

Home Health Services: Retrospective Review

Objective:

To evaluate, on a retrospective basis, the medical necessity of services which were 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 (URC)
Physician Advisors (PA)
Technical Coordinators (TC)
Denial/Reconsideration Coordinator (DRC)
Quality Review Nurse (QRN)

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 HealthSystems of Mississippi (except services rendered to beneficiaries who have Medicare or those in the Elderly and Disabled Waiver Program).

Retrospective certification is initiated 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 (1) year of the eligibility determination date.
- The beneficiary was determined to be 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.

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

Retrospective certification may be requested for the following services:

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)*

The review request and a copy of the complete Home Health medical record must be submitted

to HealthSystems of Mississippi (HSM) by the Home Health Agency (HHA) via FAX or mail.

Review of valid requests and notification is completed within twenty (20) business days of receipt of all necessary information. Written notification of approvals is sent to agencies without autofax capabilities and the attending physician. If services are denied or partially denied, written notification is sent to the beneficiary/representative, the agency, and the attending physician.

The beneficiary/representative, the agency and the physician have the right to request a reconsideration of any denial or partial denial decision. The request for reconsideration may be submitted by telephone, FAX, or mail to HSM within thirty (30) calendar days of the date of the denial notice. Please refer to the *Reconsideration Process* section of this manual for additional information.

Procedure: Retrospective Certification

1. Home Health Agencies request a retrospective review by submitting a completed **HealthSystems of Mississippi Medicaid Home Health Care Certification Request Form** and a copy of the complete medical record to HSM as soon as the occurrence is identified. This request may be submitted by FAX or mail.
2. 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 initiate the review process.

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

HSM determines whether to proceed with the review based on the eligibility findings and the timeframe during which the services were rendered. HSM examines the request applying the following screens:

Eligibility and Review 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 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 loses her eligibility.

The following information must be considered when determining whether processing of the request is to continue:

- A. If the beneficiary is not eligible during the dates of service, HSM notifies the agency via telephone, stamps the request (**Request Invalid – Beneficiary is not eligible for Medicaid**), and returns the stamped request to the agency. This ends the review process.
 - B. If the date of service is more than one (1) year old, based on the discharge date, and the beneficiary is retroactively eligible for Medicaid, HSM will verify the retroactive eligibility status. If the request for review is received within one (1) year of the retroactive Medicaid eligibility determination, HSM will proceed with processing the request. If the request was not received within one (1) year of the retroactively Medicaid eligibility determination, HSM will notify the provider by telephone, stamps the request (**Request Invalid-Request Receipt Date Over 1 Year From Eligibility Determination Date**), and return the stamped request to the agency.
 - C. If the date of service is more that one (1) year old, based on the discharge date, and the beneficiary is retroactively eligible for Medicaid, HSM will determine if the claim was submitted timely using the Transaction Code Number (TCN). If the claim was timely, HSM will proceed with processing of the request. If the claim was not filed timely, or if a TCN was not submitted along with the review request, HSM will notify the provider by telephone, stamp the request (**Request Invalid-Dates of Service Over 1 Year**), and return the stamped request to the agency.
4. If the beneficiary is eligible for Medicaid and the review is to proceed, 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. HSM will notify the HHA 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 return the stamped request to the agency.

If the request is appropriate, the beneficiary's service limits are evaluated to ensure that the allowed twenty-five (25) home health visits for beneficiaries 21 years 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 return the stamped request to the agency.

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

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 is 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 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.

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 faxed to HSM 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**) and pends the review. The provider is afforded ten (10) business days to submit the requested information **by FAX or mail**.
8. If the requested information is not received by HSM within ten (10) 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.
9. Once all available information has been received, review of the case may proceed. The URC evaluates each visit/service (HHSK, HHAD, HHPT and/or HHST) by performing the following activities:
- Determine whether "skilled" services were rendered at the initial assessment and determines the medical necessity and appropriateness of additional services by screening the information contained in the request and medical record copy 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

The following should be kept in mind during review of the initial HHA 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 visits, 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 one (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 agency must keep proper admission and discharge records on file for all home health beneficiaries.

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 appropriateness of the number of the visits and the time span
- Ensure services that were provided are covered by Medicaid

10. If the case meets criteria, the URC certifies the initial assessment visit, additional visits, the number of visits and the time span. The on-line system will assign a Treatment Authorization Number (TAN).

11. The URC provides written notification (**Notice of Review Outcome**) to agencies without autofax capabilities and the attending physician within twenty (20) business days of receipt of all necessary information.
12. If the case does not meet criteria and/or a quality screen is failed, the URC refers the case to the Physician Advisor (PA).
13. The PA reviews the case and all available information and if necessary, contacts the attending physician and/or the agency. The PA and/or reviewer requests the information from the physician or the agency via telephone with written follow-up (**Request for Additional Information**). A period of ten (10) days is allowed for submission of additional information **by FAX or telephone**. The case is then pended.

If the requested information is not received by HSM within ten (10) days; 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 the PA for review.

14. 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 for the attending physician, 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.

15. If the services are approved, the URC enters the PA's review documentation and completes step 9 eleven (11) described above.
16. If services are denied, the case is routed to the Denial/Reconsideration Coordinator (DRC) to record the review findings and required information. Written notification (**Notice of Review Outcome - Denial**) is sent to the beneficiary/representative, the agency, and the attending physician within twenty (20) business days of receipt of all necessary information.

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

- reason for determination and/or modification
- date(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 or partially denied
- the principal and clinical rationale for denial (*applies to provider and physician notices only*)
- the process for submitting a reconsideration
- the reconsideration time frames

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 or partial 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 quality 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 any confirmed quality issue. Refer to the *Quality Re-review Policy and Procedure* section of this manual for additional information.