Indiana Health Coverage Programs

P R O V I D E R B U L L E T I N

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To: All Indiana Health Coverage Programs Home Health Providers

Subject: Prior Authorization Requests for Home Health

Overview

The Indiana Health Coverage Programs (IHCP) and the Office of Medicaid Policy and Planning's (OMPP's) prior authorization (PA) contractor, Health Care Excel (HCE), reviews the completed prior authorization request, the plan of care developed and signed by the attending physician, and any additional documentation submitted for review by the home health agency before rendering a decision on the prior authorization request. *405 IAC 5-16-3(d)(2) (G)* requires a home health agency to state the amount of time required to complete the treatment task.

> *Note: The prior authorization contractor requires the specific frequency and duration to be on the signed plan of care and the prior authorization request. For example, a skilled nurse is required for wound care, two hours per day, Monday through Friday, for nine weeks.*

Also, an authorized representative of the home health agency must sign the request. A completed plan of care, a cost estimate, and the signature of the attending physician must accompany the PA request. The provider should also keep a copy of the completed PA request on file for audit purposes.

Pursuant to *410 IAC 17-5-1(a)(1)* and *(2)*, patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the agency in the patient's place of residence. Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, or podiatrist, as follows:

(1) The medical plan of care shall be developed in consultation with the agency staff and all pertinent diagnoses, including the following:
    (A) Mental status.

(B) Types of services and equipment required.
(C) Frequency of visits.
(D) Prognosis.
(E) Rehabilitation potential.
(F) Functional limitations.
(G) Activities permitted.
(H) Nutritional requirements.
(I) Medications and treatments.
(J) Any safety measures to protect against injury.
(K) Instructions for timely discharge or referral.
(L) Any other appropriate items.

Orders for therapy services shall include the specific procedures and modalities to be used and the amount, frequency, and duration. The therapist and other agency personnel shall participate in developing the medical plan of care.

(2) The total medical plan of care shall be reviewed by the attending physician, dentist, chiropractor, or podiatrist, and home health agency personnel as often as the severity of the patient's condition requires, but at least once every two (2) months. Agency health care professional staff shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care. A written summary report for each patient shall be sent to the physician, dentist, chiropractor, or podiatrist at least every two months.

When an existing plan of care overlaps a new prior authorization request, a new plan of care must be submitted. For example, if the plan of care covers a period from March 15 to May 15, and the new prior authorization request is from April 20 to October 20, then the plan of care period overlaps into the requested prior authorization period and a new plan of care must be submitted with the prior authorization request.

An ***encounter*** is a direct personal contact between a patient and the person authorized by the home health agency to furnish services to the patient. The ***frequency of visits*** is the number of encounters in a given period between a patient and the person authorized by the home health agency to furnish services to the patient. *Frequency of visits* may be expressed as a number or range. The number of encounters must be at least one.

Note: To meet both Indiana State Department of Health (ISDH) and PA guidelines, the specific frequency and duration must be on the signed plan of care and the prior authorization request, as given in the example: a skilled nurse is required for wound care setup, two hours per day, Monday through Friday, for nine weeks.

A similar federal regulation is cited at *42 CFR 484.18(a) Standard: Plan of care.*

(a) *Standard: Plan of care:* The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan. Orders for therapy services include the specific procedures and modalities to be used and the amount, frequency, and duration. The therapist and other agency personnel participate in developing the plan of care.

Guidelines for the federal regulations state that there may be a specific range in the frequency of visits for each service (such as two to four visits per week) of which the ISDH will not accept **0** as a frequency.

*Note: During the surveying process, at a Home Health Agency, the ISDH will cite the Home Health Agency, for noncompliance if **0** is used as a frequency.*

The patient or caregiver may decrease the amount of visits or hours. For example, a daughter may be visiting her mother and may not need the home health aide that day. This must be documented in the records as to why it was changed. When hours on a particular prior authorization period are not used, they cannot be used as cumulative hours in the current authorization period, nor are they allowed to be carried over to the next prior authorization period.

If there are any questions about this bulletin, please call EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.