

OVERVIEW OF PROGRAM

This section contains general information about HealthSystems of Mississippi's (HSM's) review program for certifying home health services rendered to Medicaid beneficiaries. For more details regarding how and when review is performed, we strongly encourage you to read through the sections in this manual which contain HSM's policies and procedures for all review, criteria, and review request forms.

The Division of Medicaid has authorized HSM to carryout the Peer/Utilization Review Services program for the State of Mississippi. In this role, HSM will conduct utilization and quality review as outlined in general below, and in more detail throughout this manual. Our offices are located in downtown Jackson at the following address: **175 East Capitol Street, Suite 250, Lockbox 13, Jackson, MS, 39201.**

HSM's Operations

HSM's business offices are open from 8:00 a.m. to 5:00 p.m., Monday through Friday. Our direct office telephone number and primary FAX number are:

Voice Telephone: (601) 352-6353
FAX Telephone: (601) 352-6358

Certification requests for home health services may be **FAXED or mailed** to HSM or may be submitted via the **web** according to the timelines provided in this manual. HSM's **FAX number** through which home health agencies can request precertification, concurrent certification, and retrospective certification is: **1-888-204-0159**. Faxes received after 5:00 p.m. are considered received the next business day.

You can mail your reviews to:

HealthSystems of Mississippi
Attention: Home Health Department
175 East Capitol Street, Suite 250, Lockbox 13
Jackson, MS 39201

HSM also provides a toll-free **hot-line** through which beneficiaries and providers can report quality concerns and/or complaints. This hot-line can be accessed from the hours of 8:00 a.m. through 5:00 p.m., Monday through Friday. The hot-line number is **1-888-204-0221**.

There is a "**help-line**" available for questions regarding certification review decisions and other review processes during the hours of 8:00 a.m. through 5:00 p.m., Monday through Friday. This number is: **1-601-360-4888**.

Summary of Review Activities

Certification Request Procedure

To request certification, the home health agency must complete the **Home Health Care Certification Request Review Form** and relevant clinical information (as described in HSM's policy and procedure for each review type) and submit it, along with the signed physician's order or verbal order for service.

Precertification

HSM performs precertification review of proposed home health services to determine the medical necessity and appropriateness of services to be provided in the home, appropriateness of the agency, the types of services, the number of visits, and time span reasonably required to treat the beneficiary's condition.

All home health skilled nursing, speech and physical therapy, and home health aide services must be precertified (**except services rendered to beneficiaries who have Medicare or those in the Elderly and Disabled Waiver Program**). Information must be submitted to HSM by fax or mail after the initial assessment visit. Requests for review must be submitted to HSM at least three (3) business days prior to delivery/initiation of additional home health visits/services.

Emergency home health admissions do not require precertification. However, agencies are required to request certification for all emergency admissions according to the following timelines:

- Admissions on Monday through Thursday: on the next day.
- Admissions on weekends, defined as Friday, Saturday, or Sunday: on the following Monday.
- Admissions on holidays: on HSM's next business day.

An **emergency admission** is defined as: the admission to a home health agency results from the sudden onset of a medical condition or injury requiring skilled care and manifesting itself by acute symptoms of sufficient severity that the absence of immediate home health care could result in hospitalization, moderate impairment to body function, serious dysfunction of any bodily organ or part, or other serious medical consequences.

Please read the policies and procedures section of this manual for more details on this process.

Concurrent Certification

All **continuing** home health skilled nursing, speech and physical therapy, and home health aide services must be precertified by HSM (**except services rendered to beneficiaries who have Medicare or those in the Elderly and Disabled Waiver Program**). Review request and relevant clinical information must be submitted via fax or mail. HSM will review the request for the need of continued home health services. Requests for continued services must be submitted to HSM on or before the last certified visit.

If the initial assessment visit and admission to the home health program was not precertified and the beneficiary continues to receive services, the agency should request a concurrent review as soon as the occurrence is identified. HSM will review only those proposed visits that will occur after the request date, i.e., visits occurring prior to the certification request will not be reviewed for certification except instances where services were provided on an emergency basis. HSM will perform all required review on the case, and determine whether emergency and/or continued service(s) is necessary.

Retrospective Certification

Retrospective certification is initiated **(except services rendered to beneficiaries who have Medicare or those in the Elderly and Disabled Waiver Program)** when the beneficiary was not Medicaid eligible at the time of admission but has since received a retroactive eligibility status.

