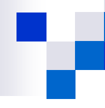
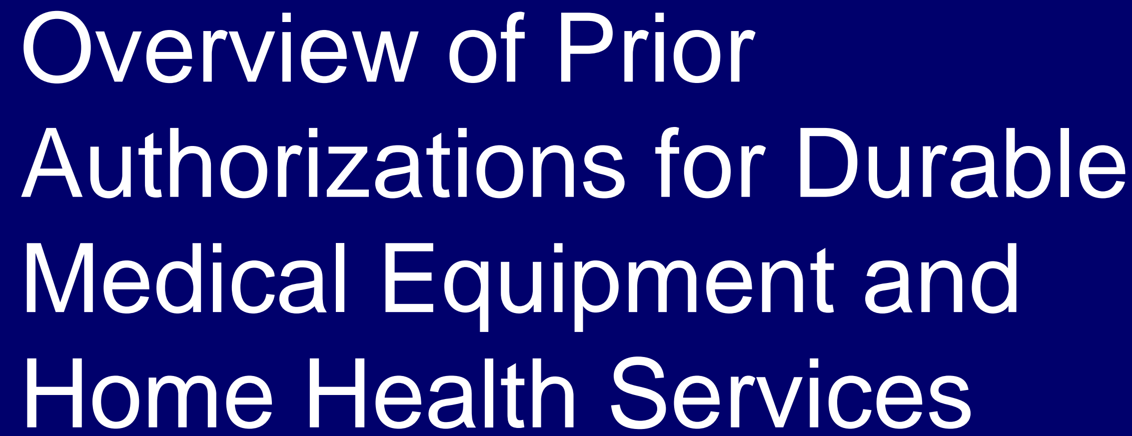
Prior Authorization for Department of Developmental Services (DDS) Waiver Participants

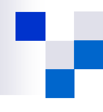
February 6, 2019



DDS Overview

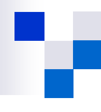
- DDS Waiver can't pay for exactly the same goods and/or services under the waiver that are covered by the HUSKY Health program until you first use those services


Overview of Prior Authorizations for Durable Medical Equipment and Home Health Services



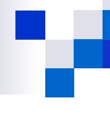
Objectives

- Overview of the Prior Authorization (PA) process for Durable Medical Equipment (DME) and Home Health Services
- Access and use of the Department of Social Services (DSS) Fee Schedule
- Understanding references for basic and complex DME
- Understanding references for Home Health Services
- Review timeframes
- Prior Authorization clarification



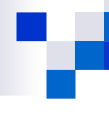
Overview

- All HUSKY Health members are eligible to receive healthcare goods or services from Connecticut Medical Assistance Program (CMAP) enrolled providers
- ***Only CMAP enrolled providers will be reimbursed*** for goods or services provided to HUSKY Health members
- All ordering, prescribing, or referring providers must be enrolled as either an ordering/prescribing/referring (OPR) or CMAP provider
- Determinations are made on a case-by-case person-centered clinical assessment of members and their clinical needs



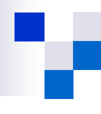
Overview (cont.)

- The Community Health Network of Connecticut, Inc. (CHNCT) Prior Authorization department works in conjunction with the Connecticut Department of Developmental Services (DDS) to coordinate care for HUSKY Health members with DDS waiver services. The goal of this coordination is to help the member obtain needed care at the right time, in the right setting, and at the most appropriate level of service
- HUSKY Health members residing in DDS medication-certified group homes will be authorized for skilled nursing visits required to administer injectable medication or perform fasting blood sugar checks. Oral medications and g-tube feedings are expected to be administered by the medication-certified staff, or a transitional plan will be expected to be initiated
- Home health aide (HHA) services should not be required for a HUSKY Health member residing in a group home. Personal care assistance is part of the services that are provided by the group home staff



Overview (cont.)

