

HealthSystems



HealthSystems
OF MISSISSIPPI

A blue silhouette of the state of Mississippi is positioned behind the title text.

Home Health Provider Manual

Effective 01/01/09

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Of Mississippi

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I. Introduction

HealthSystems of Mississippi (HSM) is the Utilization Management and Quality Improvement Organization contracted to perform precertification and quality of care review for home health services rendered to Mississippi Medicaid beneficiaries.

We have been contracted with the Mississippi Division of Medicaid (DOM) providing utilization and quality of care review since 1997. Our review is performed for the following types of services.

- Inpatient Acute Hospitals.
- Free Standing Psychiatric Inpatient Hospitals.
- Psychiatric Residential Treatment Facilities.
- MYPAC – Mississippi Youth Programs Around the Clock.
- Hospital Outpatient Mental Health Services.
- Community Mental Health Post Payment Review.
- Outpatient Physical, Occupational and Speech Therapy.
- School Health Related Outpatient Physical, Occupational and Speech Therapy.
- Home Health.
- Durable Medical Equipment, Orthotics, Prosthetics and Supplies.
- Private Duty Nursing.
- Medical Necessity Review for Organ Transplant.

The purpose of this manual is to assist providers in successfully navigating through HSM's review requirements and process.

II. Getting Started - Helpful Tips

Before submitting any request to HSM, providers must verify beneficiary eligibility and available benefits through DOM's fiscal agent at <https://msmedicaid.acs-inc.com/msenvision/index.do> or 1-800-884-3222 or 601-206-3000. The above contact information is also used if you have a billing question.

Providers must read and be familiar with DOM's policies and procedures located at <http://www.medicaid.ms.gov/manual.aspx>.

Contact HSM for home health certification for beneficiaries under age 21 who are approaching their 26th home health visit within a given state fiscal year (July 1st through June 30th). The initial 25 visits include any combination of skilled nurse, home health aide, physical therapy and/or speech therapy visits.

Request for precertification should be submitted to HSM following:

- Identification of the need for home health level of care by a physician.
- Receipt of an order for home health services.
- Discussion between the provider and attending physician regarding the need for services and the beneficiary's plan of care.

III. Information You Need to Know

The majority of home health providers submit review requests and receive HSM certification responses via the Web. HSM's HIPAA secure Web-based system provides 24 hour a day 7 days a week access to real-time electronic submission of:

- Review requests.
- Additional information for specific reviews when requested by HSM (when the original review was submitted by Web).
- Helpline inquiries.

One of the benefits to providers who are enrolled to use the electronic Web submission is that you can check the status of your reviews at any time. The reporting module is provider-specific and available 24 hours a day 7 days a week.

If you do not have a HSM logon, contact HSM's Education Department at education@hsom.org or by phone at: (601)-360-4949 or toll-free at 1-866-740-2221 to request enrollment and training.

In addition to Internet access, minimum computer specifications are:

- Pentium 133 with 32 RAM and 8 mg free space for drivers
- Color monitor
- 28.8K modem connection or higher (phone line quality will determine speed of connection)
- Internet Explorer Version 4.0 or higher.

In the event a home health provider cannot submit via the Web, a dedicated fax number is provided to assist with certification needs. Although we can accept mailed requests, fax submission provides a faster response to your request. When submitting review requests by fax or mail the required forms and instructions are included in this manual and can be downloaded from the HSM Web site at www.hsom.org.

The table below lists our fax number, helpline phone number, and hours of operation.

Purpose	Description	Hours of Operation and Number(s)
Precertification Review Request Submission	Used by providers to submit review requests and additional information requested by HSM.	<p>Web reviews: www.hsom.org click on "Submit Review Requests" link.</p> <p>Hours: 24 hours, 7-days a week.</p> <p>Faxes received after 5:00 p.m. or over the weekend or holidays are considered received the next working day.</p> <p>FAX: 1- 866-740-2292</p> <p>Mail: Attn: HSM – OPH 175 East Capitol Street Suite 250, Lock Box 13 Jackson, Ms 39201</p>
Helpline	Used by providers for questions regarding the certification process and to request assistance.	<p>Hours of availability: 8:00 a.m. – 5:00 p.m. (business days)</p> <p>Web Helpline: www.hsom.org click on "Reports and Communications" link.</p> <p>Local: 601-360-4949 Toll Free: 1-866-740-2221</p>

