to retro eligibility and *all* requests for modifications to existing authorizations must be faxed to CHNCT at 203.265.3994
- Retrospective and modification requests must be faxed in using the Outpatient Prior Authorization Request Form



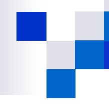
Required Documentation: HHA Initial

- A start of care nursing assessment
- A completed and signed 485 form, if available. Otherwise, a verbal order from the doctor overseeing the plan of care and ordering the HHA services, followed by faxing the signed 485 when complete
- The ***15-minute breakdown*** of hands-on ADL tasks expected to be provided to the member as well as the specified days and hours
- CHNCT reserves the right to request additional clinical information in order to make a medical necessity determination



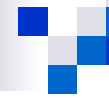
Required Documentation: HHA Re-authorization

- 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 ADL tasks expected to be provided to the member as well as the specified days and hours
- CHNCT reserves the right to request additional clinical information in order to make a medical necessity determination



Required Documentation: 15 Minute Breakdown

- The 15 minute breakdown is the documented plan of care for the HHA as designated by the primary care nurse
- It outlines the days of the week and the scheduled hours of each day that the HHA is providing services to the member broken down in 15 minute increments
- The breakdown must show that the HHA is providing the member with *hands-on* personal care assistance for every 15 minute increment for the duration of the visit



Medical Necessity: 15 Minute Breakdown

The 15 minute breakdown should typically reflect reasonably appropriate amounts of time for:

- Bathing
- Toileting
- Dressing
- Feeding
- Transfers/Ambulation
- Prompting or cueing necessary for a member to self administer medication(s) or independently perform personal care/ADL tasks

Example # 1

1 hour AM - 6:15 a.m. - 7:15 a.m. (Sunday – Saturday)

6:15 a.m. - 6:30 a.m. – Get client into shower

6:30 a.m. - 6:45 a.m. – Shower and dry client

6:45 a.m. - 7:00 a.m. – Provide mouth care, grooming

7:00 a.m. - 7:15 a.m. – Dress client for day program or for activity with family

2 hours PM - 7:00 p.m. - 9:00 p.m. (Sunday – Saturday)

7:00 p.m. - 7:15 p.m. – Toilet client

7:15 p.m. - 7:30 p.m. – Assist client with preparation for shower for incontinent care

7:30 p.m. - 7:45 p.m. – Assist with shower

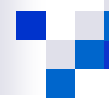
7:45 p.m. - 8:00 p.m. – Continue to assist with shower/washing hair

8:00 p.m. - 8:15 p.m. – Dry client and apply lotion

8:15 p.m. - 8:30 p.m. – Mouth care and hair care

8:30 p.m. - 8:45 p.m. – Toilet client and redirect as needed

8:45 p.m. - 9:00 p.m. – Dress client for bed



Medical Necessity:
15 Minute Breakdown (cont.)

The 15-minute breakdown should *not* typically include:

- Assistance getting off of a bus and into a residence
- Participating in recreational activities
- Household chores (washing dishes, laundry)
- Preparing meals/snacks
- Inordinate amounts of time allotted for transfers, ambulating from room to room, and carrying out basic ADL tasks

Example # 2

2 hours AM - 6:15 a.m. - 8:15 a.m. (Sunday – Saturday)

6:15 a.m. - 6:30 a.m. – Wake client up

6:30 a.m. - 6:45 a.m. – Assist client to get out of bed and walk to bathroom

6:45 a.m. - 7:00 a.m. – Stand-by assist with toileting

7:00 a.m. - 7:15 a.m. – Assist with washing face/hands

7:15 a.m. - 8:00 a.m. – Assist with dressing

8:00 a.m. - 8:15 a.m. – Assist client to kitchen for breakfast

3 hours PM - 3:00 p.m. - 6:00 p.m. (Sunday – Saturday)

3:00 p.m. - 3:15 p.m. – Assist client off bus and into house

3:15 p.m. - 3:30 p.m. – Assist client to bathroom

3:30 p.m. - 4:00 p.m. – Assist client with toileting and washing hands

4:00 p.m. - 4:15 p.m. – Assist client to kitchen

4:15 p.m. - 5:00 p.m. – Prepare client a snack

5:00 p.m. - 5:15 p.m. – Supervise client eating snack

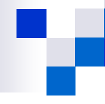
5:15 p.m. - 5:30 p.m. – Assist client to living room

5:30 p.m. - 5:45 p.m. – Assist with reading a book

5:45 p.m. - 6:00 p.m. – Assist with activity of client’s choice

HHA Visit: Medication Prompting

- Requested and billed with HCPCS Code H0033: "Oral medication administration, direct observation"
- Intended for individuals requiring daily or more frequent medication administration (MA) visits
- HHA does not administer, only "prompts" the client to take medications pre-poured by a licensed nurse
- Requires PA from either medical – CHNCT, or behavioral – CT Behavioral Health Partnership ASO depending on the driving need for assistance to maintain medication compliance
- Required documentation mirrors that of HHA visits for personal/ADL care with the exception of the 15-minute breakdown (not required)

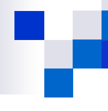


HHA Visit: Medication Prompting (cont.)

HCPCS Code H0033 may *not* be billed with HCPCS Code T1004:

"Services of a qualified nursing aide, up to 15 minutes"

- Exception: If individual requires medication administration prompting (H0033) at a time that *cannot* coincide with the scheduled home health aide visit (T1004), agency may request authorization and bill for both codes on same date of service

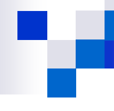


Medical Necessity Determinations

- Once all necessary information is received, requests for HHA 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 requests for HHA services in excess of 14 hours per week require PA
- The intent of HHA services is to provide non-skilled, hands-on assistance for personal care and ADLs
- HHA services are not intended to provide companion, respite, or homemaker services such as shopping, making meals, doing laundry, or any other housecleaning chores
- The HHA plan of care is expected to include a 15 minute breakdown reflecting reasonably appropriate time allotments for basic ADL tasks
- 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

Questions/Comments