- Skilled wound care may be required for HUSKY Health members in a group home, and will only be authorized as per coordination of benefits
- If the HUSKY Health member is homebound (i.e., it is considered a taxing effort to leave the home because he/she requires the aid of a wheelchair/cane, or the assistance of a person) and has Medicare prime, the wound care should be billed to Medicare first. Medicare does consider care performed to maintain the status of an individual's condition, or to slow or prevent the deterioration of the condition, as skilled care. Therefore, skilled wound care is coverable under Medicare. It is important to note that the ongoing need for skilled level of care must be documented in order to receive reimbursement from Medicare
- Please refer to the Provider Bulletin 2013-79 on the publications page of the website www.ctdssmap.com, or Chapter 11 on the same website for further billing instructions



Prior Authorization Requirements

- Required for the rental and/or purchase of select DME
  - 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 based on the member having active coverage, benefits, and policies in effect at the time of service
- 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 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

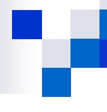
Definition of Medical Necessity (cont.)

(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

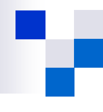
(4) Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury, or disease

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



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 co-morbid 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

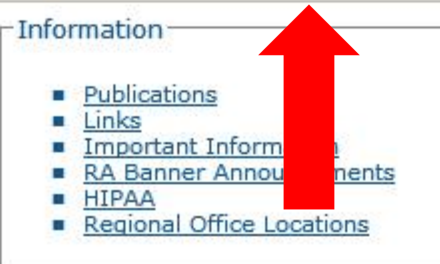
DSS Fee Schedule

Locating the DSS Fee Schedule

- Go to www.ctdssmap.com
- Click on ***"Provider"***

Help
Friday, October 16, 2015

Home Information Provider Trading Partner Pharmacy Information Hospital Modernization



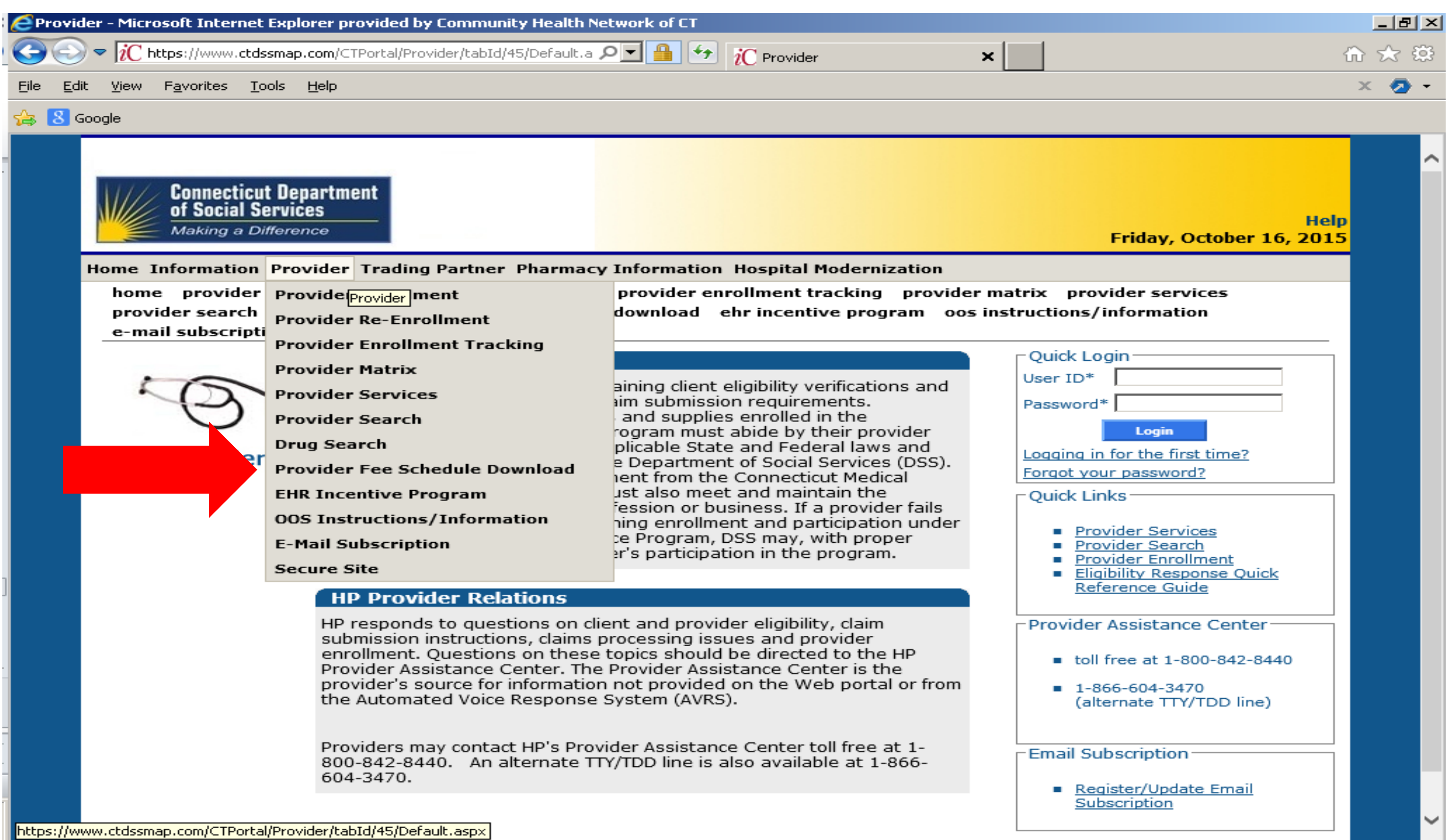
TO THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM

