September 4, 2007

To: **All Nebraska Medicaid enrolled Home Health Agencies and Hospice Providers**

Provider Bulletin 07-19

From: Vivianne Chaumont, Director
Division of Medicaid and Long Term Care

By: Gaylene R Jeffries, Administrator I
Heather Leschinsky, Program Specialist

RE: **CHANGE IN PRIOR AUTHORIZATION PROCESS**

This change is effective October 1, 2007 and applies to dates of service October 1, 2007 and following. The change will reinstate the prior authorization process utilized before June 5, 2007. (For dates of service 6/5/07-9/30/07 utilize the process outlined in Memos 07-13 and 07-14.)

1. Home health prior authorization (PA) requests must use the DHSS worksheet (see attached) and include a completed 485. Please check for legibility, accuracy and completeness. Any illegible, inaccurate or incomplete requests will not be processed. DHHS staff will not make corrections.

Common errors for both Home Health and Hospice are an incomplete or inaccurate Medicaid ID number, provider number, ICD-9, units columns (Home Health only), certification period and a lack of accompanying care plan/orders.

Hospice PA requests are submitted on the MS-44 with the required attachments listed at the bottom of the form.

NEW: Please include provider e-mail address on the PA Request for both Home Health and Hospice providers (see example at end of Memo).

2. Each client's home health or hospice PA request must be faxed separately. Sending information on several clients in the same fax will prevent DHSS staff from accessing your PA request.

3. Do not use a cover sheet when sending the PA request. Using a cover sheet will prevent DHSS staff from accessing your PA request.

4. The format for your return Prior Authorization for both home health and hospice will look the same as it did prior to June 5, 2007 and will be returned to you via FAX.

5. Please check the returned PA information. For Home Health, if it is incorrect, please complete an Additional Request Worksheet that makes the necessary corrections. Failure to do this may result in several PA numbers issued for the same request, which then suspends payment.

For Hospice PA, if the information is incorrect, please call Heather Leschinsky at 402-471-9389.

6. Prior authorization for Home Health will be implemented according to the following effective dates:

1) Initial, beginning October 1, 2007
2) Changes/additional requests, beginning October 1, 2007
3) Recertifications, beginning at the date of the next certification

Prior Authorization for Hospice will be implemented according to the following effective dates:

1) Initial, beginning October 1, 2007
2) Reauthorizations, beginning at the date of the next benefit period

7. For Home Health clients on Nebraska Medicaid Managed Care Plans – Primary Care + and Share Advantage – please contact the client's plan directly. For clients who are receiving psychiatric Home Health services through Magellan, please contact Magellan for their prior authorization process.

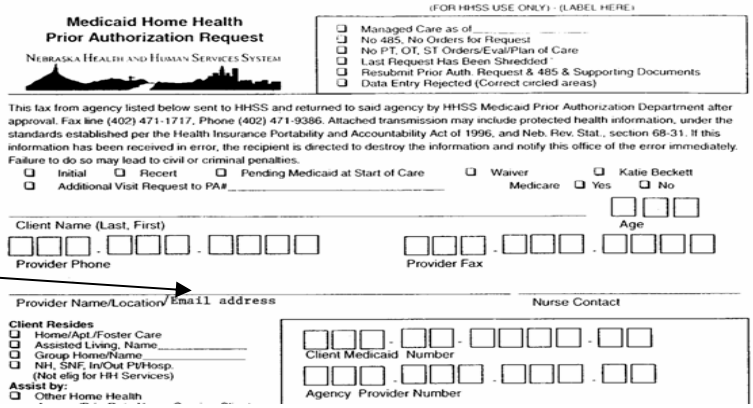
8. Home Health Fax Numbers**: 402-742-2341** or **1-877-680-2172**
Hospice Fax Number**: 402-742-8300**

9. For Home Health Agency and Hospice billing questions, please contact Danny Vanourney, Payment Reviewer at **402-471-0161**.

10. For questions on this memo, please call:
Home Health - Gay Jeffries at **402-471-9415**
Hospice - Heather Leschinsky at **402-471-9389**

THANK YOU!

NOTE:
Please include e-mail address


Medicaid Home Health
Prior Authorization Request
Nebraska Health and Human Services System

(FOR HHSS USE ONLY) - (LABEL HERE)
- Managed Care as of
- No 485, No Orders for Request
- No PT, OT, ST Orders/Eval/Plan of Care
- Last Request Has Been Shredded
- Resubmit Prior Auth. Request & 485 & Supporting Documents
- 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

Client Name (Last, First)
Age
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

Client Medicaid Number
Agency Provider Number

Medicaid Home Health Prior Authorization Request

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

(FOR HHSS USE ONLY) - (LABEL HERE)

- ❑ Managed Care as of_____
- ❑ No 485, No Orders for Request
- ❑ No PT, OT, ST Orders/Eval/Plan of Care
- ❑ Last Request Has Been Shredded
- ❑ Resubmit Prior Auth. Request & 485 & Supporting Documents
- ❑ Data Entry Rejected (Correct circled areas)

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❑ Initial ❑ Recert ❑ Pending Medicaid at Start of Care ❑ Waiver ❑ Katie Beckett

❑ Additional Visit Request to PA#_____ Medicare ❑ Yes ❑ No

Client Name (Last, First) _____ Age ☐☐☐

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 Asistant
- ❑ 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.

printed on SOY INK printed on recycled paper

MILTC-18 (34550) 11/04
(Previous version 9/03 should NOT be used)

Hospice Prior Authorization Request Form

Prior Authorization Number (For HHSS Use Only)

This fax from agency listed below sent to HHSS and returned to said agency by HHSS Medicaid Prior Authorization Department after approval. 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.

Type of Prior Authorization request:
☐ Initial ☐ Recertification ☐ Additional service request to PA

Client Medicaid Number	Client Name
Agency Provider Number	Provider Name/Location
Provider Phone/Fax Number	
County of Client	Email Address
Primary Diagnosis/ICD9 Code	Six-month Authorization Period: to

This authorization includes the following services at the indicated number of units:

Service	Code	# of Units
Routine Home Care	T2042	180/certification period
Continuous Home Care	T2043	72 hours
Inpatient Respite Care	T2044	5 days/month
General Inpatient Care	T2045	10 days/month

Does the Client have Medicare A? ☐ Yes ☐ No
If "Yes", list date and reason Medicare A hospice benefits exhausted_____

Have the following been notified of Hospice involvement?
Pharmacy? ☐ Yes ☐ No comments_____
Equipment? ☐ Yes ☐ No comments_____
Other suppliers ☐ Yes ☐ No comments_____

Is Client on Managed Care? ☐ Yes ☐ No
Is Client on Medicaid Waiver? ☐ Yes ☐ No

If Client resides in or moves to a long term care facility (NF, AL, CDD, ICF/MR or IMD):
Facility Name/location:_____
Hospice provider number for that facility (if applicable):_____
Has facility billing office been notified of Hospice involvement? ☐ Yes ☐ No
Is there a signed contract between facility and hospice provider? ☐ Yes ☐ No
List effective date of contract_____
Other Medicaid services provided to client _____

Attachments to this request (Required):
- ☐ Signed election statement
- ☐ Physician certification of terminal illness with life expectancy of 6 months or less
- ☐ Hospice plan of care
- ☐ Listing of all medications, biologicals, supplies, and equipment for which hospice is covering
- ☐ Clinical Criteria to support terminal status or supportive documentation for functional decline

*Prior authorization: void if client not Medicaid enrolled
*Not valid until Share of Cost is met if client has excess income
*If client is on Medicaid Waiver, please contact Services Coordinator for continued coordination