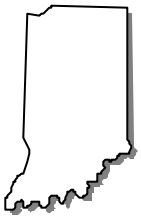
Indiana Health Coverage Programs



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: Required Documentation for Prior Authorization Requests for Home Health Services

> *Note: The prior authorization, payment methodology, and maximum fees information in this bulletin may vary for providers rendering services to members enrolled in the risk-based managed care (RBMC) delivery system.*
>
> *When billing for services for members enrolled in the PrimeStep/PCCM delivery system, the PMP Certification Code must be on the claim.*

Overview

The purpose of this bulletin is to clarify the type of information to be submitted with prior authorization (PA) requests for home health services. Health Care Excel (HCE) reviews the completed PA request form, 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 PA request.

> *Note: It is the responsibility of the provider to compile and submit the necessary documentation for the PA request in a timely manner.*

Prior Authorization Process Requirements

The PA request form must contain demographic information for the member and provider, written evidence of physician involvement, and personal patient evaluation to document acute medical needs. A current plan of treatment indicating the date of onset of medical problems and progress notes regarding the necessity, effectiveness, and goals of therapy services must also be included. The appropriate diagnosis and codes for the requested services or supplies must be documented on the PA request

form along with the name of the suggested provider of services or supplies. A description of previous services or supplies provided, length of such services, or when supply or modality was last provided on the PA request form is also required.

The following information must be submitted with the PA request:

- An estimate of the costs for the required services as ordered by the physician and set out in the written plan of treatment. The cost estimate must be provided with the plan of treatment and signed by the attending physician. The cost estimate must reflect the overhead rate, of each service requested, for the time period reflected on the plan of treatment. For example: The plan of treatment reflects skilled nursing one time per month for two months. The cost estimate of the requested service would be the registered nurse hourly rate of $28.76 times two hours, or $57.52, plus the overhead rate of $21.97 times two overheads, or $43.94. The total of the wage component and the overhead component equals $101.46.
- A list of caregivers available to provide care for the member including whether the caregiver works outside the home or attends school outside the home. A copy of the caregiver's work schedule from the employer or the class schedule from the school must be submitted with the PA request.
- Documentation indicating if the member works or attends school outside the home including what assistance is required. The documentation must include a list of services currently provided in the home, such as services provided through CHOICE, Waiver, or others.

Prior authorization consideration will include the following factors when determining the appropriate services, units of service, and length of period for prior authorized services for home care members:

- Review of the information provided in the written Medicaid prior review and authorization form, and any additional required or requested documentation.
- Severity or stability of the illness or condition and symptoms.
- Changes in medical condition that affect the type or units of services that can be authorized.
- Treatment plan, including identifiable goals.
- Complexity of the member's medical needs and the intensity of care required to meet those medical needs.
- Rehabilitation potential.
- Whether the services required in the current plan are consistent with prior care plans.
- Need for instructing the member on self-care techniques in the home or need for instructing the caregiver.

- Other caregiving services received by the member, including, but not limited to, services provided by Medicare, Medicaid waiver programs, CHOICE, vocational rehabilitation, and private insurance programs. The number of hours per day and the days per week for each service must be listed.
- Number and availability of non-paid caregivers available to provide care for the member, including consideration of whether the caregiver works or attends school outside of the home. The provider is responsible for coordinating home care services with the caregiver's work or school schedule to meet the member's needs, and clearly documenting this information on the *Indiana Prior Review and Authorization Request Form*.
- Number and physical limitations of the caregiver that inhibit the ability of the caregiver to provide care to the member, whether the caregiver has additional child care responsibilities, and how and when the units of service requested will be used to assist the caregiver in meeting the member's medical needs.
- Whether the member works or attends school outside of the home, including what assistance is needed.

Home health services must be prescribed and ordered in writing by a physician, and in accordance with a written plan of treatment developed by the attending physician. The services should be intermittent or part time except for ventilator-dependent patients who have a developed plan of home care. Members requiring 24-hour monitoring may be authorized up to 12 hours per day skilled nurse or home health services to prevent deterioration in life sustaining systems. For example, the non-stable ventilator-dependent member who requires 24-hour direct supervision, monitoring of body systems and frequent administration of medications, treatments, and feedings, may be authorized up to 12 hours per day if the caregiver is unable to sleep or maintain own personal hygiene in the absence of the home health provider. However, the stable ventilator-dependent member who does not require 24-hour direct supervision and does not require frequent administration of medications, treatments, or feedings, may not be authorized up to 12 hours per day if the caregiver is able to sleep and perform own personal hygiene. Prior authorization will take into consideration the previously mentioned factors when determining the appropriate services, units of service, and length of period for services for home care members. The services must be reasonable and necessary and must be health related. Homemaker, chore services, and sitter or companion service are not covered, except as specified under the applicable Medicaid waiver programs.

When there is more than one member receiving home health services in a single household, care must be coordinated in order to use services in the most efficient manner. Only one overhead component can be billed per encounter. Agencies are responsible for reporting this aspect of the case and should indicate this fact on the PA request form that is submitted for each member of the household receiving home care services.

Additional Information

Additional information about required Home Health Services documentation may be found in *405 IAC 5-3-5, 405 IAC 5-16-3, 405 IAC5-16-3.1*, the *Indiana Health Coverage Programs (IHCP) Provider Manual*, and IHCP Banner Page *BR200208*. If there are any questions about the contents of this bulletin, please contact EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area, or 1-800-577-1278.