Purpose	Description	Hours of Operation and Number(s)
Hot Line	Used by beneficiaries and providers to report quality concerns and/or complaints.	Hours of availability: 8:00 a.m. – 5:00 p.m. (business days) Toll Free: 1-888-204-0221

K-baby Admissions

Providers may access a list of K-Baby reviews that have been performed on our Web site. We also notify each home health agency of K-Baby reviews via a weekly faxed list. In order for HSM to release the treatment authorization number (TAN) the home health agency should:

- Obtain the baby's personal Medicaid ID number and date of birth. Access HSM's Web system reports module and enter the required information, or
- Record the baby's personal Medicaid ID number and date of birth in the space provided on the faxed list and fax the updated list to HSM.

This information will be used to update the review certified under the mother's Medicaid ID number to the baby's Medicaid ID number. Only after this process has occurred can the previously issued TAN be transmitted to the Fiscal Agent (FA). Claims for services should not be submitted to the FA until after this activity has been performed.

IV. Home Health Review Exclusions

Medicaid policy exempts certain services from HSM review. Providers should not submit reviews for these situations. The table below outlines some of the most common reasons for exclusion.

Reason	Description
Child and Youth Beneficiaries	No HSM certification is required for the initial 25 visits in a given state fiscal year (July 1 st through June 30 th) for beneficiaries under age 21.
Adult Beneficiaries	No HSM certification is required for beneficiaries 21 years of age and older.
No Medicaid Eligibility	No HSM certification is required if the beneficiary is not eligible for Medicaid. If the patient has applied for Medicaid and the <u>eligibility determination is pending</u> , HSM cannot perform review. Once eligibility has been determined, HSM performs review based on the eligibility begin date.
Medicare Eligibility	No HSM certification is required if the beneficiary has Medicare coverage (Part A and/or Part B) and the Medicare benefits are not exhausted.
Elderly & Disabled Waiver Participant	No HSM certification is required if the beneficiary is in the Elderly and Disabled Care Waiver.
Skilled Nursing Home (SNF)	No HSM certification is required if the beneficiary is in a skilled nursing facility or SNF.
Long Term Care	No HSM certification is required if the beneficiary is in a long-term care or ICF/MR.
Hospice	No HSM certification is required if the beneficiary is in a hospice program.
Family Planning Waiver	No HSM certification is required if the beneficiary's Medicaid eligibility is for the family planning waiver.
Private Duty Nursing Recipient	No HSM certification is required if the beneficiary is receiving PDN services.

Notes:

- Certification should be obtained from HSM when the beneficiary:
 - Has Medicare Part A and Part B and benefits are exhausted and the beneficiary has private insurance.
 - Has Medicaid eligibility and third party insurance.

V. Certification Review Process

A. Requests for Certification Review

The majority of home health providers submit requests for review directly to HSM through the Web at www.hsom.org. In the event that your organization does not have Web capabilities, fax or mail is available. Review requests and supporting documentation (when required) must be submitted within the specified time frames.

Remember: only children and youth under the age of 21 require certification beginning January 1, 2009, and only require certification for visits beyond the 25th session per state fiscal year (July 1st through June 30th). An initial request for certification beyond 25 visits is an admission review. A subsequent review to determine if additional visits/continuation of services is medically necessary and appropriate is a continued stay review. If a retroactive determination of Medicaid eligibility is made while a beneficiary is receiving services, a request for admission review is submitted.

Please note that retrospective certification review may be performed only when a retroactive Medicaid eligibility determination is made and the beneficiary is no longer receiving services.

The following table describes the types of review, timeframes for submission, and required documentation for each type of review.

Description	Review Type	Timeframe	Required Documentation
Beneficiary has not received home health services from current agency, but has reached 25 visits.	Admission	Prior to services or up to 30 days following delivery of services.	Enter information required by Web-based system. OR Complete and fax or mail the following to HSM: <ul style="list-style-type: none"> • HSM Home Health Care Certification Form. • HSM Plan of Care form. • Admission assessment. • Physician order for home health care.
Beneficiary has received home health services from current agency, and has reached 25 visits.	Admission	Prior to services or up to 30 days following delivery of services.	Enter information required by Web-based system. OR Complete and fax or mail the following to HSM: <ul style="list-style-type: none"> • HSM Home Health Care Certification Form. • Updated current status and HSM Plan of Care form. • Admission assessment. • Physician order for home health care.
Beneficiary requires continued treatment from same home health agency. A previous review was performed by HSM, a treatment authorization number has been issued by HSM, and additional services are requested.	Continued Stay	Prior to services or up to 30 days following delivery of services.	Enter information required by Web-based system. OR Complete and fax or mail the following to HSM: <ul style="list-style-type: none"> • HSM Home Health Care Certification Form. • Updated Plan of care. • Progress summaries. • Monthly summaries and visit notes.