WELCOME TO THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM WEB SITE, PROVIDED BY HP ON BEHALF OF THE CONNECTICUT DEPARTMENT OF SOCIAL SERVICES. THIS SITE PROVIDES IMPORTANT INFORMATION TO HEALTH CARE PROVIDERS ABOUT THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM. THIS SITE CONTAINS A WEALTH OF RESOURCES FOR PROVIDERS INCLUDING ENROLLMENT, BILLING MANUALS, BULLETINS, PROGRAM REGULATIONS, PLUS INFORMATION ON ELECTRONIC DATA INTERCHANGE AND THE AUTOMATED ELIGIBILITY VERIFICATION SYSTEM.

Provider
- Provider Services
- Provider Search
- Provider Enrollment
- EHR Incentive Program
- OOS Instructions/Information
- Secure Site

Locating the DSS Fee Schedule (cont.)

- Click on ***"Provider Fee Schedule Download"***



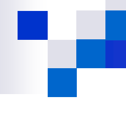
Locating the DSS Fee Schedule (cont.)

- Click on the ***"I Accept"*** button at the bottom of the License Agreement
- Choose the desired Provider Fee Schedule

***** Click here for the Fee Schedule Instructions *****

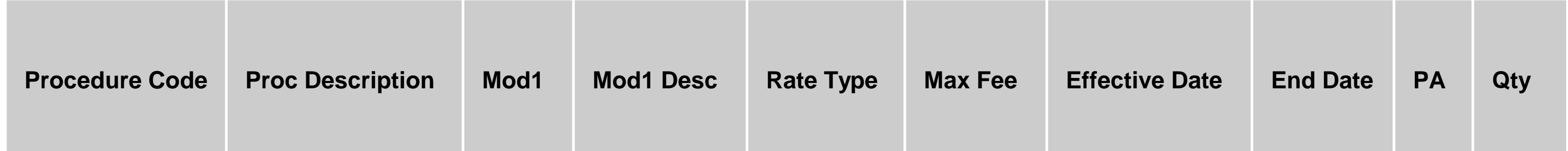
Provider Fee Schedule Download

- Home Health PDF
- MEDS - DME CSV
- MEDS-Hearing Aid/Prosthetic Eye CSV
- MEDS-Medical/Surgical Supplies CSV
- MEDS-MISC CSV
- MEDS-Parenteral-Enteral CSV
- MEDS-Prosthetic/Orthotic CSV



Navigating the DSS Fee Schedule: DME

- The columns on the Fee Schedule are as follows:



Procedure Code	Proc Description	Mod1	Mod1 Desc	Rate Type	Max Fee	Effective Date	End Date	PA	Qty

