

Home Health Services: Precertification Review

Objective:

Determine the medical necessity and quality of 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
Utilization Review Coordinators (URCs)
Physician Advisors (PA)
Technical Coordinators (TC)
Quality Review Nurse (QRN)
Denial/Reconsideration Coordinator

Policy:

All 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 initial assessment with documentation of the agreed upon Plan of Care and a copy of the physician's orders for home care must be submitted to HealthSystems of Mississippi (HSM) by the Home Health Agency (HHA) after the initial assessment visit via web, FAX, or mail. HSM will review the results of the initial assessment visit and the physician's plan of care for the need for admission to the home health program, if applicable. The request for review must be submitted to HSM at least three (3) business days prior to initiation of additional home health visits/services.

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

- 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.

If a beneficiary is referred by a physician on Friday, Saturday, or Sunday and is subsequently admitted for home health services on the same day for a non-emergency condition, the agency must request certification on HSM's next business day if the beneficiary is still receiving home health services.

HSM provides notification of the determination to providers by telephone or autofax within two (2) business days 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 determination. Those with the ability to be autofaxed will receive only FAX notification. **Example:** Request received by HSM on Monday (day 0), Tuesday is day 1, review determination and verbal/autofax notification is due Wednesday (day 2). Written notification to non-autofax home health agencies is sent no later than Thursday (day 3). 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 of 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 Policy and Procedure section of this manual for additional information.

Procedure: Precertification Review

1. Home Health agencies submit a request for precertification to HSM after the initial assessment visit has been completed and the agency and the physician agree to a plan of care. The request should be submitted at least three (3) business days prior to initiation of subsequent home health services.

The following services require precertification by HSM:

- HHSK - Home Health Skilled Nursing Services
- HHAD - Home Health Aide
- HHPT - Home Health Physical Therapy (for children under 21 years old)
- HHST - Home Health Speech Therapy (for children under 21 years old)

To expedite the certification process, the agency is responsible for gathering the beneficiary identification information, the physician's orders and plan of care and the clinical information obtained during the assessment visit (assessment notes). The agency collates the information and submits a **completed HealthSystems of Mississippi Medicaid Home Health Care Certification Request Form, the initial assessment (with documentation of the agreed upon Plan of Care), and a copy of the physician's orders for home care.** The request may be submitted by web, FAX, or mail.

Emergency Home Health Admissions

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

- 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 resulting 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 bodily function
- Serious dysfunction of any bodily organ/part or other serious medical consequences

In addition to the form and documentation required for routine certification, the HHA must indicate on the certification request form the reason for the emergent services.

Non-emergency Weekend Admissions

If a beneficiary is referred by a physician on Friday, Saturday, or Sunday and is subsequently admitted for home health services on the same day for a non-emergency condition, the agency must request certification on HSM's next business day if the beneficiary is still receiving home health services.

2. If review of a request that is submitted by FAX or mail 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. Review requests submitted via the web are processed by URCs and do not require review by the TC.

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.

3. Upon receipt of the precertification request, HSM verifies beneficiary eligibility. The home health agency's provider number and attending physician's identification are also verified including 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***), updates the tracking system and ends the review process. The stamped request is returned 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 twenty-one (21).
- 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 under 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 request to the home health 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 21 year and older 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 provider 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.

4. Once steps 2 and 3 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.
5. If the request is a duplicate, HSM will update the tracking system, stamp the request [(1) **Request Is for Home Health Services Previously Certified- Duplicate Request OR** (2) **Provision of These Home Health Services would result in a duplication of service(s).**] HSM will provide verbal notification to the agency and return the stamped request along with the results or status of the original review, if available, to the agency. Once the requested information is received, the request is forwarded to the URC.
6. Whether forwarded by the TC or received via the web, the URC assesses the case to determine if there is sufficient clinical information to make a determination. If additional information is needed, the URC 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 provider is afforded three (3) business days to submit the requested information by FAX or telephone. If the initial request is made via the web, additional information may be requested and submitted via the web. Otherwise, additional information must be submitted by fax or mail.
7. If the requested information is not received by HSM within three (3) business days, the reviewer will close the case. A **Notice of Incomplete Information - Certification Suspended** is sent to the provider informing the party that the case has been closed. In the event the requested information is received at a later date, the case may be

reopened for review.