Description	Review Type	Timeframe	Required Documentation
Beneficiary has retroactively received Medicaid eligibility and the patient is no longer receiving home health services.	Retrospective	Within one year of Medicaid eligibility determination.	Complete and fax or mail the following to HSM: <ul style="list-style-type: none"> • HSM Home Health Care Certification Form. • The complete medical record.

B. Processing of Review Requests

HSM’s Web-based review is the most efficient method by which precertification is obtained because the review request is routed directly to first level reviewers. HSM has a diverse group of professionals that assist at various stages of the review process such as our Intake staff, who handle administrative functions. Our clinical staff is composed of registered nurses, physicians and physician consultants. These highly qualified professionals make the certification review determinations for home health services. The following table describes staff functions.

Staff	Functions
Non-clinical Support Staff (Intake Staff)	<ul style="list-style-type: none"> • Screen requests for completeness. May request additional non-clinical information. • Perform verbal notification of review determination, as appropriate. • Support all review functions.
First level reviewers (Registered Nurses)	<ul style="list-style-type: none"> • Apply DOM policy. • Apply DOM approved medical necessity criteria. • Apply quality of care triggers and screens. • May request additional information. • Approve services based on policy or criteria. • Refer requests that cannot be approved to a physician.
Second level reviewers (Physicians)	<ul style="list-style-type: none"> • Make certification, denial or reconsideration determinations. The determination is: <ul style="list-style-type: none"> - Based on documentation that supports medical necessity and appropriateness of setting* - Patient-centered and takes into consideration the unique factors associated with each patient care episode. - Sensitive to the local healthcare delivery system infrastructure. - Based on his or her clinical experience, judgment and generally accepted standards of healthcare. • May request additional information. <p>*The physician reviewer may request additional information and attempt to contact the attending physician to obtain additional information when the documentation submitted does not clearly support medical necessity.</p> <p>Note: See the <i>Reconsideration Process</i> section of this manual for information on the reconsideration process.</p>

There are three types of situations that may cause a review to be pended for additional information. The following table describes each situation with its corresponding timeframes for submission of the requested information. If the information is not submitted by the due date then HSM suspends review of the request.

If the review can not proceed because ...	then ...	Review Type	Timeframe for submission
Administrative information is missing or incomplete.	Non-clinical information necessary to proceed with the review is requested.	<ul style="list-style-type: none"> • Admission • Continued Stay • Retrospective 	Three business days.
Clinical information is needed by the first level reviewer.	Clinical information required to complete the review is requested.	Admission	Three business days.
		Continued Stay	One business day.
		Retrospective	Ten business days.
Clinical information is needed by the second level reviewer.	Clinical information required to complete the review is requested.	<ul style="list-style-type: none"> • Admission • Continued Stay 	One business day.
		Retrospective	Ten business days.

C. Notification of Review Outcome

HSM provides written notification of review results to providers and to beneficiaries or the beneficiary's or youth's legal guardian or representative/responsible party when services are not approved as requested. Verbal notification of approvals will only occur if the provider is unable to receive written auto-fax notification. Providers also receive verbal notice of denials.

The home health agency, the attending physician, the beneficiary or youth's legal guardian, or representative/responsible party may request a reconsideration of a denial determination. A second physician, one not involved in the initial decision, will review the request and make a determination. If the decision to deny is upheld or modified, the beneficiary or youth/guardian, or representative/responsible party may appeal the decision directly to the Division of Medicaid. See the **Reconsideration Process** section of this manual for additional information.

The following table contains the details of the notification process based on review outcome.

Review Outcome	Details
Certification (Approval)	<ul style="list-style-type: none"> • Written notification of approval review results is sent to the provider and attending physician. • Verbal notification will only occur if the provider is unable to receive written auto-fax notification.
Denial	<ul style="list-style-type: none"> • If HSM determines that services are not medically necessary and appropriate, a denial letter will be issued and reconsideration rights will apply. • Written notification of denial determination is sent to the home health provider, attending physician and beneficiary/representative/responsible party. • The beneficiary/representative/responsible party's notice does not contain the medical basis for the denial. • Verbal notice is given to the provider for all review types except retrospective review.
Suspended	<ul style="list-style-type: none"> • HSM will notify the requester (verbally and in writing) when additional information is required and the review will be pended. If the requested information is not submitted by the due date then HSM issues a written notice of Review Suspended.