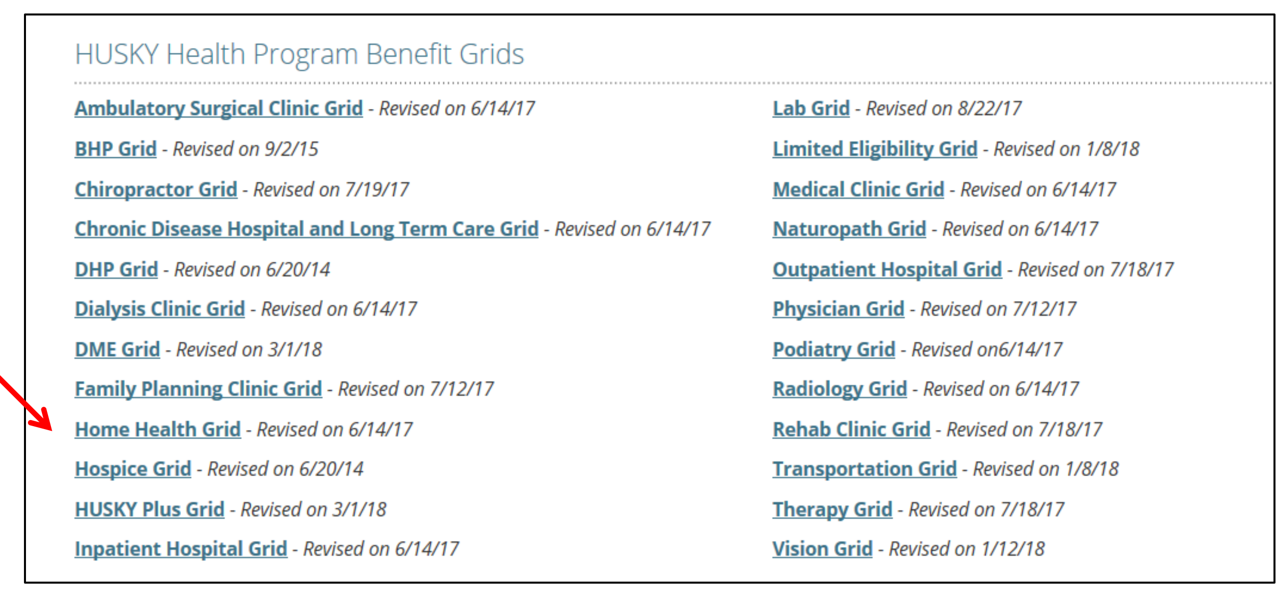
- If there is a “Y” in the ***“PA”*** column, then Prior Authorization is required for that item
- If a member needs a larger quantity than what is listed under the ***“Qty”*** column (even if there is no “Y” listed), then prior authorization is required for that item

Navigating the DSS Fee Schedule: Home Health

Revenue Ctr.Code	HCPCS Code	Modifier	Mod.	Mod.	Description	Unit	MaxFee*	Effective date	End date	PA
580	T1503				Adm of medication other than oral and/or injectable, by a health care agency/professional, per visit	per visit	$51.96	7/1/2016	12/31/2299	^
580	T1503	TT			Adm of medication other than oral and/or injectable, by a health care agency/professional, per visit, more than one patient in the same setting	per visit	$25.98	7/1/2016	12/21/2299	^
580	T1001				Nursing Assessment/Evaluation, RN	per hour	$95.20	1/1/2015	12/21/2299	
580	T1002				RN services, up to 15 minutes, (must be billed with T1001,TD)	15 min. = 1 unit	$23.80	1/1/2015	12/31/2299	
580	T1016				Katie Beckett Waiver, Case Management, each 15 minutes	15 min. = 1 unit	$23.80	1/1/2015	12/31/2299	
570	T1004				Services of a qualified nursing aide, up to 15 minutes	15 min. = 1 unit	$6.16	1/1/2015	12/31/2299	^
580	T1021				Home Health aide or certified nurse assistant, per visit	1 unit per day	$28.00	1/1/2015	12/31/2299	Y
580	H0033				Oral medication administration, direct observation	per visit	$22.00	10/1/2015	12/31/2299	Y

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***"



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

Clinical Documentation/ Medical Policies

Required Documentation
Prior Authorization Requests: DME

- Completed Outpatient Prior Authorization Request Form
- Prescription for the goods/services signed by the ordering physician
- Clinical documentation from the ordering physician (or evaluating therapist, if applicable) supporting the medical necessity of the requested goods/services

Clinical Information Required

- Reference Clinical Policies for information on specific goods. Visit www.ct.gov/husky, click "***For Providers***," "***Medical Management***," then "***Policies, Procedures & Guidelines***."

Policies, Procedures, & Guidelines

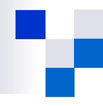
The policies, procedures, and guidelines page provides information to providers in the form of clinical policies and guidelines.

