Home Health

Per Medicaid Policy, Home Health services require an authorization for services that exceed the allotted 60 visits in a calendar year. Request must be submitted within 10 business days. Please note: The request must meet medical necessity and there is no guarantee the service will be authorized.

To request a Home Health authorization, Providers will submit via the DDE portal. If you're an employee without a User ID to logon, you can fax the Private Duty Nursing prior authorization request form to the fax number included on the form. Please Note: the system will need to be accessed to obtain the status of your request.

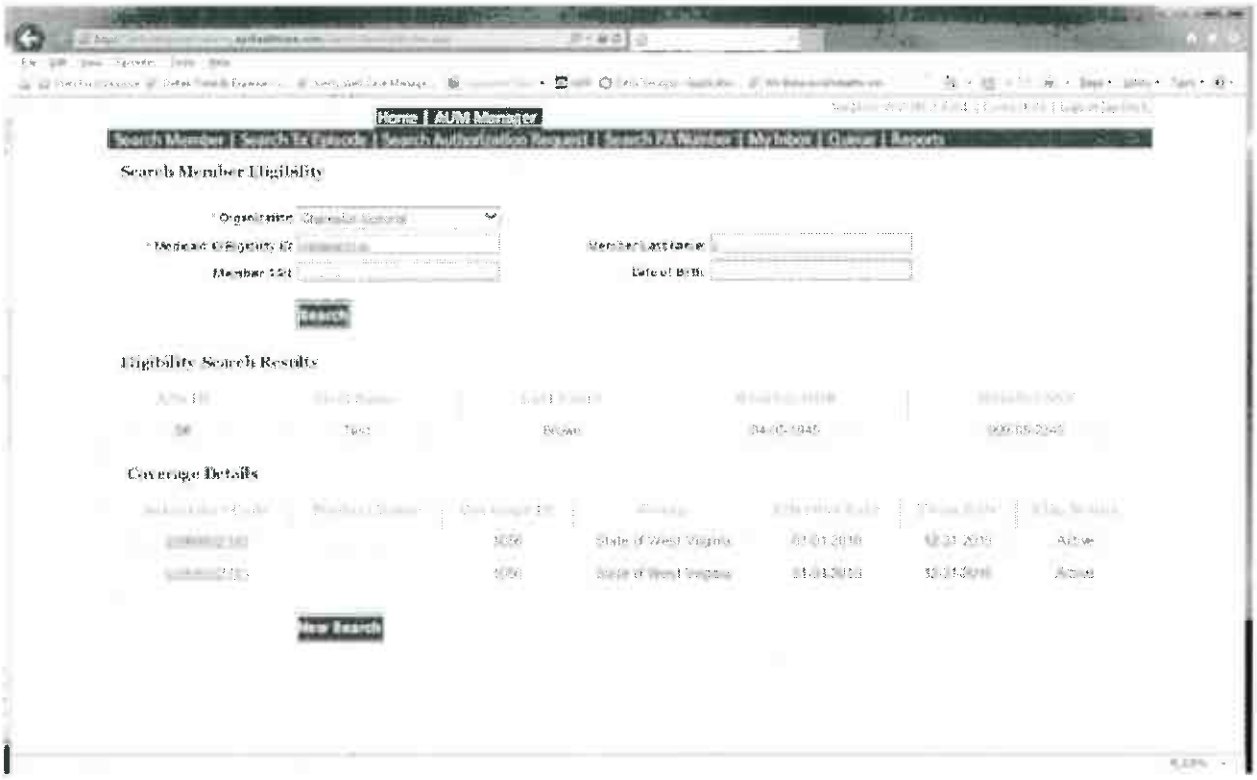
How to submit a Home Health Request

Go to https://providerportal.kepro.com and enter you login ID and password

Click on AUM Manager Tab

Click on Search member and enter the WV Medicaid ID number and the member's last name then click Search. (Hint: you can enter the first initial of the last name and click search)

Under "Coverage Details," click on the subscriber code that matches the one you entered on the Search Member screen that has not termed.