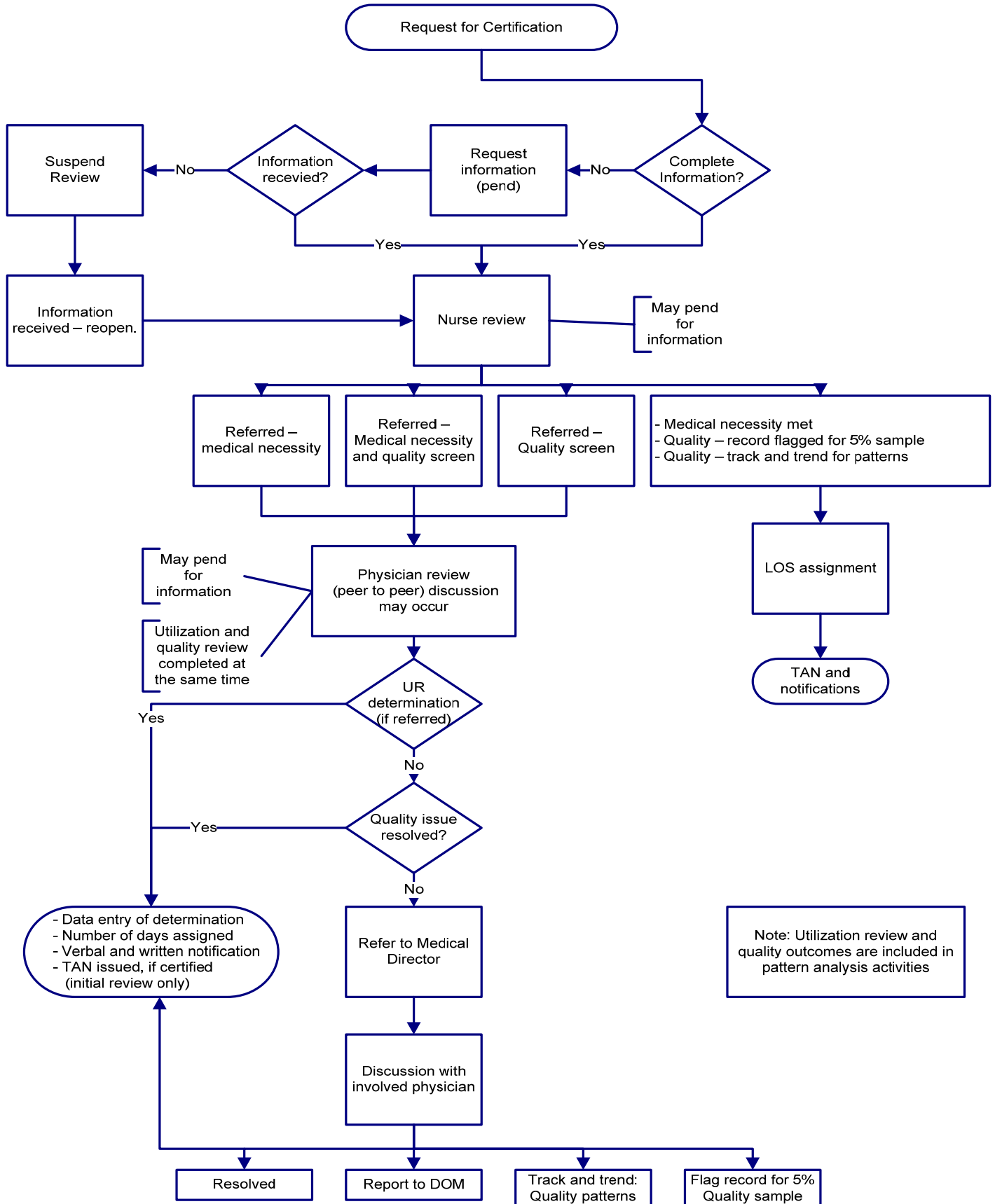
Review determination and notification timeframes are displayed in the following table.