Clinical policies and guidelines are utilized by Community Health Network of Connecticut, Inc. (CHNCT), when reviewing requests for the prior authorization (PA) of various goods and services. The criteria, included in the policies, are based on the best clinical evidence available. All requests are reviewed in accordance with the Department of Social Services' (DSS) definition of medical necessity. Prior authorization means the approval from the Department of Social Services (DSS), or a contracted agent (in this case CHNCT), of a service or the delivery of goods before the provider actually performs the service or delivers the goods. To receive reimbursement from the DSS, a provider must comply with all prior authorization requirements. Obtaining PA does not guarantee paymen ensure client eligibility. It is the responsibility of the provider to verify cl eligibility for the appropriate date(s) of service.

Clinical Policies

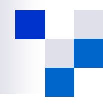
- Bathing and Toileting Equipment – Posted on 4/12/18
- Botulinum Toxin – Chronic Migraine – Revised on 6/26/18
- Botulinum Toxin – Hyperhidrosis – Revised on 4/12/18
- Compression Garments – Posted on 4/13/18
- Compressive Orthoses for Correction of Pectus Carinatum and Excavatum - *Posted on 6/26/18*
- Cranial Remodeling Devices - *Posted on 6/26/18*
- DSS Pricing Policy for MEDS Items - *Revised on 9/28/18*
- Electric Tumor Treatment Field Therapy - *Revised on 9/19/18*
- Enclosed Bed Systems - *Revised on 9/19/18*
- EXONDYS 51™ (eteplirsen) - *Posted on 11/14/17*
- Implantable Intrathecal and Epidural Infusion Pumps - *Revised on 4/12/18*
- Incontinence Supplies - *Revised on 4/12/18*
- Intrapulmonary Percussive Ventilation Systems for Home Use - *Pos on 6/26/18*
- KYMRIAH™ (tisagenlecleucel) - *Posted on 3/27/18*
- LUXTURNA™ (voretigene neparvovec-rzyl) - *Posted on 3/27/18*
- Organ Transplant Waiting List - *Revised on 4/12/18*
- Orthognathic Surgery - *Posted on 6/26/18*
- Orthopedic Shoes Clinical Guidelines - *Revised on 6/26/18*
- OVA1®)(Multivariate Index Assay) - *Revised on 6/28/18*

http://www.huskyhealthct.org/providers/policies_procedures.html



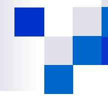
Medical Policies

- Enclosed Bed Systems
- External Insulin Pumps
- Foot Orthoses
- Functional Electrical Stimulation
- Hospital-Grade Breast Pumps
- Incontinence Supplies
- Orthopedic Shoes
- Patient Lifts
  - Hoyer, sit to stand and fixed ceiling lifts



Miscellaneous Equipment

- Standard bathing/hygiene equipment
- Custom bathing/hygiene equipment
- Stair glides
- Alternative positioning devices
- Specialty walkers and gait trainers
- Specialty beds and mattresses