8. Once all available information has been received, review of the case may proceed. The reviewer evaluates each proposed service (HHSK, HHAD, HHPT and/or HHST) by performing the following activities:
 - Determine whether “skilled” services were rendered at the initial assessment.

Assessment Visit for Skilled Services (HHSK, HHST and/or HHPT) and Aide (HHAD)

- A. If a beneficiary is assessed without a skilled service and not admitted to the home health program, the initial visit (assessment) is not approved and can be claimed as an administrative cost.
- B. If a beneficiary is assessed with a skilled service and is admitted to the home health program for continuation of visit, the initial visit (assessment) is not an administrative cost and the visit should be certified with HSM.
- C.1 If a beneficiary is assessed with a skilled service and is admitted to the home health program for the initial visit (assessment) only, the agency may elect to claim this as an administrative cost without certifying the visit with HSM,
OR the agency may elect the following option:
- C.2 If a beneficiary is assessed with a skilled service and admitted to the home health program for the initial visit (assessment) only, the agency may elect to admit and discharge the beneficiary in the home health program for this 1 visit. This is not an administrative cost and must be reviewed by HSM.

NOTE: THE AGENCY MAY ELECT C.1 OR C.2, BUT NOT BOTH.

The HHA must keep proper admission and discharge records on file for all home health patients.

HSM will determine the skilled services by reviewing the physician’s plan of care and the assessment (nursing) notes.

Assessment Visit for Aide Service Only (HHAD)

1. If a beneficiary is assessed for aide services only without a skilled service being performed during the initial visit (assessment) and not admitted to the home health program, the initial visit (assessment) is not approved and can be claimed as an administrative cost.
2. A. If a beneficiary is assessed for aide services only and is admitted to the home health program and a skilled service is performed during the initial visit (assessment), the agency may elect to claim the assessment as an administrative cost without certifying the visit with HSM.

OR, the agency may elect the following option:

2. B. If a beneficiary is assessed for aide services only and is admitted to the home health program and a skilled service is performed during the initial visit (assessment), the agency may elect to certify the assessment visit with HSM as a skilled service.

NOTE: THE AGENCY MAY ELECT 2A OR 2B, BUT NOT BOTH

- 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 Criteria
 - Determine the number of visits and the time span
 - Ensure services to be provided are covered by Medicaid
 - Determine whether the delivered services meet the criteria for "emergency" status, if applicable.
9. If the case meets criteria the reviewer certifies an initial length of treatment time span (beginning with the initial assessment visit) and number of visits. The on-line system will assign a Treatment Authorization Number (TAN).
 10. The reviewer provides notification of the determination to providers by telephone or autofax within two (2) business days of receiving the request and all necessary information. Written notification (**Notice of Review Outcome**) is sent to the provider, and the attending physician within one (1) business day of the determination. Those with the ability to be autofaxed will receive only FAX notification. Example: Request received by HSM on Monday (day 0), Tuesday is day 1, review determination and verbal/autofax notification is due Wednesday (day 2). Written notification to non-autofax home health agencies is sent no later than Thursday (day 3).
 11. If the case does not meet criteria, the reviewer refers the case to the Physician Advisor (PA).
 12. The PA reviews the case and all available information and, if necessary, contacts the attending physician or the agency. The PA and/or the reviewer request the information from the agency or physician via telephone with written follow-up (**Request for Additional Information**). Twenty-four (24) hours is allowed for submission of additional information **by FAX or telephone**.

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

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

13. Upon receipt of the case, 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.

14. If the PA contacted the attending physician, the results of the contact and whether the attending physician was notified of the review determination is also documented. In all instances, review is completed within two (2) business days of receiving the request and all necessary additional information.
15. If the services are approved, the reviewer enters the PA's determination and completes step (10) described above, updating the on-line review system with all necessary review outcome data.

If services are denied, the case is routed to the Denial/Reconsideration Coordinator 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 of Review Outcome – Denial**) is sent to the beneficiary/representative, the agency, and the attending physician within one (1) business day of the determination.

Notices of Review Outcome – Approval of services are sent to the agency and the attending physician and 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:

- dates(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.

17. 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.
18. 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 reviewer's issue is confirmed or a different issue identified and 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.
19. The physician and/or HHA may request a re-review of all confirmed quality issues. Please refer to the *Quality Re-review* Policy and Procedure section of this manual for additional information.