

PROVIDER BULLETIN

NO. 08-11

April 18, 2008

TO: Home Health Agencies Participating in the NE Medicaid Program

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RE: Changes in the Home Health Agency Prior Authorization Process

Please share this information with billing, clinical and administrative staff

Currently, all Home Health Agency services must be prior authorized in order for claims to be paid for services provided to Nebraska Medicaid clients. This process is performed initially and every 60 days thereafter.

Certain clients receiving Home Health Agency services have medical conditions and service needs that are stable and predictable per the definition below and essentially require the same service from certification period to certification period. In order to streamline the process for this population, certain services may be authorized for longer than 60 days at a time.

Stable or predictable means that a client's clinical and behavioral status and nursing care needs are determined to be non-fluctuating and consistent or fluctuating in an expected manner, including an expected deteriorating condition.

Please note the following:

- **There is no separate application or process to request this extended review and authorization.** DHHS staff will determine which services will be authorized for an extended period.

FOR A 60-DAY AUTHORIZATION PERIOD:

For the standard 60-day authorization, there is NO CHANGE in the authorization request process. All paperwork (including the Plan of Care and physician's certification) is required when the authorization request is submitted. A Prior Authorization (PA) number will be assigned after clinical review by DHHS staff. Submissions will continue to be submitted through the eFax system (402) 742-2341.

FOR AN AUTHORIZATION PERIOD LONGER THAN 60 DAYS:

- Extended authorizations will be made in increments of 60 days (e.g. 120,180, 240 days).
- Decisions on length of authorization period will be made based on DHHS review of the submitted information, client's past utilization of services and clinical judgment.
- If the authorization is for a period longer than 60 days, the Home Health Agency will be notified regarding the length of the extended authorization period and the date when the next clinical review will be performed by DHSS staff.
- The Home Health Agency will receive multiple authorizations with specifically assigned PA numbers for each 60-day period (e.g. for a 180-day authorization period, the Home Health agency will receive 3 separate authorizations with 3 separate PA numbers).
- There must be separate and updated Plans of Care (POCs) and worksheets, with the appropriate certification dates, for each 60-day period, regardless of the anticipated authorization period.
 - For example, for a 180-day authorization period, in addition to the initial POC already submitted by the Home Health Agency, the Home Health Agency must also submit the 2 subsequent POCs completed during that time period, prior to the end of the 180 days.
 - For the same example, if a reauthorization is requested at the end of the 180-day period, the Home Health Agency must submit the current POC, along with the 2 previously completed POCs.
- These 60-day POCs serve as documentation of services provided, but do not substitute for the requirement to maintain nurse's notes.

- A separate PA number will be assigned to each specific 60-day authorization period. **In order for claims to be paid as quickly as possible, the assigned PA number must be used for its corresponding 60-day period** (e.g. claims for the dates 05/01/08-06/30/08 must be submitted with the PA number assigned to these specific dates).
- If a Home Health Agency uses an incorrect PA number on a claim, even if it was one assigned to a recent authorization period for the same client, it will result in non-payment.
- Authorization change requests will be handled according to the current process.
- Please allow 10 working days for the prior authorization requests to be processed before sending in a second request. **Duplicate requests will result in significant delays in processing payments.**

All current Nebraska Medicaid Title 471 and Licensure Title 175 regulations pertaining to Home Health Agency services remain in effect. This includes regulations pertaining to the supervision of Home Health Aides, which is required, but is not a billable service.

Nebraska Medicaid Home Health Agency regulations are available on the DHHS website at <http://www.dhhs.ne.gov/reg/reg.htm> (i.e. Title 471, Chapter 9 and Title 175, Chapter 14). Additional information, including provider handbooks, fee schedules and provider bulletins, is available at <http://www.dhhs.ne.gov/med/provhome.htm>

If you have questions on this Bulletin or the changes to the Home Health Agency Prior Authorization process, please contact Gaylene Jeffries at 402-471-9415 or gaylene.jeffries@dhhs.ne.gov. Please do not send client specific Protected Health Information via email.

If you have questions on current Home Health Agency authorizations, please call Melissa Haecker at 402-471-9202 or melissa.haecker@dhhs.ne.gov