Miscellaneous Equipment Documentation

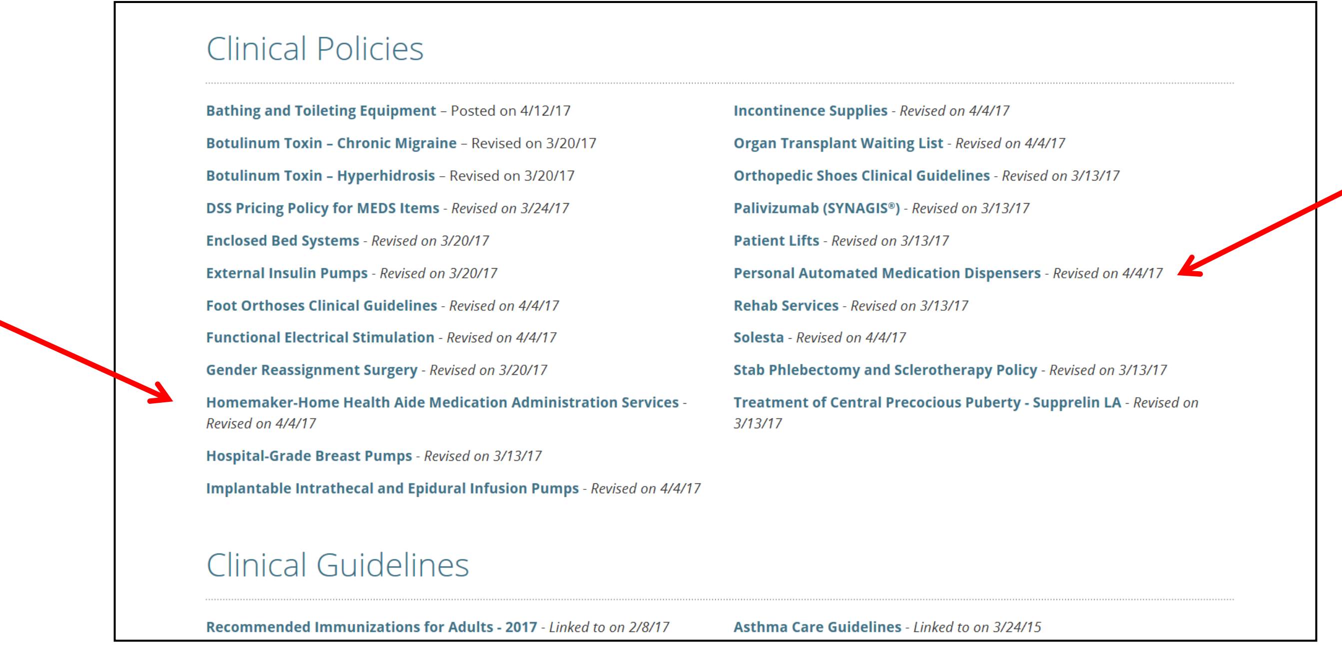
- Therapist evaluation
- Results of the equipment trial or simulation
- What else was tried or ruled out
  - Reasons it was ineffective
  - Will need to identify why less costly alternatives will not work
- Home evaluation, if applicable
- Home accessibility confirmed

Required Documentation
Prior Authorization Requests: Home Health

- 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

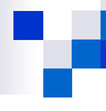
Required Clinical Information

Please reference the Clinical Policies located on the "***Policies, Procedures, & Guidelines***" page of the HUSKY Health provider website if submitting PA for Home Health Aide Medication Administration (MA) or use of a Personal Automated Medication Dispenser:



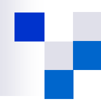
http://www.huskyhealthct.org/providers/policies_procedures.html

Submitting Initial PA Requests: Home Health



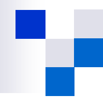
Skilled Nursing or Complex Nursing

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



Medication Administration

- 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 planned visits e.g. *BID 7 days a week*



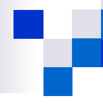
Home Health Aide

- 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 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: Home Health

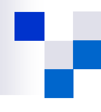
Skilled Nursing or Complex Nursing

- 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



Medication Administration

- 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



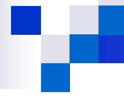
Home Health Aide

- 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
- Schedule of days and hours the aide will be in the home and the 15-minute breakdown of continued ADL tasks to be provided

Review Timeframes

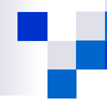
Review Timeframes: DME

- All requests for DME are reviewed within 14 calendar days from the date of receipt
- 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



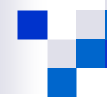
Review Timeframes: Home Health

- 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



Request Approvals

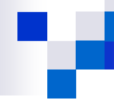
- Approval notifications are given within 24 hours of the determination
- Approval letters are distributed by:
  - Fax to DME and Home Health Providers
  - Mail to members



Request Denials

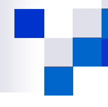
- Denial letters are faxed to requesting providers and referring physicians
- Denial letters are mailed to members within three business days from the decision date

Prior Authorization Clarification



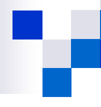
Prior Authorization Clarification

- Decisions are made within 14 calendar days if no additional information is needed
- If additional information is needed, a decision is made by the 20th calendar day
- Urgent requests are reviewed within 24 hours
  - Either to facilitate a discharge into the community or to prevent a hospitalization
- All requests are reviewed on an individual case-by-case basis
- Under Early & Periodic Screening, Diagnostic & Treatment (EPSDT), all requests must be reviewed for medical necessity
  - “Not a covered benefit” is not applicable



