



INTEGRATED CARE MANAGEMENT AND QUALITY IMPROVEMENT

KePRO's Prior Authorization Process for Home Health Services August 20, 2009



Home Health Presentation on Prior Authorization Process

- Helpful Hints for Submitting Requests for Home Health Services
- iEXCHANGE® Demonstration
- Questions

Prior Authorization Process for Home Health Services

- Provider gathers information for the PA submission process
- Provider verifies eligibility by using the DMAS web based ARS at <http://virginia.fhsc.com> or Medicaid at 1-800-884-9730 or 1-800-772-9996.
- PA request can be submitted via iEXCHANGE®, fax, phone or mail.

Prior Authorization Process for Home Health Services

- The preferred submission method is **iEXCHANGE**.
Advantages: 24 hour availability to submit and allows provider to check on status of case.
- Once a request is entered into the system by a provider or customer service representative a case ID number is assigned.
- Each 60 day Plan of Care(POC) must be requested as a new case, with a new case ID assigned.

- **If the recipient's requested demographic information is not complete, this will delay your case from being evaluated by the clinical reviewer.**
- **The customer service representative will have to pend the case and request the insufficient information by fax notification from the provider.**

- **The provider will have until 11:59 PM the next business day to submit the insufficient information or the case will be voided in our system.**
- **A voided case is when there is not enough information to create a case (i.e. missing key demographic information). It is not a denial.**

Home Health Service Type

- **It is extremely important that the request has the service type (0500) clearly marked.**
- **Omission delays the case from being placed in the correct work queue for the nurse reviewer to evaluate.**

Prior Authorization Process for Home Health Services

- **A case is sent to the Home Health work queue for review by the clinical reviewer once all demographic information and the service type is entered.**
- **The reviewer will evaluate the case for medical necessity by applying criteria.**

Criteria Used to Review Cases for Medical Necessity

- Criteria that is used for review consists of the InterQual Home Health and/or supplemental criteria/DMAS rules.
- The DMAS Provider Manuals provide additional information that will give important details regarding coverage of home health and the prior authorization process.

- Access to the DMAS Provider Manuals may be found at the DMAS website at <http://dmas.virginia.gov>
- Under Provider Services section, select Provider Manuals. Select Home Health, Chapter IV (reviews covered services and limitations) and Appendix D (reviews the prior authorization services)
- Or KePRO's website @ <https://dmas.kepro.org>, click on “DMAS Manuals”.

Revenue Codes for Home Health

REVENUE CODES FOR HOME HEALTH

Home Health Revenue Codes	
<i>(PA Submission – Prefix revenue code with a capital “R” but do not submit claims with the “R” prefix)</i>	
Revenue Code	Code Description
0550	Skilled Nursing Assessment
0551	Skilled Nursing Care, Follow-Up Care
0559	Skilled Nursing Care, Comprehensive Visit
0571	Home Health Aide Visit (no PA required)
0424	Physical Therapy, Home Health Assessment
0421	Physical Therapy, Home Health Follow-Up Visit
0434	Occupational Therapy, Home Health Assessment
0431	Occupational Therapy, Home Health Follow-Up Visit
0444	Speech-Language Services, Home Health Assessment
0441	Speech-Language Services, Home Health Follow-Up Visit

For maintenance services include the following:

- Can the recipient perform the procedure?**
- If the recipient cannot perform the procedure, is there a caregiver who is willing and able to perform the procedure?**

Documentation Required in Order to Determine if Recipient Meets Criteria

- **If the provider states that there is no one willing or able to perform the service, further explanation may be needed.**
- **B-12 injections and insulin injections should include the following documentation: the physician certifies that there is a need for a home health visit for this procedure, no one else is willing or able to perform the procedure, and information to support that the procedure is medically necessary.**

Documentation Required in Order to Determine if Recipient Meets Criteria

Central venous access devices (dressing changes, etc.)- provide the following information:

- Is the recipient currently getting medication through the line, how frequently is it being accessed, what type of central line is it (PICC, Groshog, Hickman, Porta Cath, etc)?**
- The physician certifies that there is a need for a Home Health visit for this procedure, no one else is willing or able to perform the procedure, information to support that the procedure is medically necessary.**

Helpful Tips for Home Health

Provide the following information:

- **Was the patient recently discharged from hospital or nursing facility? Is patient home-bound or confined to a bed? Describe the reason for the referral and the patient's condition. Ex: patient just discharged from hospital with new onset of diabetes, needs diabetic teaching, is wheelchair bound, with minimal support system. (Please do not just send in the hospital history and physical)**
- **What services will be rendered under each skill set needed (example: skilled nursing, wound care, frequency, treatment, physical therapy, gait training, balance, therapeutic exercise, occupational therapy, ADL's, adaptive equipment training)**
- **If submitting via fax, using the editable version is very helpful by making it easier to read.**

Helpful Tips for Home Health

- **All requests must be submitted prior to services being rendered except if request is a retrospective review: i.e. patient receives Medicaid eligibility after services rendered or order is received on a Friday evening and services are provided Saturday and Sunday. In this instance- the request should be submitted on the next business day. Retrospective cases are still reviewed for medical necessity by using same criteria. Please provide clinical information. If denied by Medicare and then submitted to Medicaid this would also be a retrospective review.**
- **Contact information including name and direct phone extension number is especially important if the reviewer has any questions concerning the case.**

- **Each July 1, recipients have 5 visits that do not require PA for each service (skilled nursing, OT, PT, Speech Therapy).**
- **If a provider knows that the recipient will need treatment beyond 5 visits, the provider must request PA through KePRO.**

What occurs when key clinical information is missing from the case?

- **If additional clinical information is missing from the request after the initial evaluation of the case, the nurse reviewer will pend the case for 3 business days.**
- **Additional information is requested from the provider via phone or fax notification.**
- **The provider will have until 11:59 PM of the 3rd business day to supply this information.**

Prior Authorization Process for Home Health Services

- If the case can be approved, the clinical reviewer will post an approval note in iEXCHANGE® and a notification will be automatically sent to provider via fax.
- If the case cannot be fully approved, it will be forwarded to a peer reviewer (MD) for medical necessity determination or a Supervisor for administrative denial reasons.

Prior Authorization Process for Home Health Services

- The determination is then transmitted to First Health and a prior authorization number is issued.
- In addition to the fax notification that KePRO sends out, First Health also sends a notification letter to the provider and recipient.

- **This program is for recipients under the age of 21 and is in place to assure that health problems are diagnosed and treated as early as possible, before the problem becomes complex and treatment more costly.**
- **Some Home Health requests will be approved under the already established Home Health Criteria, but for those cases where the Home Health Criteria are not met and the recipient is under age 21, EPSDT criteria will be applied to the case as well.**

- **Registration is required. User login and password is usually sent by e-mail within 10 business days.**
- **Information may be found by going to the KePRO website- <https://dmas.kepro.org>. For questions call 1-888-827-2884 or e-mail at ProviderIssues@kepro.org.**

- **Eliminating transcription errors**
- **Eliminating rejected cases when basic demographic information is not included**
- **Increasing speed of reviewer access to PA requests-cases submitted go directly to a review queue**

- **Confirmation of successful submissions occurs in real time at the time of submission**
- **PA requests, updates and case viewing are available at any time, from virtually anywhere high speed internet access is available. Once a PA is generated, it is available for viewing in iEXCHANGE.**

Requests may also be submitted via

- Fax at 877-652-9329**
- Telephone at 888-827-2884 or 804-622-8900 (local)**
- Mail to: KePRO**
2810 North Parham Rd, Suite 305
Richmond, VA 23284

- PA request forms are posted on the DMAS and KePRO websites.
- Use the DMAS 363 “Outpatient Prior Authorization Request Form” for home health requests.
- See number 13, “PA Service Type” and select the box for “0500 Home Health.”
- 2 Versions
 - A PDF version that providers can download and complete manually
 - An editable Word version

Should You Want to Appeal A KePRO Decision

Appeals are to be submitted in writing to:

**Director Appeals Division
Department of Medical Assistance Services
600 East Broad Street, 11th Floor
Richmond, VA 23219**

**(Additional information can be found in the
DMAS Provider Manuals.)**

- KePRO Website <https://dmas.kepro.org>
- DMAS Website www.dmas.virginia.gov
- For any questions regarding the submission of PA requests, please contact KePRO at 888-827-2884 or 804-622-8900
- For claims or general provider questions, please contact the DMAS Provider Helpline @ 800-552-8627 or 804-786-6273.

Questions After iEXCHANGE Demonstration