HOME HEALTH UPDATE 2017

KEPRO
INTELLIGENT VALUE

Home Health

- Fee for service Medicaid patients can receive up to 60 visits of Home Health per calendar year without prior authorization; however the home health provider must register the member's initial 60 with BMS UMC.

- A calendar year is January 1st and December 31st.

Initial vs. Established

Initial Request

- An initial request is the first prior authorization request submitted by the provider for that calendar year
- Initial request are submitted **BEFORE** the 60 visits have been utilized.
- An initial request is made at the beginning of each calendar year for patients seen in the previous calendar and still being seen. This is true even if the patient exceeded 60 visits in the previous year.
- If the patient has not used their 60 visits for a current calendar year it is considered an Initial Request.

Established Request

- This should only be used if the patient in question has used their 60 visits for the current calendar year.
- Once an established request has been initiated, the patient's benefit of 60 visits without prior authorization can no longer be utilized.
- **ALL** Established Requests submitted will be reviewed for medical necessity, regardless of number of visits used without PA.

Initial vs. Established Scenarios

60 visits available

- Jane has come to a Home Health provider on January 1st for a complaint.
- Jane has yet to use her 60 visits available through her benefit.
- Even if Jane has been a patient of that provider for the last 9 months. Once the new calendar year begins the provider would start the Initial Prior Authorization Request in the C3 system.
- The system will suppress authorization number and provider can start rendering services.

60 visits utilized

- Jane has been seen by a Home Health provider for all 60 visits after January 1st.
- The provider would start an Established Prior Authorization request in the C3 system.
  - Even if the provider cannot see an initial request started in C3, but knows patient has been seen for 60 visits.
    - If an initial request is already approved the system will not allow another to be created for that calendar year.
- The system will generate a billable authorization number when case is completed and approved.

Home Health Authorization Process

- The Initial requests prior authorization number will be suppressed.
  - This means that no authorization number will be generated and sent to Molina.
  - The system will generate all 0's (example: 0000000000).
- If an Initial prior authorization request is submitted, even if the member has used all 60 visits this calendar year, no authorization number will be generated it will be suppressed.
  - The provider will have to do a Copy for New Submission/New Request to create an Established request. Once this is submitted, it will be reviewed for medical necessity. If approved, an authorization number will then be generated and sent to Molina. The provider will be able to view the PA as they always have.
- If an Established prior authorization request is submitted before the initial, it will be reviewed for medical necessity and the member's 60 visits without PA will become unavailable.
- Once an actual PA is sent to Molina (claims payer) there must be a PA on subsequent claims for any Home Health provider.
  - You can not go back to the 60 visits once the Established request has been initiated.

Please choose carefully!

Alternative Benefit Plan

- An authorization number for billing purposes is needed if a Medicaid member is part of the expansion (ABP) and is in transition.
- If an Initial case is requested but later it is found the member has ABP. The provider can do a Copy for New Submission/New case to receive an authorization number.
- It is up to the providers to be sure of what type of Medicaid the member has.
- Just keep in mind that Initial authorization requests will not generate a billable authorization number.

Modifications

- **COPY FOR NEW SUBMISSION:** A copy for new submission is requested when a copy for correction cannot be completed due to:
  - Closure of previous authorization request
  - Request is stuck in saved mode and won't submit.
- **MODIFICATION FORM:** Modification forms can be used for modifications to existing authorization for extension of end dates and units only.
- **COPY FOR CORRECTION:** A copy for correction is requested to change or correct services previously authorized. These include but are not limited to:
  - Code Changes
  - Service start dates.
  - Authorization number combination.
  - PLEASE BE SURE TO ADD ALL SERVICE LINES ON THE COPY FOR CORRECTION!!