Review Type(s)	Review Determination and Verbal Notification	Written Notification
<ul style="list-style-type: none"> Admission Continued Stay 	Within two business days of receipt of review request and necessary information.	Within one business day of review determination.
<ul style="list-style-type: none"> Retrospective 	Verbal notification is not given for this review type.	Within 20 business days of receipt of review request and necessary information.

Written notifications of review certification (approval) and determinations involving denials are sent to various parties as noted above. Notices of review outcome include the following information.

Review Outcome	Information	Review Type	
		Continued Stay	Retro
Certification (Approval)	Date of notice.	√	√
	Brief statement of HSM's authority and responsibility for review.	√	√
	Reason for determination.	√	√
	Date(s) of service being approved.	√	√
	Type of service certified.	√	√
	Number of units certified.	√	√
	Total number and type services certified to date.	√	√
	Total time span approved to date.	√	√
	Treatment Authorization Number (TAN).	√	√
Denial	Date of notice.	√	√
	Brief statement of HSM's authority and responsibility for review.	√	√
	Principal and clinical reason for denial.	√	√
	Type of procedures or services, number of units, and dates of services being denied.	√	√
	Total number and time span for previously certified procedures or services.		√
	Process for submitting a reconsideration request.	√	√
	Reconsideration timeframes.	√	√

D. HSM Review Process Flow Chart



VI. Reconsideration Review Process

If any of the following parties disagree with the initial determination made by HSM, a request for reconsideration may be requested.

- Beneficiary/representative/responsible party.
- Home Health Provider.
- Attending physician.

A second HSM physician, one not involved in the initial decision, will review the reconsideration request and make a determination. If the decision to deny is upheld or modified, the beneficiary/representative/responsible party may appeal the decision directly to the Division of Medicaid.

Please see the ***Reconsideration Manual*** for additional details.

VII. Quality Review Process

The Mississippi Division of Medicaid (DOM) requires review of the quality of care provided to Medicaid beneficiaries receiving home health services. Quality of care review is conducted for all review types as well as through a randomly selected 5% quality sample of cases certified by HSM and will include a sample of home health services provided to beneficiaries age 21 and over.

HSM identifies aberrant patterns and/or trends by provider. Quality sampling may include health care services provided to all age groups.

Please see the ***Quality Review Process Manual*** for additional details.

VIII. Utilization Analysis, Focused Studies, Outcome Reports and Proposals for Improving Health Care Delivery System

Under contract with DOM, HSM will conduct intensive studies of data and practice patterns. We will report the results of the studies and make recommendations for improving the health care delivery system. For this requirement we will:

- Collect and analyze Medicaid service utilization data from various sources as approved by DOM including review results data.
- Evaluate the efficiency of health care delivery, appropriate use of services, and opportunities to improve quality of care for Mississippi Medicaid beneficiaries.
- Propose, design and implement focused studies related to programs, beneficiaries, providers, services, and other topics related to Medicaid.
- Identify opportunities for improving efficiencies in various programs and provide to DOM recommendations and strategies for improving the delivery of health care.
- Provide education to providers with demonstrated aberrant utilization practice patterns or that have quality of care issues.

The identification of aberrant practice patterns and the design of appropriate projects increase the efficiency of delivery of health care and reduce gaps in quality of care of Medicaid beneficiaries.

We look forward to working with DOM and the Medicaid provider community on this endeavor.

IX. Forms and Instructions

- Certification Review Request
- Additional Information

I. BENEFICIARY INFORMATION	
PATIENT'S INFORMATION	K-BABY -CHECK BOX AND COMPLETE BELOW:
Patient/Baby Name: _____ Medicaid #: _____ Date of Birth: ___/___/___ Age: _____ Sex: ___ (M or F)	<input type="checkbox"/> K-Baby - <i>Check Here and complete the following:</i> Mother's Name: _____ Mother's Date of Birth: _____
II. HOME HEALTH AGENCY INFORMATION	
Agency Name : _____ MS Medicaid Provider #: _____ Address: _____ _____	
III. CONTACT INFORMATION FOR THIS REQUEST	
AGENCY CONTACT	PRIMARY PHYSICIAN INFORMATION
Request Date: _____ Contact/Requester: Telephone #:(____) _____ - _____ Ext. _____ Fax #: (____) _____ - _____	Name: _____ Medicaid Billing No. OR MS License #: _____ Phone #: (____) _____ - _____ Ext. _____ Date of Last Appointment with Beneficiary: _____ Date of Next Scheduled Appointment: _____
IV. REQUEST TYPE - Select one	
<input type="checkbox"/> Admission Review – <i>Attach Copy Of Initial Nursing Assessment, last Visit Notes and Plan Of Care</i> Dates of: Assessment Visit: ___/___/___ Next Planned Visit: ___/___/___ <input type="checkbox"/> No Additional Visits Planned	
<input type="checkbox"/> Continued Stay** Existing Certification #: _____ Last Service Date Authorized: ___/___/___ Date of Next Planned Visit: ___/___/___ Include all required copies. See form completion instructions. <i>** If patient seen on "emergency" basis prior to certification by HSM, also provide information about the emergency.</i>	
<input type="checkbox"/> Retrospective Review <input type="checkbox"/> Patient's Medicaid eligibility became effective retroactively during admission or after discharge. ICN (If applicable): _____ Complete this form and attach a copy of the medical record, including all nurses, PT & ST notes.	

