INSTRUCTIONS FOR THE PROVIDER

Increased State Plan Home Health Form

The "Prior Authorization of Increased State Plan Home Health Services" form should be used to request a review for State Plan Home Health Services that will exceed the current limits of the State Plan Home Health Services for individuals who are 21 years or older.

Review Process for increased State Plan Home Health Form

It is to the advantage of providers to be knowledgeable of the procedure for requesting increased State Plan Home Health prior authorization reviews.

1. The provider shall obtain the form through the Permedion website www.hmspermedion.com. (once the new form is uploaded to the website).
   The provider shall submit the form and **all required clinical documentation** that support the need for the service to fax number **1-855-474-4306**. If the individual is on one of the identified waivers, include the individual's Service Plan for up to one year prior.
2. If you need to send in review requests for multiple individuals, the information for each request must be faxed separately.
3. Within 4 working days of receipt, a licensed nurse shall review the documentation for medical necessity. The prior authorization request shall then be approved, pended for additional information, or denied. A technical denial shall be issued if all required documentation is not received within 4 working days of a request for any additional documentation needed to complete the review process.
4. Those referred for physician review shall be determined within 2 additional working days.
5. When a PA request is approved, Permedion shall generate a letter to the individual via MITS, as well as to the provider, and if on waiver the case manager or SSA.
6. When the PA request is denied, Permedion will make a courtesy call to the provider. A letter will then be generated to the individual, as well as to the provider and, (if applicable) to the case manager or SSA. The letter will provide information on how the individual can, within 90 days, appeal the decision through a state hearing.

Increased State Plan Home Health Services Prior Authorization Requests

In accordance with OAC 5160-1-01 that defines medical necessity, please attach or fax documents that support the medical need for services that are over the State Plan limits. Permedion is responsible for reviewing the medical necessity of all increased State Plan Home Health Services prior authorization requests as directed by the Bureau of Long Term Care Services and Supports.

Clinical Documentation

Complete documentation provided by agencies is extremely important in that it both influences the timeliness of processing and potentially impacts the final determination. The Permedion reviewer shall make an appropriate determination and is reliant solely on the provider to submit documentation that ensures this can occur. It is to the provider's advantage that the reviewer be presented with a clinical picture that adequately reflects the individual's needs, as well as the specific benefit derived as a result of the increased State Plan Home Health services. The provider must make it very evident as to why these services are medically necessary.

Waiver Service Plans

Inclusion of the waiver service plans for up to one year prior to the request date enhances the Permedion reviewer's comprehension of how home health services are being utilized, and its relationship to medical necessity. The service plan must always accompany the clinical documentation.

It is the agency's responsibility to be aware of the expiration date of the expanded services and not provide any services past that date. If services are provided without a valid authorization, then no reimbursement will be allowed and there will be no backdating of any service request.

Rules (in red)

Home Health Care Services - Nursing services under the mandatory home health benefit must be provided inside the home. Such services are defined in 42 CFR 440.70(b)(1) as part-time or intermittent.

OAC 5160: 12-01 A) "Home health services" includes home health nursing, home health aide and skilled therapies as defined in paragraph (F)(G) of this rule.

(B) Home health services are covered only if the qualifying treating physician certifying the need for home health services documents that he or she had a face-to-face encounter with the consumer within the ninety days prior to the home health care start of care date, or within thirty days following the start of care date inclusive of the start of care date. To be a qualifying treating physician, the physician must be a doctor of medicine or osteopathy legally authorized to practice medicine and surgery as authorized under Chapter 4731. of the Revised Code in which he or she performs that function or action. Advanced practice nurses in accordance with rule 5101:3-8-21 of the Administrative Code and in collaboration with the qualifying treating physician, or a physician assistant in accordance with rule 5160:-4-03 (5101:3-4-03) of the Administrative Code and under the supervision of the qualifying treating physician, have the authority to conduct the face-to-face encounter for the purposes of the supervising physician certifying the need for home health services. The face-to-face encounter with the consumer must occur independent of any provision of home health services to the consumer by the individual performing the face-to-face encounter. The face-to-face encounter must be documented:

