

Home Health Services: Concurrent Review

Objective:

Determine the medical necessity of continuing services to be provided in the home, the types of services, the number of visits, and time span reasonably required to treat the beneficiary's condition.

Performed By:

Home Health Review Supervisor
Home Health Review Coordinator (URC)
Utilization Review Coordinators (URCs)
Physician Advisors (PA)
Technical Coordinators (TC)
Quality Review Nurse (QRN)
Denial/Reconsideration Coordinator (DRC)

Policy:

All continuing Home Health skilled nursing, speech therapy (provided to beneficiaries under 21 years old), physical therapy (provided to beneficiaries under 21 years old), 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). The completed **HealthSystems of Mississippi Medicaid Home Health Care Certification Request Form**, the most recent case conference/progress notes, clinical notes from the last visit prior to the request for concurrent review and a copy of the physician's orders for home care may be submitted to HealthSystems of Mississippi (HSM) by the Home Health Agency (HHA) via web, FAX, or mail. HSM will review the request for the need of continued home health care. The request for review 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 or the beneficiary received retroactive eligibility. HSM will perform all required review activity on future visits and determine whether continued services are necessary.

Emergency home health services do not require precertification. However, agencies are required to request certification from HSM for all emergency services according to the following timeframes:

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

HSM provides notification of the determination to providers by telephone or autofax within one (1) business day of receiving the request and all necessary information. Written

notification (**Notice of Review Outcome**) is sent to the provider and attending physician within one (1) business day of the receipt of complete information. Those with the ability to be autofaxed will receive only fax notification. If services are denied, written notification is mailed to the beneficiary/representative, HHA, and attending physician.

The beneficiary/representative, the agency and the physician have a right to 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. Please refer to the *Reconsideration Process* section of this manual for additional information.

Note: It is the responsibility of the home health agency to ensure that concurrent review takes place and that all visits are certified.

Procedure: Concurrent Review

1. **Admission to Home Health Program was Certified:** The Home Health agency must request certification of additional visits and services through HSM by submitting a completed **HealthSystems of Mississippi Medicaid Home Health Care Certification Request Form**, the most recent case conference/progress notes, clinical notes from the last visit prior to the request for concurrent review, and a copy of the physician's orders for home care to HSM after the agency and the physician agree on a plan of care. To expedite the certification process, the agency is responsible for gathering the beneficiary identification information, the physician's plan of care and the clinical

The request is to be submitted on or before the last certified visit and before any additional uncertified home health services are provided. The request may be submitted by web, FAX, or mail. Process continues with step 3.

2. **Admission to Home Health Program was Not Precertified – Beneficiary Continues to Receive Services:** If the admission was not precertified and the beneficiary continues to receive services, the agency should request a concurrent review by submitting the completed **HealthSystems of Mississippi Medicaid Home Health Care Certification Request Form**, the most recent case conference/progress notes, clinical notes from the last visit prior to the request for concurrent review and a copy of the physician's orders for home care to HSM after the agency and the physician agree on a plan of care and 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 or the beneficiary received retroactive eligibility.
3. If review of a request cannot be initiated due to a lack of necessary information, the non-clinical Technical Coordinator (TC) verbally notifies the requestor by telephone and requests the necessary information. The TC attempts telephone contact two (2) times and documents the attempts in the electronic tracking notes screen. The DME provider

has three (3) business days to submit the necessary information.

If the information is not received within three (3) business days from the date of verbal notification, the TC stamps the review request (Lack of Information – Unable to Initiate Review) and returns the request to the requestor as written notification that the review cannot be initiated. If review is still necessary, the Home Health agency must re-submit the review request again and all necessary information to reinstate the review process.

4. Upon receipt of the request, HSM verifies beneficiary eligibility. The home health agency's provider number and attending physician's identification are also verified as well as pertinent telephone and FAX numbers.

If the beneficiary is not eligible, HSM notifies the provider via telephone, stamps the request (**Request Invalid – Beneficiary is not eligible for Medicaid**), and returns the stamped request to the agency.