HSM will conduct retrospective review of cases with dates of service older than one (1) year ONLY in the following situations:

- The beneficiary's Medicaid eligibility was retroactively established and the request for certification was received within one year of the eligibility determination date.
- The beneficiary was retroactively Medicaid eligible at the time of admission and the agency submits proof that the claim was filed with the fiscal agent in a timely manner by submitting the Transaction Code Number (TCN) assigned to the claim.

Cases not meeting the above criteria are not eligible for certification and should not be submitted for review.

The review request and a copy of the complete medical record must be submitted to HSM via FAX or mail.

HSM Review Process

HSM employs only licensed professionals in all of its review activities. The registered nurses, Utilization Review Coordinators (URCs), utilize criteria and their clinical knowledge and experience to determine medical necessity and appropriateness of admissions and continued service. If a case does not meet criteria, the reviewer must refer the case to a Physician Advisor (PA). Only physicians can make adverse determinations (denials).

Pended Cases

HSM will provide verbal and written notice to the agency when additional information is required to complete certification review. Timeframes for submission of the information are detailed in HSM policies and procedures included in this manual and are dependent upon the type of review (precertification, concurrent, etc.). If the requested information is not received in the allotted timeframe, HSM will suspend review of the case and notify the agency, in writing, that further review of the case is not possible. Review will resume once HSM receives the requested information.

Quality Review Activities

On a quarterly basis, HSM will select a five percent (5%) sample of all Medicaid cases certified for home health services. HSM will review these cases, using a copy of the medical record, to assess the quality of services rendered and to validate the information provided during precertification, concurrent, and retrospective certification. Results of this review will be profiled to identify improvement opportunities and/or patterns of problems by the agency or the physician. If patterns are confirmed by HSM's Quality Intervention Committee, HSM will work with those agencies or physicians to plan, implement, and monitor improvement efforts aimed at remedying the issue. Please refer to the policies and procedures related to the quality review contained in this manual to learn more about this activity.

Submission of Records

HSM will request that agencies submit copies of complete medical records for the 5 percent (5%) quarterly quality sample. HSM will send a letter to each agency, which includes a list of the records to be sent to our office. Included with this letter will be an inventory sheet for each case selected for review and listed in the letter. This inventory sheet is to be attached to the copy of the appropriate medical record. Facilities will have a maximum of twenty (20) calendar days from HSM's request date to submit the records to HSM at the following address:

**HealthSystems of Mississippi
175 E. Capitol Street, Suite 250
Lockbox 13
Jackson, MS 39201
ATTN: 5% Quarterly Quality Sample**

Denials/Reconsiderations and Quality Re-Reviews

If a **Notice of Review Outcome - Denial** letter is issued denying home health services, the agency, beneficiary/representative, or physician has the right to request a reconsideration of any denial decision. The request for a reconsideration may be submitted by telephone, fax, or mail to HSM within thirty (30) calendar days of the date on the denial notice for non-expedited reconsiderations. Expedited reconsiderations must be submitted within three (3) business days of the denial notice. If Refer to the *Reconsideration* Policy and Procedure section of this manual for additional information.

Any agency or physician who receives a **Notice of Quality/Utilization Issue** letter and disagrees with the determination of a confirmed issue may request a re-review of that determination and supply any information which might resolve the issue. The request must be in writing and contain the reason the agency or physician disagrees with HSM's determination. The written request must be faxed or sent by mail, within thirty (30) calendar days from the date of the **Notice of Quality/Utilization Issue** letter.

HSM has developed a **Reconsideration/Quality Re-review Request Form** for facilities and physicians to use for this purpose.

Electronic Submission

Providers may choose to electronically submit requests for certification of home health admissions and concurrent review via HSM's web site. Additional information, requested by HSM, may be submitted electronically if the initial review was submitted via the web.

HSM's web-based review system includes a provider-specific reporting module that can provide real-time status of reviews previously submitted to HSM. This feature can be accessed without utilizing the review submission option.

Providers must contact HSM's Data department for a provider-specific password and an electronic review User's Guide before submitting a review.

Providers are required to have Internet access for personnel submitting certification requests or accessing provider reports electronically. The 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

HSM ensures that all electronic submissions are secured and maintains a current understanding of HIPPA security regulations.

Mississippi 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, conditions, and limitations of the Medicaid Program.