(1) For home health services unrelated to an inpatient hospital stay, the face-to-face encounter must be documented by the qualifying treating physician using:

(a) The JFS 07137 "Certificate of Medical Necessity for Home Health Services and Private Duty Nursing Services" (rev. 2/2011) or

(b) The consumer's plan of care may be used to certify medical necessity for home health services if all of the data elements specified for home health services unrelated to an inpatient hospital stay in the JFS 07137 "Certificate of Medical Necessity for Home Health Services and Private Duty Nursing Services" (rev. 2/2011) are included and the plan of care contains the physician's signature, physician's credentials and the date of the physician's signature.

(2) For post hospital home health services, the face-to-face encounter must be documented by the qualifying treating physician using the JFS 07137 "Certificate of Medical Necessity for Home Health Services and Private Duty Nursing Services" (rev. 2/2011).

(3) For a dual eligible consumer, if the face-to-face encounter date for medicare home health services falls within the ninety days prior to the medicaid home health services start of care date, or within thirty days following the medicaid start of care date inclusive of the medicaid start of care date, may be used on the JFS 07137 "Certificate of Medical Necessity for Home Health Services and Private Duty Nursing Services" (rev. 2/2011) and the supporting documents attached to this form.

(B)(C) Home health services are covered only if provided on a part-time and intermittent basis, which means:

(1) No more than a combined total of eight hours (thirty-two units) per day of home health nursing, home health aide, and skilled therapies except as specified in paragraph (G)(H) of this rule;

(2) No more than a combined total of fourteen hours (fifty-six units) per week of home health nursing and home health aide services except as specified in paragraphs (C)(D) and (G)(H) of this rule; and

(3) Visits are not more than four hours (sixteen units). Most visits are usually less than two hours (eight units). Nursing visits over four hours (sixteen units) may qualify for coverage in accordance with rule 5101:3-12-02 of the Administrative Code.

(C)(D) A combined total of twenty-eight hours (one hundred twelve units) per week of home health nursing and home health aide services is available to a consumer for up to sixty consecutive days from the date of discharge from an inpatient hospital stay of three or more covered days, if all of the following are met by the consumer as certified by the qualifying treating physician using the JFS 07137 "Certificate of Medical Necessity for Home Care Certification Health Services and Private Duty Nursing Services " (rev. 7/20062/2011):

(1) Consumer has a discharge date from an inpatient hospital stay of three or more covered days. For the purposes of this rule, a covered inpatient hospital stay is defined in rule 5101:3-2-03 of the Administrative Code and is considered one hospital stay when a consumer is transferred from one hospital to another hospital, either within the same building or to another location. The sixty days will begin once the consumer is discharged to the consumer's place of residence or to a nursing facility as defined in paragraph (D)(3)(E)(4) of this rule, from the last inpatient stay whether or not the last inpatient stay was an inpatient hospital or inpatient rehabilitation unit of a hospital.

(2) Consumer has a comparable level of care as evidenced by either:

(a) Enrollment in a home and community based services (HCBS) waiver; or

(b) Has a medical condition that temporarily meets the criteria for an institutional level of care which are any of the following rules defined in rule 5101:3-3-05 of the Administrative Code for skilled level of care (SLOC), or defined in rule 5101:3-3-06 of the Administrative Code for intermediate level of care, or defined in rule 5101:3-3-07 of the Administrative Code for ICF/MR level of care. In no instance does this requirement constitute the determination of a level of care for waiver eligibility status, or admission into a medicaid covered long term care institution.

(3) Requires home health nursing or a combination of private duty nursing/home health nursing/waiver nursing/skilled therapy services at least once per week that is medically necessary in accordance with rule 5101:3-1-01 of the Administrative Code.