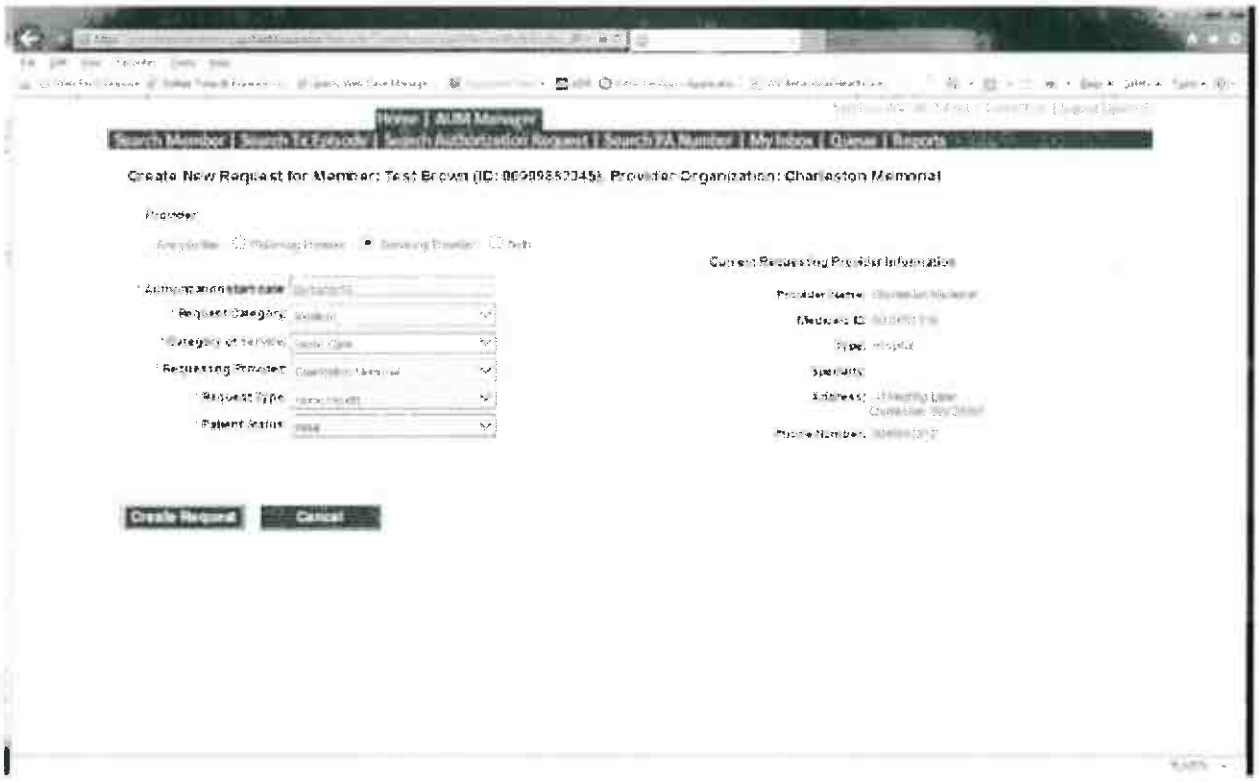


This will bring you to the Treatment Episode Screen which shows all the previous requests for the member. Click on the ADD NEW MEDICAL REQUEST button.

This brings you the Create New Request Screen. Under 'Provider,' you will need to choose rather you are the referring provider, servicing provider or both.

- Referring- Choose if requestor will **NOT** be billing WV Medicaid for requested service.
- Servicing- Choose if requestor **WILL** bill WV Medicaid for requested service
- Both- Please DO NOT choose this option for Home Health Requests

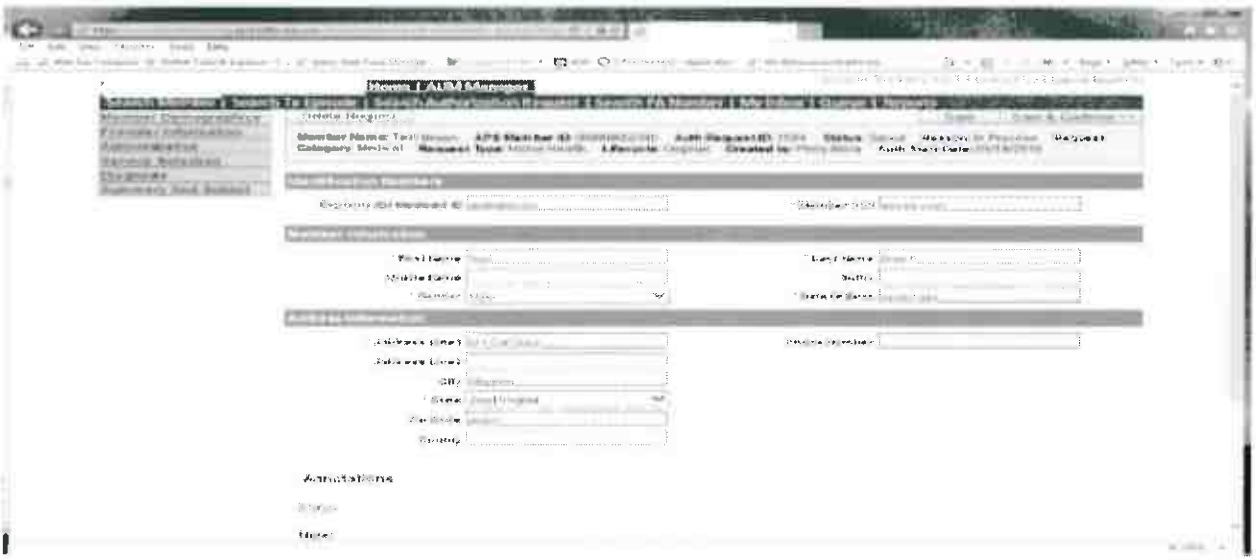
Next, enter the start date (the date the admission), the request category (Medical), the category of service (Home Care), choose the requesting provider(there will only be a list available if your registration is complete and your provider NPI numbers have been attached), enter the request type(Home Health), and enter Patient Status (choose initial if brand new patient and established if current patient and additional visits are being requested)scroll to the end of screen and click "Create Request"



If the member has previous treatment episodes, it will ask you if you want to Attach or Do Not Attach, just choose Do Not Attach. If the member does not have any previous treatments, click Continue