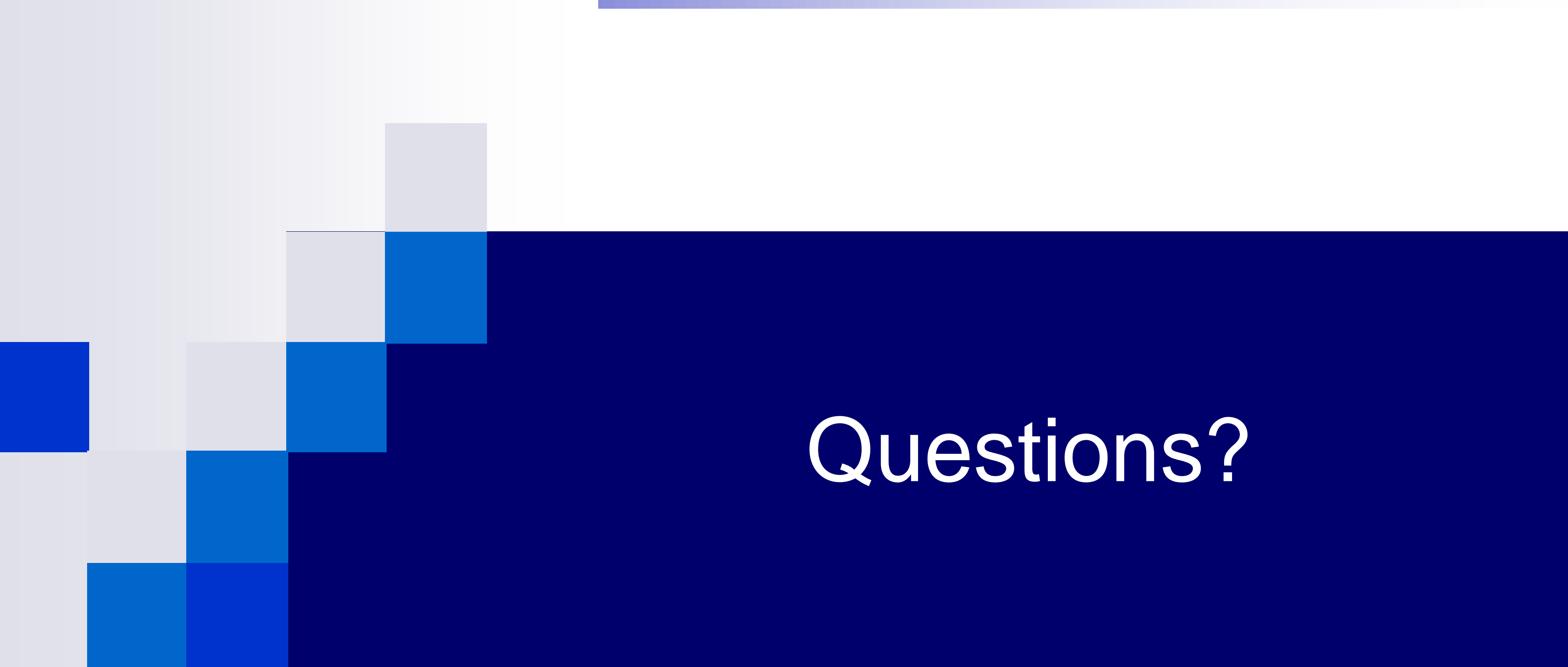
Prior Authorization Clarification (cont.)

- Any good or service denied by HUSKY Health will always be accompanied by a denial letter
- HUSKY Health members residing in DDS medication-certified group homes may be approved for skilled nursing visits to administer injectable medication or perform fasting blood sugar checks. Oral medications and g-tube feedings should be expected to be administered by the medication certified staff, or a transitional plan will be expected to be initiated



Prior Authorization Clarification (cont.)

- HHA services should not be requested for a HUSKY Health member residing in a group home. Personal care assistance is part of the services that are provided by the group home staff
- There is no PA requirement for home care services up to two skilled nursing visits; 14 hours of a home health aide; two physical therapy/speech therapy visits and one occupational therapy visit per week. All services exceeding that weekly frequency require the home care agency to submit a PA request for medical necessity review


Questions?