(4) The consumer has had a covered inpatient hospital stay of three or more days, with the discharge date recorded on form JFS 07137 "Certificate of Medical Necessity for Home Care CertificationHealth Services and Private Duty Nursing Services" (rev. 7/20062/2011).

(D)(E) The only provider of home health services is the MCRHHA (medicare certified home health agency) that meets the requirements in accordance with rule 5101:3-12-03 of the Administrative Code. In order for home health services to be covered, MCRHHAs must:

(1) Provide home health services only if the qualifying treating physician has documented a face-to-face encounter with the consumer as specified in paragraph (B) of this rule.

(1)(2) Provide home health services that are appropriate given the consumer's diagnosis, prognosis, functional limitations and medical conditions as ordered by the consumer's treating physician for the treatment of the consumer's illness or injury.

(2)(3) Provide home health services as specified in the plan of care in accordance with rule 5101:3-12-03 of the Administrative Code. Home health services not specified in a plan of care are not reimbursable. Additionally the MCRHHA's plan of care must provide the amount, scope, duration, and type of home health service as:

(a) Identified on the all services plan as defined in rule 5101:3-45-01 of the Administrative Code that is prior approved by ODJFS or the case management agency when a consumer is enrolled in an ODJFS-administered home and community based services (HCBS) waiver. Home health services that are not identified on the all services plan are not reimbursable; or

(b) Documented on the services plan when a consumer is enrolled in an ODA- (Ohio department of aging) administered or an ODMR/DDDODD- (Ohio department of mental retardation and developmental disabilities) administered HCBS waiver. Home health services that are not documented on the services plan are not reimbursable.

(3)(4) Provide home health services in the consumer's place of residence, in a licensed child day-care center, or for a child three years and under in a setting where the child receives early intervention services (EI) as indicated in the individualized family service plan (IFSP).

(a) "Consumer's place of residence" is wherever the consumer lives, whether the home is the consumer's own dwelling, an apartment, an assisted living residence, a relative's home, or an other type of living arrangement. The place of residence does not include a hospital, nursing facility, or intermediate care facility for the mentally retarded (ICR/MR).

(b) For the purposes of this chapter, "licensed child day-care center" means a "child day-care center" as defined in section 5104.01 of the Revised Code that is licensed pursuant to section 5104.03 of the Revised Code but does not include a licensed child day-care center that is the permanent residence of the licensee or administrator.

(c) "Setting" is the natural environment in which the services will appropriately be provided.

(4)(5) Not provide home health nursing and home health aide services for the provision of habilitative care, or respite care, and not provide skilled therapies for the provision of maintenance care, habilitative care or respite care.

(a) "Maintenance care" is the care given to a consumer for the prevention of deteriorating or worsening medical conditions or the management of stabilized chronic diseases or conditions. Services are considered maintenance care if the consumer is no longer making significant improvement in his or her medical condition.

(b) "Habilitative care" is in accordance with Chapter 5101:3-1 of the Administrative Code42 U.S.C. 1396n(C)(5) (March 30, 2010).

(c) "Respite care" is the care provided to a consumer unable to care for himself or herself because of the absence or need for relief of those persons normally providing care.

(5)(6) Bill for provided home health services in accordance with the visit policy in rule 5101:3-12-04 of the Administrative Code.

(6)(7) Bill for provided home health services using the appropriate procedure code and applicable modifiers in accordance with rule 5101:3-12-05 of the Administrative Code.

(7)(8) Bill after all documentation is completed for the services rendered during a visit in accordance with rule 5101:3-12-03 of the Administrative Code.

(E)(F) Consumers who receive home health services must:

(1) Participate in a face-to-face encounter as specified in paragraph (B) of this rule for the purpose of certifying their medical need for home health services.