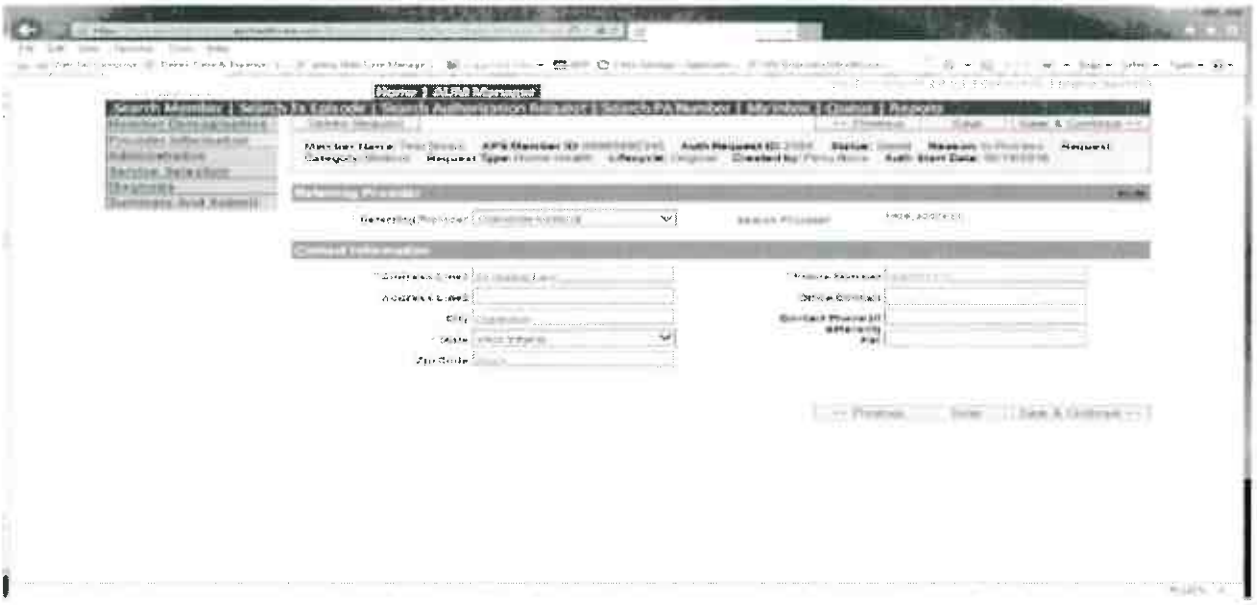
You are now ready to begin the application.

Member Demographics



If the address is not correct, change it and click Save and Continue. If everything is correct, simply click Save and Continue.

Provider

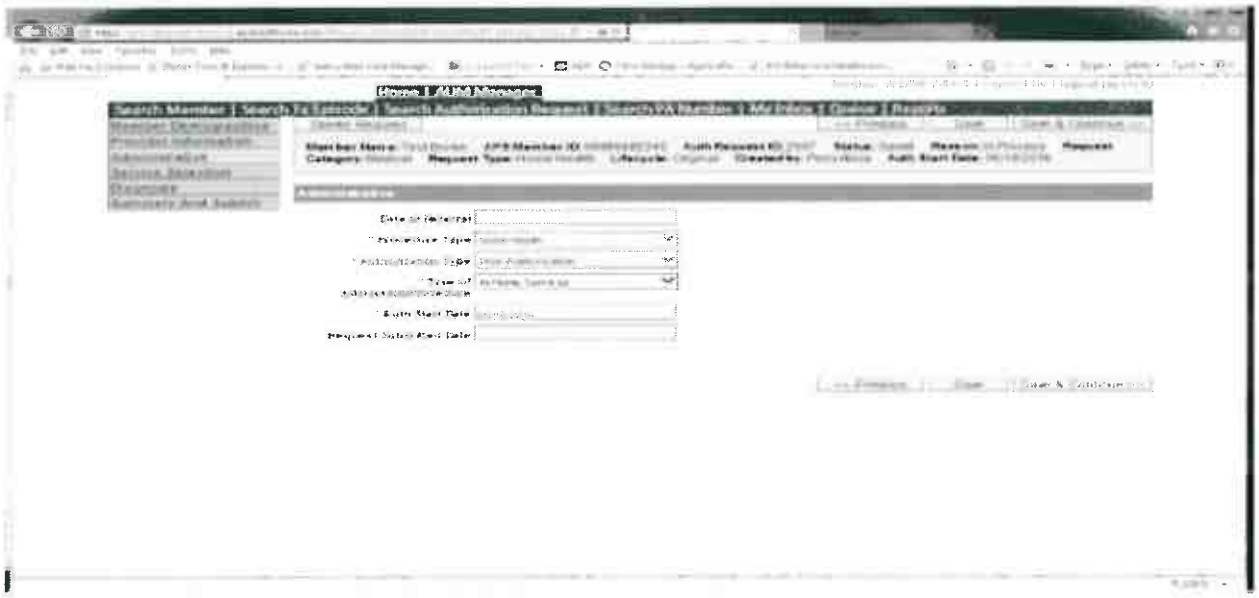


This brings you to the Provider Information screen. If you chose the referring provider option, this will auto-populate. This information cannot be changed.

If you are the servicing provider, you will need to attach the referring physician information to the request. To find physician:

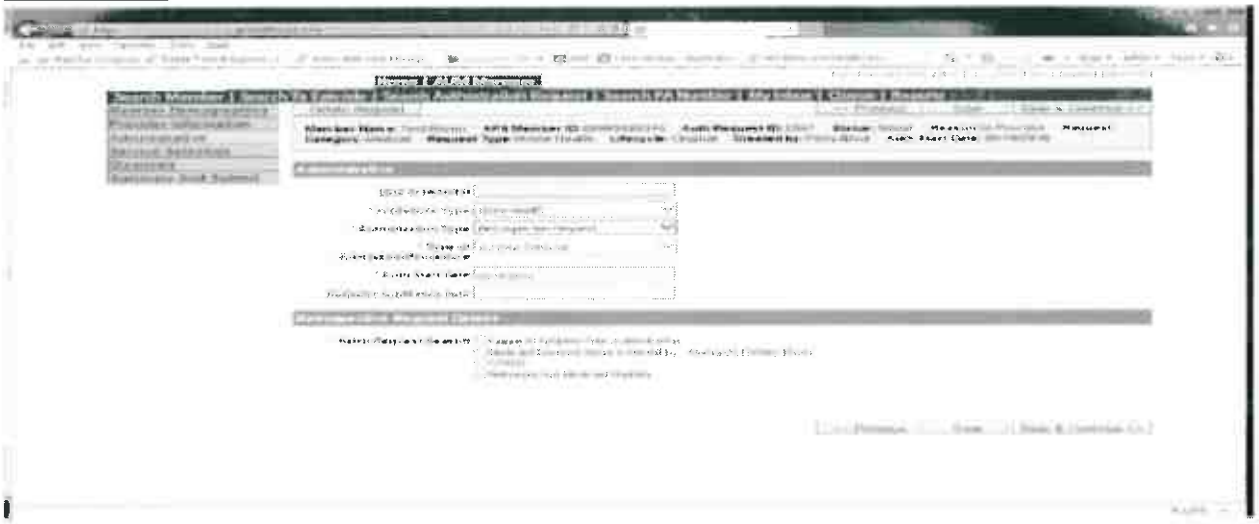
- Click on the Search provider
- Enter the physician's name in the Name field and change Any Words to ALL WORDS and click Search or
- You can select NPI from the dropdown on the right side and enter the NPI number and click search
- DO NOT ENTER ANY OTHER INFORMATION IN ANY OTHER FIELDS. JUST NAME OR NPI NUMBER.
- Once you have found the physician you are looking for, click the paper clip to attach.
- Enter your direct phone number where you can be reached in the Contact Phone field
- Click Save and Continue.

Administrative



Answer all questions with the red *. Procedure Type=In-Home services. Type of Admission/Procedure=In-Home Services. If your start date is within 10 business days of admission date, the authorization type will be Prior. Please note: If an admission is within 10 business days of the date you are submitting, please choose Prior authorization and not retrospective. This will ensure your request does not pend incorrectly for eligibility to process prior to UM review.

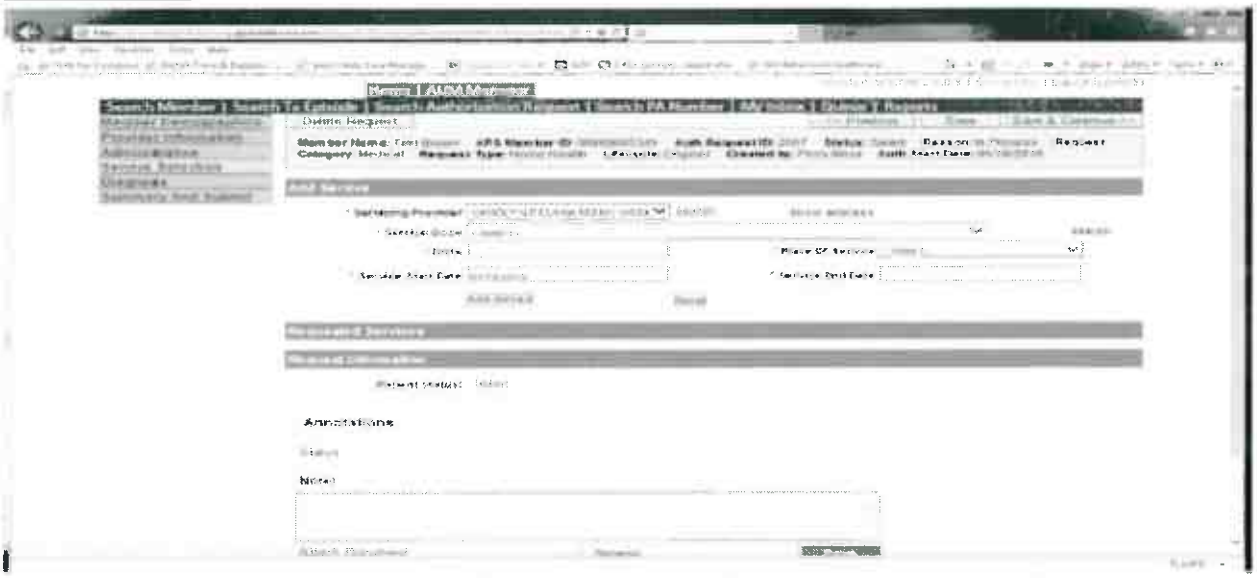
Administrative



If any other time span, the authorization type will be 'Retrospective Request.' Per BMS policy, there are timelines to request an authorization. If a request is submitted outside of the designated 10 day timeline, a retrospective policy denial letter will be issued. A retrospective reason will need to be selected and there are four options

- Failure to request prior authorization
- Medicaid covered service denied by Member's primary payer-If this reason is chosen, documentation will need to be provided
- Other: If this reason is chosen, please make sure to provide as much information as possible.
- Retrospective Medicaid Eligibility-Only choose if Medicaid coverage has been backdated to cover date of service.