Eligibility and Age Specifications

The following information must be considered when eligibility determinations are made:

- Children and adolescents are covered under expanded Medicaid program services through the last day of the birthday month of the year they reach 21 years of age.
- Medicaid covers infants born to a mother who is Medicaid eligible at the time of the baby's birth through the first year of life provided he/she remains in the household of the mother. These claims may be filed with (1) the infant's full name, and (2) the mother's Medicaid number (with a "K" suffix), until the baby is assigned its own number. The baby is covered for one year after birth even if the mother becomes ineligible.

If the beneficiary is eligible for Medicaid, HSM reviews the Beneficiary's Lock-in indicator information. If the indicator denotes that the beneficiary has Medicare or is in the **Elderly and Disabled Waiver Program** the home health services **cannot** be certified through HSM. HSM will notify the agency via telephone, stamps the request [(1) **HSM Certification Not Applicable – Beneficiary has Medicare, or** (2) **HSM Certification Not Applicable – Beneficiary is in the Elderly and Disabled Waiver Program**], and returns the stamped request to the agency.

If the request is appropriate, HSM will evaluate the beneficiary's service limits to ensure that the allowed twenty-five (25) home health visits for beneficiaries over 21 years old per fiscal year (July 1 - June 30) have not been exhausted. These visits may be home health skilled nursing or home health aide. If the beneficiary is twenty-one (21) years or older and all twenty-five (25) visits have been used, HSM notifies the HHA via telephone, stamps the request (**Request Invalid – Beneficiary has Exhausted Home Health Benefits for this fiscal year**), and returns the stamped request to the agency.

NOTE: The twenty-five (25) visit limit applies to adults only.

NOTE: Physical Therapy and Speech Therapy services will no longer be covered by Medicaid for adults (twenty-one years or older) in the home health setting, effective 7/1/05. HSM will not issue certification for these services provided after 6/30/05.

5. Once step 3 and 4 are completed, HSM will check the fiscal agent's history on the beneficiary file to determine what services have already been authorized and/or provided to the beneficiary.

If the request is a duplicate, HSM notifies the HHA via telephone, stamps the request [(1) **Request Is for Home Health Services Previously Certified- Duplicate Request** **OR** (2) **Request For These Home Health Services would result in a duplication of service(s)**] and ends the review process . HSM will provide verbal notification to the agency and return the stamped request.

6. Once steps 3 and 4 are completed and the request is to be reviewed, HSM assesses the information for completeness. If additional information is required, HSM will stamp the request (**Request for Additional Information: write in specifics**), write in the specifics of the missing information, notify the agency by telephone, and return the request to the agency. The additional information should be submitted to HSM via FAX before the review can be processed. Once all information is received review of the case continues.
7. The reviewer assesses the case to determine if there is appropriate clinical information to make a determination. If additional information is needed, the reviewer requests the information via telephone and in writing (**Request for Additional Information**) within one (1) business day of receipt of the request and pends the review. The agency has (1) business day to submit the requested information by FAX or telephone. If the request is submitted via the web, additional information must be submitted via the web.
8. If the requested information is not received within one (1) business day, the reviewer will close the case. A **Notice of Incomplete Information - Certification Review Suspended** is sent to the agency informing them that the case has been closed.
9. In the event the requested information is received at a later date, the case may be reopened for review.
10. Once all available information has been received, review of the case may proceed. The reviewer evaluates each proposed additional service (HHSK, HHAD, HHPT and/or HHST) by performing the following activities:
 - Determine the medical necessity and appropriateness of additional proposed services by screening the information contained in the request against the following criteria as appropriate:
 - Medicare guidelines for home health coverage and eligibility
 - InterQual's ISD-HC Severity of Illness (SI) and Intensity of Service (IS) Criteria for Home Care or
 - Division of Medicaid's Psychiatric Home Health and Continued Care Criteria
 - Determine the number of additional visits and the time span
 - Ensure that services to be provided are covered by Medicaid
 - Determine whether "emergency services" were in fact emergent.
11. If the case meets criteria, the reviewer certifies an additional number of visits and time span. The on-line system will assign a Treatment Authorization Number (TAN) for cases where admission precertification was not obtained. The previously assigned TAN will

apply to cases where precertification was obtained.