(1)(2) Be under the supervision of a treating physician who is providing care and treatment to the consumer. The treating physician cannot be a physician whose sole purpose is to sign and authorize plans of care or who does not have direct involvement in the care or treatment of the consumer. A treating physician may be a physician who is substituting temporarily on behalf of a treating physician.

(2)(3) Participate in the development of a plan of care along with the treating physician and the MCRHHA. An authorized representative may participate in the development of a plan of care in lieu of the consumer.

(3)(4) Access home health services in accordance with the program for the all-inclusive care of the elderly (PACE) when the consumer participates in the PACE program.

(4)(5) Access home health services in accordance with the consumer's provider of hospice services when the consumer has elected the hospice benefit.

(5)(6) Access home health services in accordance with the consumer's managed care plan when the consumer is enrolled in a medicaid managed care plan.

State Plan Home Health Services that meet OAC 5160 -12-01 may be provided without prior authorization up to 14 hours per week. State Plan Increased Home Health Services – 60 Day Post Hospital Stay, OAC 5160-12-1 may be provided up to 28 hours per week without prior authorization for 60 days after a qualifying hospital stay. Combined limits up to 8 hours per day or less will not have to be prior authorized.

To be eligible for the Increased Home Health benefit, that is defined as services beyond the limits set by the State Plan, there must be a medical need, physician's orders, and a certificate of medical necessity (JFS 07137) signed by the physician. The increased service must be prior authorized with defined limits and effective start and end dates. It is an expectation that services will not start until there is a valid authorization in place. There will be no retroactive authorizations.

Pursuant to OAC 5160 – 1-01, Medically necessary services" are defined as services which that are necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. A medically necessary service must:

(1) Meet generally accepted standards of medical practice;

(2) Be appropriate to the illness or injury for which it is performed as to type of service and expected outcome**;**

(3) Be appropriate to the intensity of service and level of setting;

(4) Provide unique, essential, and appropriate information when used for diagnostic purposes;

(5) Be the lowest cost alternative that effectively addresses and treats the medical problem; and

(6) Meet general principles regarding reimbursement for Medicaid covered services found in rule 5160-1-02 of the Administrative Code.

Increased Home Health Aide services are covered when the following requirements are met:

1. The services are medically necessary or the individual is medically stable but requires the assistance of another person for the performance of a least 3 of the 5 activities of activities of daily living. The ADL dependency requires the assistance and presence of another person during the entire activity. ADL physical functions include bathing, dressing, eating, toileting, and mobility.
2. The services are provided by a home health agency as define in OAC 5160-12-03
3. The services are authorized by the bureau/designee before they are provided
4. The services are necessary to accomplish the ADL, but are not for the sole purpose of performing incidentals
5. Not to be authorized for respite or habilitative, maintenance unless it is for therapy care
6. The individual's record must contain written documentation verifying that these requirements have been met.
7. (2) "Home health aide" is a service that requires the skills of and is performed by a home health aide employed or contracted by the MCRHHA providing the service. Home health aide services:
8. (a) Are performed within the home health aide's scope of practice as defined in 42 C.F.R. 484.36 (October 1, 2005)(June 18, 2001). The home health aide cannot be the parent, step-parent, foster parent or legal guardian of a consumer who is under eighteen years of age, or the consumer's spouse.
9. (b) Are provided and documented in accordance with the consumer's plan of care in accordance with rule 5101:3-12-03 of the Administrative Code.
10. (c) Must be provided in a face-to-face encounter.
11. (d) Must be medically necessary in accordance with rule 5101:3-1-01 of the Administrative Code to care for the consumer's illness or injury.
12. (e) Must be necessary to facilitate the nurse or therapist in the care of the consumer's illness or injury, or help the consumer maintain a certain level of health in order to remain in the home setting. Health related services can include:
13. (i) Bathing, dressing, grooming, hygiene, including shaving, skin care, foot care, ear care, hair, nail and oral care, that are needed to facilitate care or prevent deterioration of the consumer's health, and including changing bed linens of an incontinent or immobile consumer.
14. (ii) Feeding, assistance with elimination including administering enemas (unless the skills of a home health nurse are required), routine catheter care, routine colostomy care, assistance with ambulation, changing position in bed, and assistance with transfers.
15. (iii) Performing a selected nursing activity or task as delegated in accordance with Chapter 4723-13 of the Administrative Code, and performed as specified in the plan of care.
16. (iv) Assistance with activities such as routine maintenance exercises and passive range of motion as specified in the plan of care. These activities are directly supportive of skilled therapy services but do not require the skills of a therapist to be safely and effectively performed. The plan of care is developed by either a licensed nurse or therapist within their scope of practice.
17. (v) Performing routine care of prosthetic and orthotic devices.
18. (f) May also include incidental services along with health related services as listed in paragraph (F)(2)(d)(G)(2)(e) of this rule, as long as they do not substantially extend the time of the visit.
19. (i) Incidental services are necessary household tasks that must be performed by anyone to maintain a home and can include light chores, consumer's laundry, light house cleaning, preparation of meals, and/or taking out the trash.
20. (ii) The main purpose of a home health aide visit cannot be solely to provide these incidental services since they are not health related services.
21. (iii) Incidental services are to be performed only for the consumer and not for other people in the consumer's covered place of residence.