Beneficiary Name: _____ Medicaid #: _____

V. MEDICAL INFORMATION	
DIAGNOSES FOR THIS ADMISSION	ICD-9-CM CODES
1.	
2.	
3.	

Clinical Summary: Record information that describes why the patient requires home health care, including the following: patient's physical, cognitive, nutritional status (weight, height, ideal body weight), if skin breakdown, describe wound bed and size, amount and character of drainage, treatment & preventive measures and decubitus stage, if applicable. Include a record of vital signs, physical findings and pertinent lab results for the conditions requiring home care. If concurrent request, give update of clinical condition, new diagnoses, and progress towards achievement of goals since date of last request. Describe reasons why patient remains homebound. *Attach all required copies as described in form completion instructions*

NOTE: Please attach copy of physician's written and signed or verbal order for home health services. Orders are to include specified discipline(s), frequency of discipline(s), specific services to be performed by discipline(s) and length of need for services. If visits are required in support of infusion or enteral therapy, physician order specifying the drug or product, route and frequency of administration must be included. (Signed orders must be on file for QM audit).

List Medical Equipment Used By Patient (if any): _____

Primary Caregiver/Relation to Patient: _____

Care provided by other sources: Describe care provided by sources other than HHA (paid or unpaid?). Include frequency and dates/days, if applicable.

Homebound Status: Describe, when applicable: patient absences from home, anticipated date of outpatient service - MD office/rehab etc. Describe activity status, mobility, distance ambulated (i.e., number of feet)

Please List ADL's For Which Assistance is Required: _____

Functional Limitations: (Please Check Below if Applicable to this Patient)

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Contractures | <input type="checkbox"/> Mobility deficit | <input type="checkbox"/> Paralysis/Hemiparesis | <input type="checkbox"/> Bowel/bladder incontinence |
| <input type="checkbox"/> Hearing deficit | <input type="checkbox"/> Speech deficit | <input type="checkbox"/> Limited Endurance | <input type="checkbox"/> Other (specify below) |
| <input type="checkbox"/> Legally blind | <input type="checkbox"/> Amputation | <input type="checkbox"/> Dyspnea with minimal exertion | _____ |

Mental Status: Oriented Forgetful Agitated Depressed Disoriented Comatose
 Other (describe) _____

Home Environment: Describe home environment; address whether home is safe, accessible and can accommodate home plan of care (or can be modified). _____

Beneficiary Name: _____ Medicaid #: _____

Patient/caregiver capabilities and compliance with care:

- Patient: Patient/caregiver has sufficient alertness, physical ability and agrees to learn necessary techniques
- Concurrent Request: a. Patient/caregiver is capable of learning techniques and is generally compliant with Plan of Care
- b. Patient/caregiver is not capable of/willing to learn necessary techniques, is not compliant with Plan of Care