Service Selection

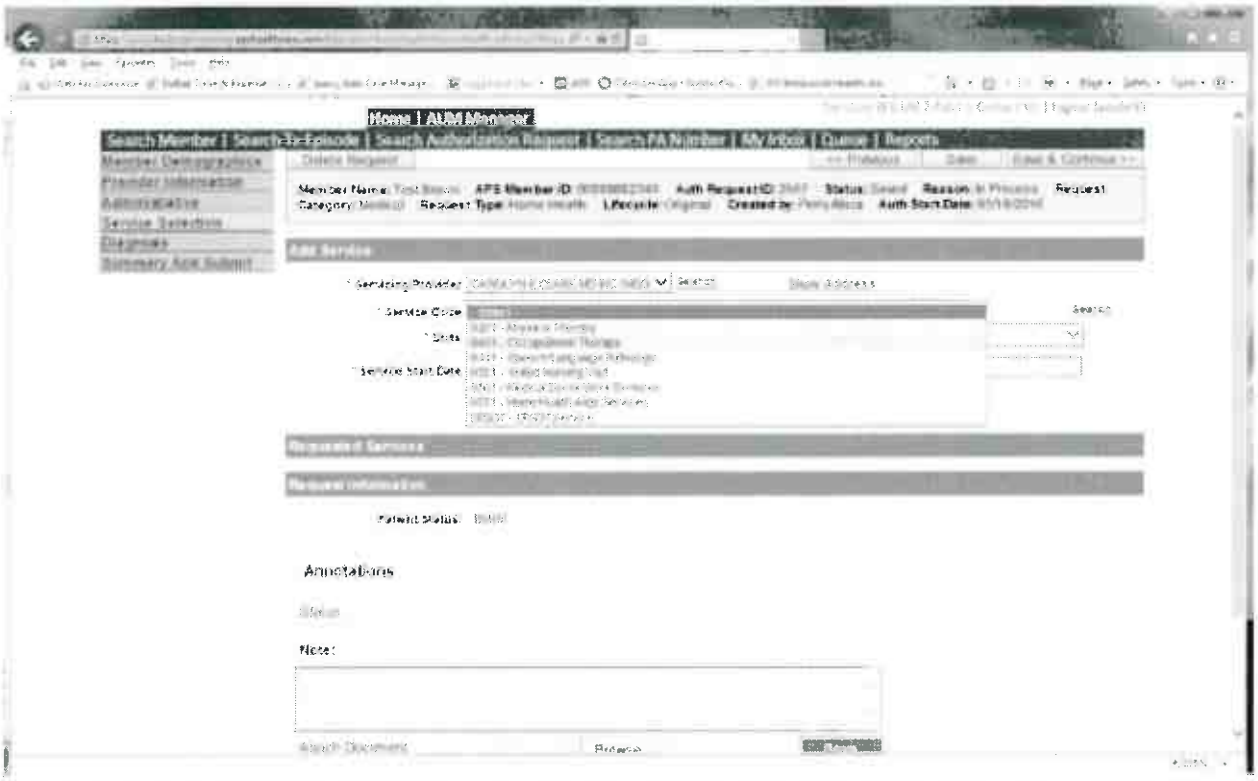


If you chose the servicing provider option, this will auto-populate. This information cannot be changed. If you are the referring provider, you will need to attach the Servicing Provider information to the request.

To find Servicing Provider:

- Click on the Search provider
- Enter the name in the Name field and change Any Words to ALL WORDS and click Search or
- You can select NPI from the dropdown on the right side and enter the NPI number and click search
- DO NOT ENTER ANY OTHER INFORMATION IN ANY OTHER FIELDS. JUST NAME OR NPI NUMBER.
- Once you have found the provider you are looking for, click the paper clip to attach.
- Click Save and Continue.