12. The reviewer provides notification of the determination to agencies by telephone or autofax within one (1) business day of receiving the request and all necessary information. Written notification (**Notice of Review Outcome**) is sent to the provider and attending physician within one (1) business day of receipt of all necessary information. Those with autofax capabilities will receive only FAX notification.
13. If the case does not meet criteria, the reviewer refers the case to the Physician Advisor (PA).
14. The PA examines the case and all available information and if necessary, contacts the attending physician or the agency to obtain additional information by FAX or telephone. A period of one (1) business day is allowed for submission of additional information by **FAX or telephone**. The PA requests the information from the physician and, when appropriate, from the agency via telephone with written follow-up (**Request for Additional Information**). The case is then pended.

If the requested information is not received by HSM within one (1) business day, the reviewer will close the case. A **Notice of Incomplete Information - Certification Suspended** is sent to the agency informing them that the case has been closed.

When the requested information is received, the case is reopened and referred to the PA for review.

15. The PA makes a determination based on practice standards, and his/her clinical experience and judgment.

If the PA's initial determination is to deny, verbal notification to the agency and/or the physician is made. PAs call the attending physician three (3) times prior to issuance of written denial determination. If no contact occurs because the physician is not available, HSM proceeds with issuance of the denial notification letter to maintain review timeframe completion requirements. During attempted telephone contacts the PA provides verbal instructions and contact information, affording the attending physician an opportunity to discuss the case (peer-to-peer conversation). HSM makes every attempt to arrange a peer-to-peer conversation within one (1) business day of a request with the same PA making the initial determination or as soon as possible.

NOTE: A peer-to-peer conversation that occurs following issuance of the determination notification in no way may change the PAs initial denial determination. If the attending physician continues to disagree with the PA's determination following the peer-to-peer conversation, the attending physician may submit a request for a reconsideration to HSM. Please refer to the Reconsideration Policy and Procedure for additional information on this process.

If the PA contacted the attending physician, he/she also documents the results of the contact and whether the attending physician was notified of the review determinations. In all instances, review is completed within one (1) business day of receiving the request and all necessary additional information.

16. If the services are approved, the reviewer enters the PAs review determination and completes step eleven (11) described above, updating the on-line review system with all necessary review outcome data.
17. If services are denied, the case is routed to the Denial/Reconsideration Coordinator (DRC) who records the review findings and required information. Verbal notification of the **denial** is made to the agency and/or the physician within two (2) business days of receiving the request and all necessary information. Written notification (**Notice Review Outcome**) is sent to the beneficiary/representative, the agency, and the attending physician within one (1) business day of the receipt of complete information.

Notices of Review Outcome Approval of services are sent to the agency and attending physician include the following information:

- reason for determination and/or modification
- dates(s) of service being approved
- the number and type visits certified
- the time span
- the Treatment Authorization Number (TAN)

Notices of Review Outcome – Denial of services are sent to the beneficiary/representative, the agency, and the attending physician and include the following information:

- date(s) of service being denied
- the principal and clinical rationale for denial
- the process for submitting a reconsideration
- the reconsideration timeframes

Note: The beneficiary’s notice will not contain the medical basis for the denial.

18. The beneficiary/representative, the agency and the physician have the right to request a reconsideration of any denial decision. Refer to the *Reconsideration* Policy and Procedure section of this manual for additional information.
19. HSM utilizes quality screens during all types of certification review. If a quality screen(s) is failed at the reviewer level, the case is referred for physician review. A case may meet criteria, but still be referred for physician review for a failed quality screen(s). If the issue is confirmed or a different issue is identified/confirmed by the PA, the case is routed to the Quality Review Nurse (QRN) to record review findings and to issue a **Notice of Quality/Utilization Issue** letter. Refer to the *Quality Screens* section of this manual for additional information on the screens utilized by HSM and to the *Quality Screening* Policy and Procedure section of this manual for additional information on this process.
20. The physician and/or the HHA may request a re-review of any confirmed quality issue(s). Refer to the *Quality Re-review* Policy and Procedure section of this manual for additional information.