Discipline	Skilled Interventions Planned	Time Span (Dates)		Frequency of Visits	Total # Visits Requested
		From	To		
HHSK	<input type="checkbox"/> Bowel/bladder management <input type="checkbox"/> Cardiorespiratory management <input type="checkbox"/> Clinical Assessment <input type="checkbox"/> Diabetes Teaching (new Dx.) <input type="checkbox"/> End stage disease/symptom management <input type="checkbox"/> Infusion therapy <input type="checkbox"/> Management and evaluation of care plan <input type="checkbox"/> Nutritional support/tube feedings/enteral therapy <input type="checkbox"/> Ostomy management <input type="checkbox"/> Other (describe) _____	<input type="checkbox"/> Pain Management <input type="checkbox"/> Periodic reassessment <input type="checkbox"/> Psychiatric evaluation/therapy <input type="checkbox"/> TPN <input type="checkbox"/> Urinary catheter care <input type="checkbox"/> Venipuncture (only with other qualifying service or with skilled assessment/lab values management) <input type="checkbox"/> Wound management	___/___/___	___/___/___	
			Goals/Objectives:		
HHPT	<input type="checkbox"/> PT evaluation <input type="checkbox"/> Therapeutic exercises <input type="checkbox"/> Gait training <input type="checkbox"/> Treatments (List) _____ <input type="checkbox"/> Other (describe) _____		From: _____ To: _____	Frequency of Visits	Total # Visits Requested
		Goals/Objectives:			
HHST	<input type="checkbox"/> ST Evaluation <input type="checkbox"/> Treatment of swallowing disorders <input type="checkbox"/> Therapy/training for voice/communication disorders		From: _____ To: _____	Frequency of Visits	Total # Visits Requested
		Goals/Objectives:			
HHAD	<input type="checkbox"/> Personal care <input type="checkbox"/> Assistance with rehab therapy services <input type="checkbox"/> Other (list) _____		From: _____ To: _____	Frequency of Visits	Total # Visits Requested
		Goals/Objectives:			

Name and Signature of Nurse or RN Case Manager: _____

MISSISSIPPI MEDICAID DISCLAIMER STATEMENT

HEALTHSYSTEMS OF MISSISSIPPI'S CERTIFICATION DETERMINATION DOES NOT GUARANTEE MEDICAID PAYMENT FOR SERVICES OR THE AMOUNT OF PAYMENT FOR MEDICAID SERVICES. ELIGIBILITY FOR AND PAYMENT OF MEDICAID SERVICES ARE SUBJECT TO ALL TERMS AND CONDITIONS AND LIMITATIONS OF THE MEDICAID PROGRAM.

**Instructions For Completing
HealthSystems of Mississippi Medicaid
Home Health Care Certification Request Form**

Section I Beneficiary Information

1. **Patient Name** - Enter the patient's last and first name as it appears on the Mississippi Medicaid ID card. If the beneficiary is a K baby, list baby's name.
2. **Medicaid #** - Enter the beneficiary's number that appears on the Mississippi Medicaid ID card.
3. **Date of Birth** - Enter the month, date, and year of the patient's birth.
4. **Age** - Enter the age of the patient at the time service is to be rendered.
5. **Sex** - Indicate the sex of the patient.
6. **K-Baby** - Indicate if the patient is a K-baby.
7. **Mother's Name** - Enter the full name of the K baby's mother.
8. **Mother's Date of Birth** - Enter the month, date, and year of the mother's birth.

Section II Home Health Agency Information

1. **Agency Name** - Enter the name of the agency that will provide the care.
2. **Medicaid #** - Enter the agency's HSM assigned Pseudo-Provider number, if applicable. This number is assigned based upon a request from the agency to identify specific branches for autofax purposes. **It is to be used for requesting HSM certification only.** It is composed of the agency's Mississippi Medicaid (Billing) Provider number with an alphabet added to the end. Pseudo-numbers are not to be used for billing for services rendered. If a Pseudo-Provider number has not been assigned by HSM, enter the agency's Mississippi Medicaid (Billing) Provider Number.
3. **Address** - Enter the home health agency's complete mailing address or post office box, including city, state, and zip code.

Section III Contact Information for this Request

Agency Contact

1. **Request Date** - Record the date of the request.
2. **Agency Contact Person/Requester** - Enter the name of the individual who is primary contact at the Home Health Agency for this case.
3. **Telephone #** - Enter the contact person's telephone number, including area code and extension.
4. **Agency Fax #** - Enter the agency contact's fax number (if changed since previous request), including area code.

Primary Physician

5. **Name** - Enter the first and last name of the physician who is ordering the home health care.
6. **Mississippi Medicaid Billing Number or Medical License Number** - Enter the ordering physician's Mississippi Medicaid billing number **or** Mississippi medical license number.
7. **Telephone #** - Enter the physician's telephone number, including area code and extension.
8. **Date of Last Appointment** - Record the date of the patient's last visit to the primary physician.
9. **Date of Next Appointment** - Record the date of the patient's next scheduled visit to the primary physician.