Service Selection

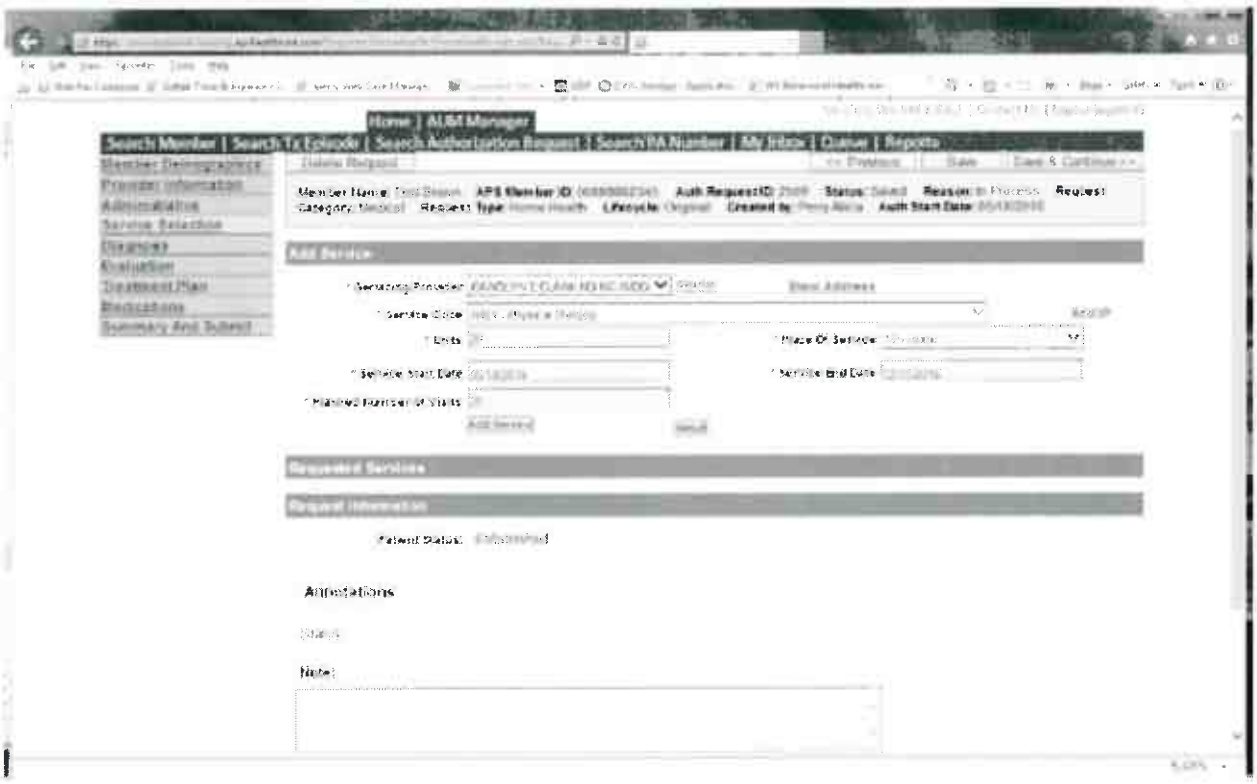


You are now ready to choose your service code. There are six services to choose from. If there are multiple services, the following steps will need to be for each one.

- Choose your Service
- The units will auto populate to 60. If this is the only service, do not change units. If there are additional services, the units for each line must total 60.
- Place of Service=Home
- The service end date will be the last day of the year requested. Please DO NOT CHANGE service end date.
- Click Add Service
- Repeat for each Service needed

Patient Status will be generated as Initial.

Service Selection



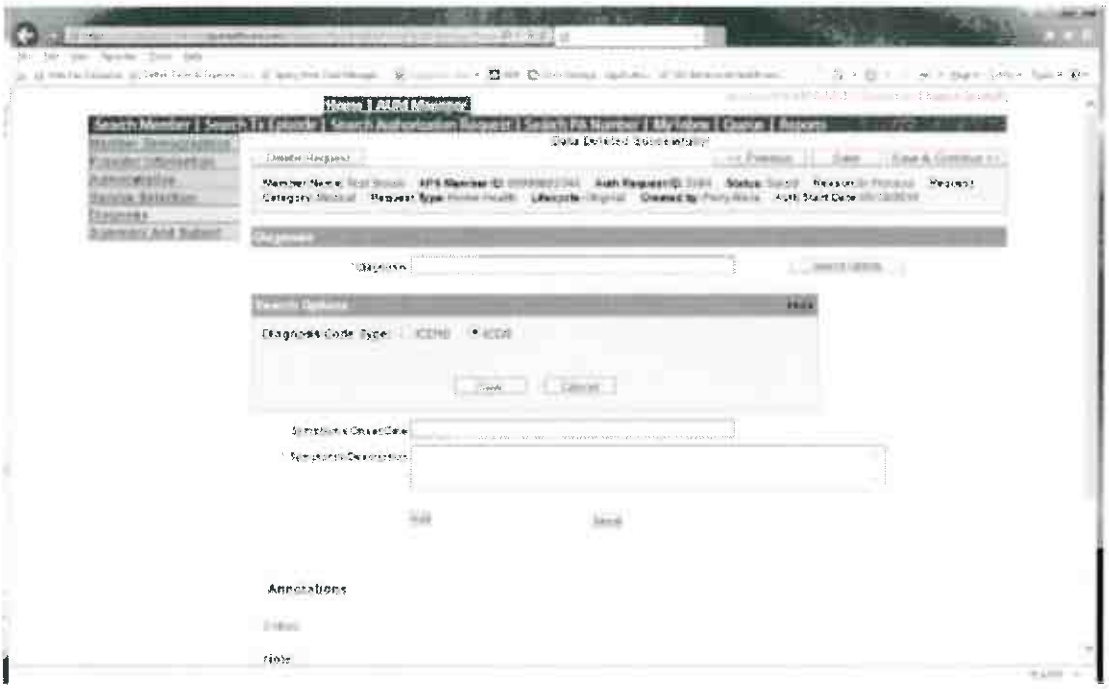
If your request is for an established patient:

