HOME HEALTH

Annual Training 2020

2020-2021

General Information

- The initial 60 visits do not require prior authorization. However, the Home Health provider must register the member's initial 60 visits with the BMS UMC (KEPRO).
- The member must meet the medical necessity requirements, including documentation of admitting diagnoses and verification of medical necessity.
- The total of 60 visits may include any combination of the following Home Health services:
  - Skilled nurse visits (SNV)
  - Physical therapy (PT)
  - Occupational therapy (OT)
  - Speech-language pathology therapy (ST)
  - Home Health aide (HHA)
- The prior authorization numbers on initial requests are suppressed.
  - This means authorization numbers are not generated.
- The system generates all 0's (example: 0000000000).
  - Please do not use this number on the claim, it will deny.
  - Do not bill with the Authorization Request ID.

Initial vs. Established

Initial Requests

- 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 members seen in the previous calendar and still being seen. This is true even if the member exceeded 60 visits in the previous year.
- If the member has not used their 60 visits for a current calendar year it is considered an Initial Request.

Established Requests

- This should only be used if the member in question has used their 60 visits for the current calendar year.
- Once an established request has been initiated, the member'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.

Member Status Selection

- If an initial request is submitted for a member who has utilized all 60 visits this calendar year, no authorization number will be generated. It will be processed as an Initial request. It is the responsibility of the submitter to select the correct status for the member.
    - 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 Gainwell Technologies. 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 Gainwell Technologies (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.

So, please choose carefully when selecting Initial or Established.

Established Requests - Timeframes

- Kepro asks all providers to submit Home Health requests timely for the prior authorization review process.
- Initial home health requests are considered by Kepro the first request submitted for the member for each calendar year. A request is considered an Established request for members who have used their initial 60 units for the current calendar year.
- When submitting an established request, we ask you to submit the request timely and all established prior authorization requests must have a physician signed form 485 for a review for medical necessity.
  - We understand obtaining the signature of the physician can be time-consuming; therefore, we are asking providers to submit the unsigned copy with the request and the Kepro nurse reviewer completing the review will pend the case in a “hold for pricing” status for up to 30 days to allow the provider the needed time to obtain the signed form 485 from the physician.
- This process will cut down on cases being closed for lack of information and help to ensure all requests are submitted within policy timeframes in compliance with the retro policy of 10 days.

Face-to-Face

- Physicians or non-physician practitioners (NPP) are required to have face-to-face encounters with beneficiaries before they certify eligibility for the home health benefit.
- The face-to-face must occur prior to ordering the provision of Home Health services and no more than 90 days prior to the Home Health start of care date or within 30 days of the start of the Home Health care.
- The date of encounter must be included in the certification documentation.
- The face-to-face encounter must be conducted by a physician, physician assistant, or an Advanced Practice Registered Nurse.
- The face-to-face is the responsibility of the Ordering, Referring, Prescribing (ORP) to perform and document in their record.
- A face-to-face is required for certification any time a new start of care assessment is completed to initiate care for services

Face-to-Face Continued…

- The non-physician practitioner (PA or APRN) performing the face-to-face encounter, working in collaboration with the certifying physician, must document the clinical findings of that face-to face patient encounter and communicate those findings to the certifying physician.
- Home Health agencies must establish internal processes to comply with the face-to-face encounter requirement mandated by the Patient Protection and Affordable Care Act for purposes of certification of a member's eligibility for Medicaid covered Home Health services.
- The documentation of the face-to-face encounter must be a separate and distinct section of the medical record and must be clearly titled, dated and signed by the certifying physician in accordance with 42 CFR §424.22
- If a Home Health agency claim is denied, the corresponding physician claim for certifying/re-certifying patient eligibility for Home Health services is considered non-covered as well because there is no longer a corresponding claim for Home Health services.
- More information can be found at https://dhhr.wv.gov/bms/pages/manuals.aspx WV Medicaid Provider Manual Section 506.3

Documentation Requirements for Face-to-Face

- Must include the date when the physician or allowed NPP saw the patient.
- A brief narrative composed by the certifying physician who describes how the patient's clinical condition, as seen during that encounter, supports the patient's need for skill services.
- This must be documented on the certification, which is signed and dated by the physician, or a signed addendum to the certification.
- It is acceptable for the certifying physician to dictate the documentation content to one of the physician's support personnel to type or can be generated from a physician's electronic health record.
  - Physician support staff are those who work with, or for the physician on a regular basis and, as part of their job duties, regularly perform documentation, take dictation for the physician and/or extract from the physician's medical records to support the physician in a variety of ways.
- It is unacceptable for the physician to verbally communicate the encounter to the HHA, where the HHA would then document the encounter as part of the certification for the physician to sign.

Hospital or Acute Care Discharge

- For patients admitted to home health upon discharge from a hospital or post-acute facility, the physician who cared for the patient in an acute or post-acute facility can inform the certifying physician regarding their encounters with the patient and of the patient's need for skilled services, in order to satisfy the face-to-face encounter requirement, much like an NPP currently can.
- Alternatively, the physician who cared for the patient in an acute or post-acute facility prior to the patient's home health admission can perform and document the face-to-face encounter and certify the patient's home health eligibility, initiate the plan of care, and hand off the plan of care to the patient's community physician.
- These physicians often complete the certification of home health eligibility for a patient, which now includes the face-to-face documentation.

Training and Technical Assistance

- The medical department offers various types of training
- We offer training via webinar, phone, and various materials.
- These are offered to make submitting online for Prior Authorization an easier process for providers.
- There are also annual reviews/trainings available to providers.
- Provider training is also offered for various provider groups.
- Each PowerPoint presentation from the provider trainings are posted to the http://www.wvaso.kepro.com in the Manuals and Reference Materials section of our website.

KEPRO Medical Contact Information
1007 Bullitt Street, Suite 200
Charleston, WV 25301

1-800-346-8272 EXT. 7996
MEDICAL SERVICES EMAIL: WVMEDICALSERVICES@KEPRO.COM
MEDICAL FAX NUMBER: 1-866-209-9632

EMILY PROCTOR	MEDICAL/IDDW/BH/SUD WAIVER DIRECTOR	EBPROCTOR@KEPRO.COM	EXT. 4455
KAREN WILKINSON	UM NURSE MANAGER	KAREN.WILKINSON@KEPRO.COM	EXT. 4474
ALICIA PERRY	OFFICE MANAGER	APERRY@KEPRO.COM	EXT. 4452
SIERRA HALL	TRAINING SPECIALIST	SIERRA.HALL@KEPRO.COM	EXT. 4454
JAMI PLANTIN	CUSTOMER SERVICE REP	JAMI.PLANTIN@KEPRO.COM	EXT. 4502
JASPER SMITH	CUSTOMER SERVICE REP	JASPER.SMITH@KEPRO.COM	EXT. 4490
JOHN JONES	CUSTOMER SERVICE REP	JOJONES@KEPRO.COM	EXT. 4431

GENERAL KEPRO AND WVCHIP INFORMATION: WWW.WVASO.KEPRO.COM
FOR SUBMITTING AUTHORIZATIONS: HTTPS://PROVIDERPORTAL.KEPRO.COM
WEBSITE FOR ORG MANAGERS TO REGISTER/ADD/MODIFY USERS: HTTPS://C3WV.KEPRO.COM

Questions?