Section IV Request Type

1. **Admission Review** - If the request is for admission, insert the following:
 - A. **Date of Assessment Visit** - Enter the date of initial assessment visit provided to patient.
 - B. **Date of Next Planned Visit** - Enter date of the next scheduled visit to provide home health service to patient.

NOTE: Attach a copy of the initial nursing assessment, last visit notes, plan of care and physician's orders for home, infusion, and/or enteral therapy.

2. **Continued Stay** - If the request is for continued stay review (certification for continuing services), complete the following:
 - A. **Existing Certification #** - Enter existing certification number.
 - B. **Date of Last Service Authorized** - Enter the date of last service authorized.
 - C. **Date of Next Planned Visit** - Enter the date of the next scheduled home health visit.

NOTE: Attach a copy of the most recent case conference/progress notes, clinical notes from the last visit prior to the (current) request for continued stay review certification and physician's orders for home, infusion, and/or enteral care.

4. **Retrospective** - Check box for retrospective review and complete the following, if applicable:
 - A. **ICN** - Internal Control Number

NOTE: A copy of the patient's home health medical record must be attached to this request form.

Section V. Medical Information

1. **Name** - Enter the patient's last and first name as it appears on the Mississippi Medicaid ID card. If the beneficiary is a K-baby, list baby's name.
2. **Medicaid #** - Enter the beneficiary's number that appears on the Mississippi Medicaid ID card.
3. **Diagnoses/ICD-9-CM Codes** - Enter the patient's primary diagnosis and secondary diagnoses for this admission (if applicable) and enter the ICD-9-CM codes that correspond to the diagnoses.
4. **Clinical Summary** - Record information that describes why the patient requires home health care, including the following: patient's physical, cognitive, nutritional status (weight, height, ideal body weight), if skin breakdown, describe wound bed and size, amount and character of drainage, treatment & preventive measures and decubitus stage, if applicable. Include a record of vital signs, physical findings and pertinent lab results for the conditions requiring home care. If continued stay request, give update of clinical condition, new diagnoses, and progress towards achievement of goals since date of last request. Describe reasons why patient remains homebound.

NOTE: Attach a copy of the required medical record parts for each type of review request (Precertification, Emergency, or Continued stay) as above, Section IV.

5. **Equipment Used** - List any medical equipment the patient is currently using, if any.
6. **Primary Caregiver/Relation to Patient** - List the primary caregiver(s) and their relation to the patient. List any alternate caregivers that could assist with the patient's plan of care.
7. **Care Provided by Other Sources** - Describe any additional home care being provided by sources other than the home health agency requesting service certification. Include relationship of caregiver to patient (i.e., mother, sitter, church member, etc.) and type of service provided.
8. **Homebound Status** - Describe, as applicable, the patient's absences from home and anticipated date of outpatient service (MD office, rehab etc.). Describe activity status, mobility (i.e., distance ambulating).
9. **ADL's for which Assistance is Required** - List all ADL's the patient requires assistance to accomplish.
10. **Functional Limitations** - Describe any functional limitations the patient has requiring physical assistance.

Check the box(es) that describe all the patient's current functional limitations. If other, specify.

11. **Mental Status** - Check the box(es) that best describe the patient's current mental status. If other, specify.
12. **Home Environment** - Describe home environment, addressing whether home is safe, accessible and whether it can be modified to accommodate home plan of care, if applicable.
13. **Name** - Enter the patient's last and first name as it appears on the Mississippi Medicaid ID card. If the beneficiary is a K-baby, list baby's name.
14. **Medicaid #** - Enter the beneficiary's number that appears on the Mississippi Medicaid ID card.
15. **Orders for Services** - Attach a copy of the physician's order (signed or verbal) for home health. If visits are requested in support of infusion or enteral therapy, physician orders specifying the drug or product, route and frequency of administration must be included.
16. **Patient/Caregiver Capabilities and Compliance** – For patients, check box if patient and/or caregiver has sufficient cognitive and physical ability to learn necessary information or techniques, and agree to assist in the plan of care. For continued stay review, check the box that best describes the patient/caregiver: a) patient/caregiver is capable of learning necessary techniques and is generally compliant with the plan of care, **or** b) patient/caregiver is not capable of/willing to learn necessary techniques and/or is not compliant with the plan of care.
17. **Visits Requested** - Specify the home care disciplines needed, the time span and number of visits requested per week and measurable objectives for each discipline requested.
18. **RN Name and Signature** - Enter the name and signature of the nurse or RN Case Manager.

