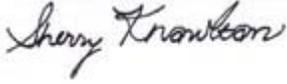


	MEDICAL ASSISTANCE BULLETIN COMMONWEALTH OF PENNSYLVANIA * DEPARTMENT OF PUBLIC WELFARE		
	NUMBER: 23-94-04	ISSUE DATE: June 10, 1994	EFFECTIVE DATE: July 5, 1994
SUBJECT: Procedures for Prior Authorization of Home Health Services		BY:  Sherry Knowlton Deputy Secretary for Medical Assistance Programs	

PURPOSE:

To provide the procedures to request prior authorization of all home health services (skilled nursing care, home health aide services, physical and occupational therapy, speech pathology and audiology services).

SCOPE:

This bulletin applies to all home health agencies enrolled in the Medical Assistance (MA) Program.

BACKGROUND:

The Felix et al. v. Casey et al. Stipulation of Settlement included a provision to add home health services to the Department's current list of services that require prior authorization. The Department announced the rule change that all home health services must be prior authorized in MA Bulletin number 1249-94-02, effective July 5, 1994. This Bulletin obsoletes Medical Assistance Bulletin 23-94-02.

The rule change also included the provision that the first home health agency visit be approved following hospitalization, the onset of an illness which does not involve a hospitalization, the onset of a new primary diagnosis or the exacerbation of an existing diagnosis which causes a change in the recipient's condition and requires a change in the plan of treatment even if the balance of services in the plan of treatment is disapproved.

DISCUSSION:

All home health services initiated on or after July 5, 1994, must be prior authorized. If a home health agency is providing services that are included in a plan of treatment that was initiated prior to July 5, 1994, no prior authorization is required for those services even if they continue beyond July 5, 1994. However, if the attending physician 1) reviews the original treatment plan (review is required at least every 60 days), 2) certifies that the recipient continues to remain homebound and home health services continue to be medically necessary, and 3) orders continued services, the continued services must be prior authorized.

Telephone Requests - The home health agency (HHA) must call 1-800-558-4477 to request prior authorization of home health services. This telephone line is staffed with nurse reviewers and is in operation Monday through Friday, 9:00a.m. to 4:00 p.m., beginning April 25, 1994.

Department Responses to Requests - The Felix v. Casey Stipulation of Settlement specifies that the Department will respond to a request for prior authorization within 48 hours of receipt. However, it is the Department's intent to respond to requests for prior authorization during the initial telephone call. If the nurse reviewer determines that the request should be reviewed by one of the Department's medical consultants before a response can be given, the nurse reviewer will call the HHA provider back as soon as possible but no later than 48 hours from receipt of the original request.

If the nurse reviewer or medical consultant requires additional documentation to make a decision, the nurse reviewer will explain to the HHA provider what information is required and how to submit the information. The 48 hour clock for response

will begin upon receipt of the requested information.

General Assistance (GA) Basic Health Care Program Request for Exception to Limits - If the recipient is subject to the GA Basic Health Care Program (HealthCare Benefit Package III; limit to a maximum of 30 visits per fiscal year), and a request for an exception to the limits is needed, the HHA can request both the prior authorization and the exception to the limits during the same telephone call.

Preparation for Phone Requests - Both the Department and home health agency providers share a mutual concern about the length of time to complete a prior authorization telephone request. Requests for prior authorization of services can be efficient and short if the home health agency prepares for the telephone call by gathering all of the required information before making the telephone call.

Post Approval of Services Rendered - The Department will accept request for post authorization after services have been rendered whenever the following occurs:

1. Services are initiated on a weekend or holiday when the prior authorization 800 telephone line is not in operation. When this occurs, the HHA must call to request post authorization of services on the next workday that the telephone line is in operation.
2. The recipient has a third party resource which the HHA billed but the claim was denied or the payment was less than the Department's fee. When this occurs, the HHA must call to request post authorization of services within seven workdays from the date of receipt of the denial or explanation of benefits from the third party resource.
3. The determination of the recipient's eligibility was delayed by the county assistance office and/or the recipient is determined to be retroactively eligible for medical assistance benefits. When this occurs, the HHA must call to request post authorization of services within seven workdays from the date that the HHA learns that the recipient was MA eligible on the dates that services were rendered.

Prior Authorization of Services for Newborns - Whenever home health services are prescribed for an MA eligible newborn who has not been assigned a recipient number, the home health agency may request prior authorization of services using the mother's recipient number, or may wait until the child is assigned a recipient number and request post approval.

