



June 1, 2007

PROVIDER BULLETIN

NO. 07-13

Home Health Agency Prior Authorization Process Changes on June 5, 2007

To: All Home Health Agencies providing services to Nebraska Medicaid clients

From: Gaylene R Jeffries, RN, BA, Administrator I
Home and Community Services Division
Nebraska Health and Human Services System

Beginning June 5, 2007, Home Health Agencies will no longer be required to obtain prior authorization for services for Nebraska Medicaid covered clients.

Home Health Agencies are still responsible to comply with all regulations concerning covered services. These regulations are found in 471 NAC§ including Chapters 1,2,3 and 9.

- 1) **Home Health Agencies must keep all records of services provided, in accordance with 471 NAC regulations.**
- 2) **Home Health Agencies may be subject to random reviews of claims and services for monitoring and quality purposes.**
- 3) **Home Health Agency follows usual claim billing process, except that a Prior Authorization number will not be required.**
- 4) **All Medicare benefits for Home Health services must be exhausted before billing Medicaid for those clients who are eligible for both Medicare and Medicaid.**
- 5) **For questions regarding claim status, use the Medicaid Inquiry Line. 877-255-3092**
- 6) **Remember to check client eligibility monthly. 800-642-6092.**
- 7) **For clients who are enrolled in a Nebraska Medicaid Managed Care Plan, please contact that plan with prior authorization questions.**
- 8) **If you have questions about this memo, please call 402-471-9415.**

Medicaid Home Health Prior Authorization Request

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM



<input type="checkbox"/>	Managed Care as of _____
<input type="checkbox"/>	No 485, No Orders for Request
<input type="checkbox"/>	No PT, OT, ST Orders/Eval/Plan of Care
<input type="checkbox"/>	Last Request Has Been Shredded
<input type="checkbox"/>	Resubmit Prior Auth. Request & 485 & Supporting Documents
<input type="checkbox"/>	Data Entry Rejected (Correct circled areas)

This fax from agency listed below sent to HHSS and returned to said agency by HHSS Medicaid Prior Authorization Department after approval. Fax line (402) 471-1717, Phone (402) 471-9386. Attached transmission may include protected health information, under the standards established per the Health Insurance Portability and Accountability Act of 1996, and Neb. Rev. Stat., section 68-31. If this information has been received in error, the recipient is directed to destroy the information and notify this office of the error immediately. Failure to do so may lead to civil or criminal penalties.

- Initial Recert Pending Medicaid at Start of Care Waiver Katie Beckett
 Additional Visit Request to PA# _____ Medicare Yes No

Age

Client Name (Last, First)

-

Provider Phone

-

Provider Fax

Provider Name/Location/Email address

Nurse Contact

Client Resides

- Home/Apt./Foster Care
- Assisted Living, Name _____
- Group Home/Name _____
- NH, SNF, In/Out Pt/Hosp. (Not elig for HH Services)

Assist by:

- Other Home Health Agency/Priv. Duty Nurse Serving Client Agency/PDN: _____
- Homemaker/Chore Worker
- Personal Assistant
- Family Assist
 - Yes No - If No; Why: _____
- Lives Alone

Skilled Nursing Need

- Oral Med Admin. _____ Freq. _____
- Med Planner Fill _____ Freq. _____
- IM/Sub. Q. Injection _____ Freq. _____
- IV Therapy _____ Freq. _____
- Prefill Insulin _____ Freq. _____
- Lab Draw _____ Freq. _____
- Trach/GT/VENT _____
- FC/SP Cath Change _____
- Wound Care - Site _____ Size _____ Freq. _____ Stage _____

- - -

Client Medicaid Number

- - -

Agency Provider Number

Service	Code	# of Visits X 8 Units Each	Total
RN/LPN	GO154	_____	_____
HHA	GO156	_____	_____
PT	GO151	_____	_____
OT	GO152	_____	_____
ST	GO153	_____	_____

Extended Services		# of 1 Hour Units	Total
RN EXT. HIGH TECH	S9123TG	_____	_____
LPN EXT. HIGH TECH	S9124TG	_____	_____
RN EXT.	S9123	_____	_____
LPN EXT.	S9124	_____	_____
HHA EXT.	S9122	_____	_____

In Home Vent Care		# of Days	Total
# OF DAYS	T1022TG	_____	_____

Primary DX ICD9 _____ Cert Period _____ To _____

Pertinent Information: _____

If Client is under Aged and Disabled/MR waiver, coordinate with services coordinator. Prior authorization void if not Medicaid enrolled/ client resides in NH/SNF/Out/In Pt. Facility/ Hospital/ or in managed care. Not valid until Share of Cost is met if client has excess income.



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