Request Form

Person Submitting Request _____ **Phone** _____ **Fax** _____ **Email**_____

Referring/Ordering Provider

(Per policy the Referring/Ordering Provider must be actively enrolled with WV Medicaid)

Name Do not write "See Above"	**NPI Number**	
Contact Information	**Phone**	**Fax:**

Place of Service/Servicing Provider

(Per policy the Place of Service/Servicing Provider must be actively enrolled with WV Medicaid)

Name Do not write "See Above"	**NPI Number**
Address, **City, State, Zip**	

Member Medicaid Number _____ **DOB**_____

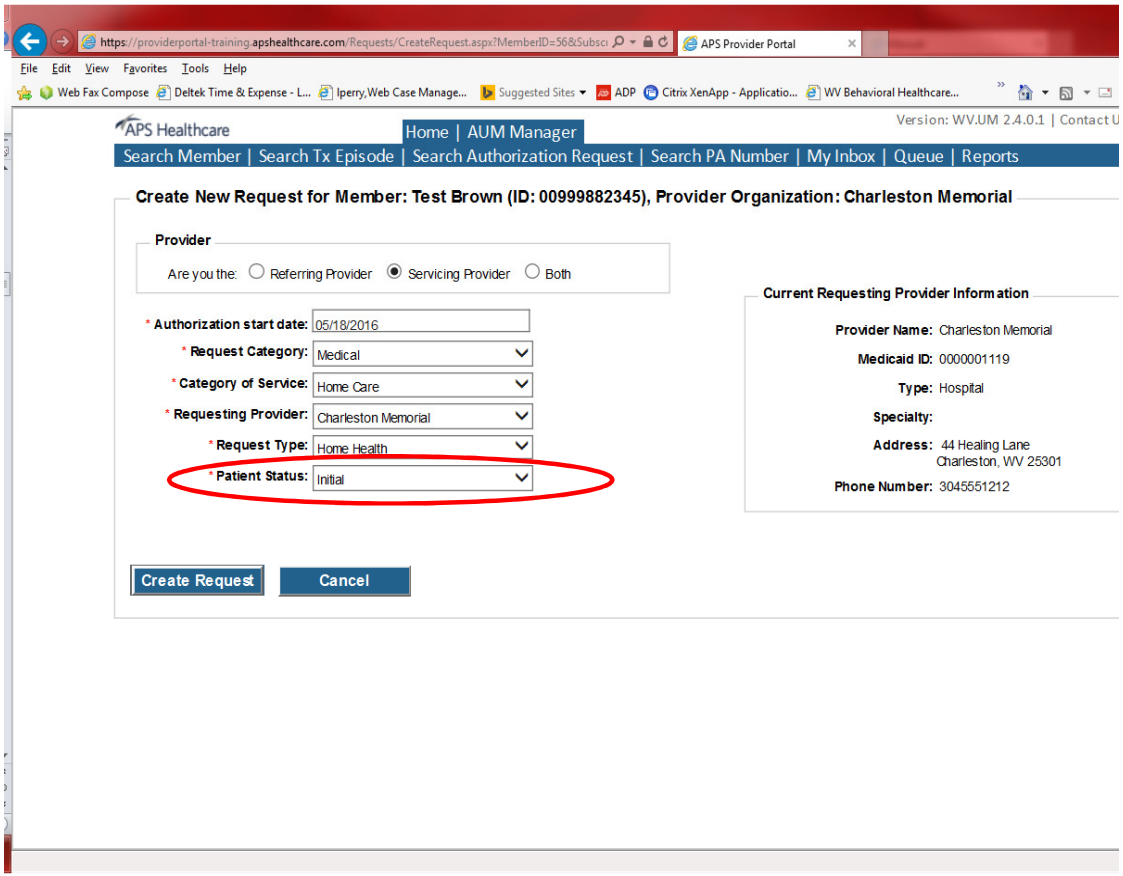
Member First Name _____ **Last Name** _____

Procedure Type: **Home Health** **Patient Status:** ☐**Initial** ☐**Established**

Authorization Type: ☐**Prior Authorization**

List Other Retro Reason:

Requesting Online



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WEBSITE FOR SUBMITTING AUTHORIZATIONS: HTTPS://PROVIDERPORTAL.KEPRO.COM

WEBSITE FOR ORG MANAGERS TO ADD/MODIFY USERS: HTTPS://C3WV.KEPRO.COM