Claims for the newborn who does not have a recipient number and whose services were prior authorized using the mother's recipient number must be billed on a paper (hard copy) invoice. Please refer to MA Bulletins Number 99-93-08 and Number 99-93-11 for procedures for invoice completion.

Claims for newborns who have been assigned a recipient number and whose services were authorized using the newborn's recipient number may be billed on paper (hard copy) invoice, by tape or diskette.

No Change to Limitations on Services - The limits on services described in MA Bulletin Number 1101-93-03 for GA recipients subject to the GA Basic Health Care Program, and in Section 1249.59, relating to limitations on payment for all other recipients, remain in effect. The requirement that the attending physician must review the treatment plan at least every 60 days (Section 1249.52(a)(5) relating to payment conditions for various services) also remains in effect.

Therefore, the prior authorization nurse reviewer can authorize only the quantity of services specified in the physician's order and subject to the limits defined in Section 1249.52(a)(5), Section 1249.59, and MA Bulletin Number 1101-93-03.

Right of Appeal - If a request for prior authorization of home health services is disapproved and the recipient disagrees with the decision, the recipient or his/her representative has the right to ask for and have a fair hearing. The procedure to ask for an appeal is explained on the notice informing the recipient of the disapproval.

PROCEDURES:

STEP 1 - The HHA calls the prior authorization unit at 1-800-558-4477 following hospital discharge, the onset of illness which does not involve a hospitalization, the onset of a new primary diagnosis or the exacerbation of an existing diagnosis which causes a change in the recipient's condition and requires a change in the plan of treatment. The HHA provides the following information based on the physician's order for home health services:

Required Information

- recipient name, 10 digit recipient number, and if available, phone number. NOTE: Caller should indicate if recipient is eligible for HealthCare Benefit Package III (limited to a maximum of 30 visits per fiscal year); number of visits received during the current fiscal year (if known); and, if an exception of the limits is being requested in addition to prior authorization.
- provider name, provider number, address code, phone number.
- payee information, if applicable.

- name of prescribing practitioner and telephone number.
- primary diagnosis and a description of the recipient's functional limitations.
- secondary diagnosis.
- homebound status; description of condition that restricts individual's ability to leave residence without assistance or makes leaving medically contraindicated.
- type of service and initial quantity of service.
- medical indications/information to support need for service.
- treatment prescribed/planned.
- prior service information, if applicable.
- tentative hospital discharge date.

Optional Information If Available

- prescribing practitioner's license number.
- prescribing practitioner's street address, city, state and zip code
- ICD-9CM diagnosis code for primary diagnosis
- ICD-9CM diagnosis code for secondary diagnosis

STEP 2 - The prior authorization unit approves or denies the request for service(s). Approved services time limit not to exceed 60 days.

The first visit is always deemed approved even if other services are denied. If other services are denied, the prior authorization unit will give the HHA a prior authorization number to bill for the first visit.

If there is a change in the recipient's condition that requires additional services beyond those already prior authorized, the HHA should call the 800 number and provide all information required to support the request for the additional services. The nurse reviewer will explain to the HHA how to use the prior authorization number to bill or the approved additional services.

If additional services beyond 60 days are medically necessary, ordered by and included in the plan of treatment established by the attending physician, the HHA must call for a new prior authorization. The HHA must provide all information required to support the request.

Billing Instructions - When submitting a claim for prior authorized services, be sure to include the prior authorization number in Field 43 on the MA 319. Also, please remember not to combine claims for services that require prior authorization with claims for compensable medical supplies that do not require prior authorization on the same MA 319. Claims for compensable medical supplies should be billed separate from home health visits that require prior authorization.

Attached are two documents to assist home health agencies under the Prior Authorization Program. Attachment 1 provides home health agencies with information on systems requirements for authorization requests, Department approval and billing. Attachment 2 provides home health agencies with prior authorization of home health services examples.

NEXT STEPS:

1. Continue to render services without prior authorization if the services are included in a plan of treatment that was initiated prior to July 5, 1994.
2. Call 1-800-558-4477 to request prior authorization of services initiated or recertified on or after July 5, 1994.
3. Prepare for the prior authorization phone request by gathering all required information before calling the 800 telephone number.
4. Remember to include the prior authorization number if Field 43 on each claim for dates of service on or after July 5, 1994.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

Pharmacy and Ancillary Services
P.O. Box 8043
Harrisburg, Pennsylvania 17105
1-800-537-8861

Visit the Office of Medical Assistance Programs website at www.dpw.state.pa.us/omap.