Choose your Service

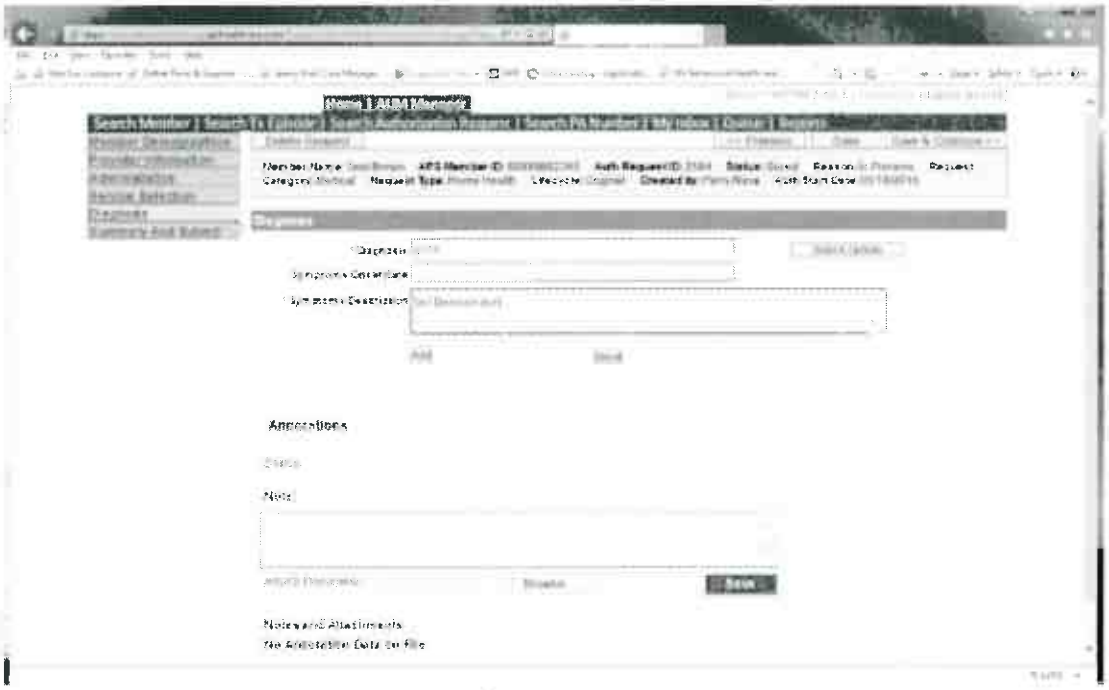
- The units will auto populate to 365. Please change units to the number of visits needed.
- Place of Service=Home
- The service end date will be the last day of the year requested. Please DO NOT CHANGE service end date.
- Planned number of visits: Enter the same amount of visits from Step 1.
- Click Add Service
- Repeat for each Service needed

Patient Status=Established

Diagnosis

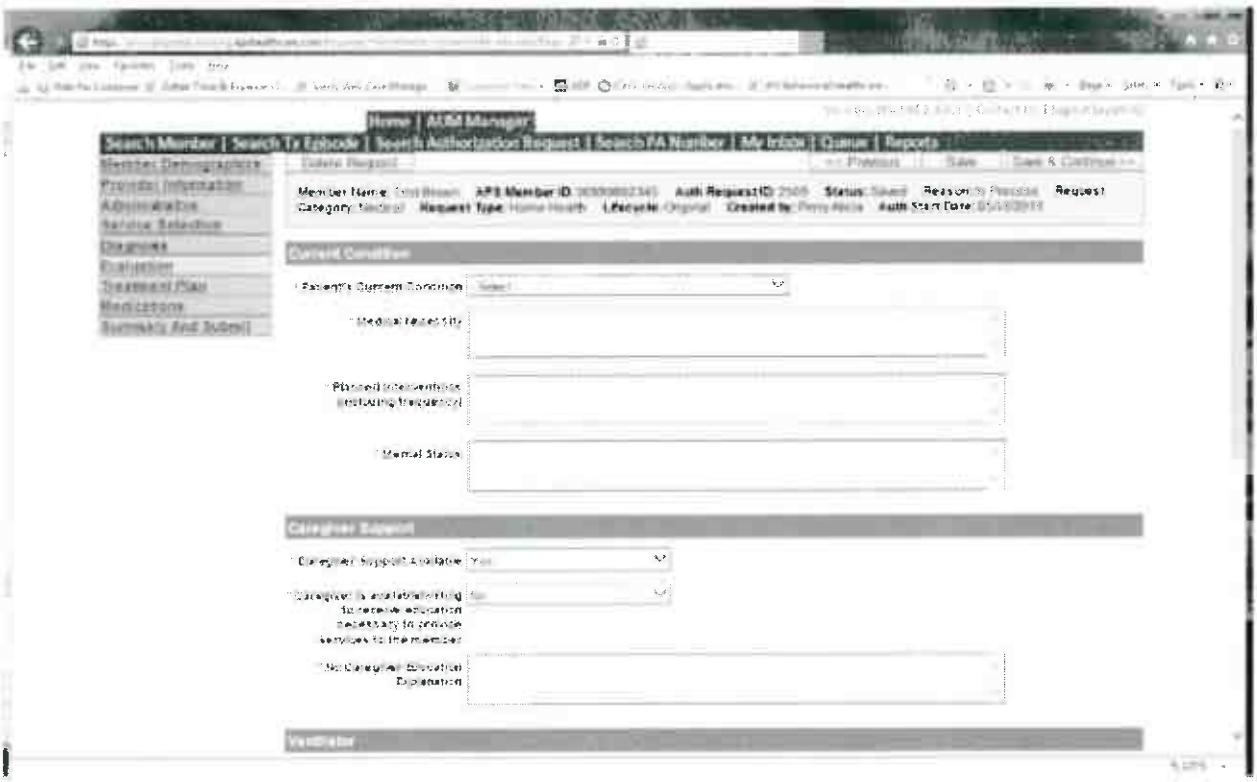


The Diagnosis screen is the next mandatory screen. ICD-10 diagnosis is required. The diagnosis code should be in the correct format for the date of service submitted. If your date of service requires an ICD-9 diagnosis code, prior to entering the numbers before the decimal, click the search options button, select ICD-9 and click save.



Enter the letter and numbers before the decimal of the diagnosis code, wait for the dropdown list, and choose the code from the list, enter symptoms in the Symptoms box, and click the Add button under the Symptoms box. Do this for as many diagnoses codes you have.

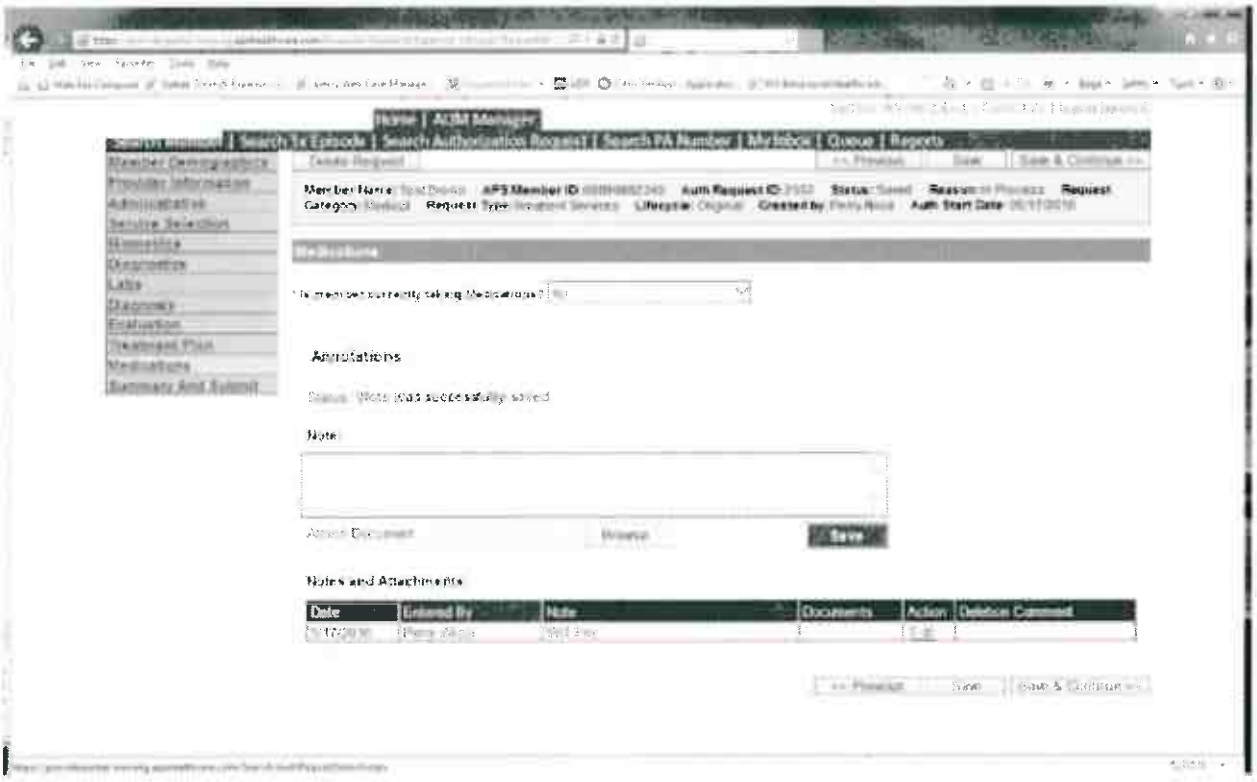
Evaluation



Please answer all questions with a red * and all required fields. If caregiver is not willing to receive education, an explanation is required.

Treatment Plan Screen does not require information to be entered. However, this information can be completed if you choose.

Medications



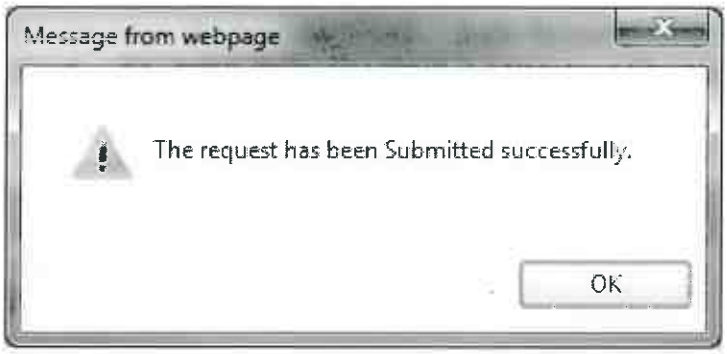
This brings you the Medications screen. This is not a mandatory screen but if you want to list medications, please leave the answer as NO and either copy and paste, or download and attach list in the Annotations/Note sections. If you are going to fax, enter a note in the Annotations/Note Section, WILL FAX, click the blue SAVE button under the notes section. Click Save and continue to the Summary and Submit page.

Summary and Submit

The Summary and Submit page allows you to scroll the document from the beginning to the end. Look over it to make sure all things have been entered correctly, scroll back up to the top of the page and click SUBMIT in the top left hand corner and NOT the SUBMIT button at the bottom of the request. **Clicking the submit button at the bottom of the page does not allow the submitter to see any errors or warning boxes that require action.**

A warning box may be received. If so, c lick continue.

And then Click OK, once the message that your request was successfully submitted has displayed.



Home Health Service Helpful Tips

- We need orders to be attached/ faxed in addition to Oasis/485 information for cases that exceed 60 visits in a calendar year . Per BMS Home Health manual --- *"All home health services that exceed 60 visits in a calendar year require prior authorization. Please see Section 508.10, Prior Authorization for additional information. It is the responsibility of the provider to maintain the plan of care (POC) form, (CMS-485 & CMS-486) or the agency's POC form of their choosing, and OASIS assessments on file. Home health agencies must have all required POC data elements in a readily identifiable location within the medical record."*
- There is no age restriction for home health services
- Skilled nursing services must be provided by an RN or LPN
- Providers can access the Home Health Policy manual at: **http://www.dhhr.wv.gov/bms/Provider/Documents/Manuals/bms_manual_%29Chapter_508_Home_Health%202015.pdf**