Increased Home Health Skilled nursing (RN/LPN) services are reimbursable when the following requirements are met:

OAC 5160-12-01 (F)(G)

(1) "Home health nursing" is a nursing service that requires the skills of and is performed by a registered nurse, or a licensed practical nurse at the direction of a registered nurse. The nurse performing the service must be employed or contracted by the MCRHHA providing the service. A service is not considered a nursing service merely because it is performed by a licensed nurse. Home health nursing services:

(a) Must be performed within the nurse's scope of practice as defined in Chapter 4723. of the Revised Code and rules adopted there under.

(b) Must be provided and documented in accordance with the consumer's plan of care in accordance with rule 5160-12-03 (5101:3-12-03) of the Administrative Code.

(c) Must be provided in a face-to-face encounter.

(d) Must be medically necessary in accordance with rule 5160 -1-01 (5101:3-1-01) of the Administrative Code to care for the consumer's illness or injury.

(e) Are not covered when the visit is solely for the supervision of the home health aide.

(f) May include home infusion therapy for the administration of medications, nutrients or other solutions intravenously, or enterally. A visit made for the purpose of home infusion therapy must be billed using the U1 modifier in accordance with rule 5101:3-12-05 of the Administrative Code.

1. The services are medically necessary and require the skills of and are performed by either a registered nurse or a licensed practical nurse at the direction of a registered nurse and are provided in one or more nursing visit.
2. The services are provided by a home health agency as define in OAC 5160-12-03
3. The services are authorized by the bureau before they are provided
4. The services are necessary to accomplish the skilled nursing interventions needed, but are not for the sole purpose of completing non-skilled nursing tasks.
5. Not to be authorized for respite or habilitative care
6. The individual’s record must contain written documentation verifying that these requirements have been met.

Increased Therapy services (PT, OT, ST) are covered when the following requirements are met:

OAC 5160-12-01 (3) "Skilled therapies" are defined as physical therapy, occupational therapy, and speech-language pathology services that require the skills of and are performed by skilled therapy providers to meet the consumer's medical needs, promote recovery, and ensure medical safety for the purpose of rehabilitation.

(a) "Skilled therapy providers" are licensed physical therapists, occupational therapists, speech-language pathologists, licensed physical therapy assistants (LPTA) under the direction of a physical therapist, or certified occupational therapy assistants (COTA) under the direction of a licensed occupational therapist who are contracted or employed by a MCRHHA.

(b) "Rehabilitation" is the care of a consumer with the intent of curing the consumer's disease or improving the consumer's condition by the treatment of the consumer's illness or injury, or the restoration of a function affected by illness or injury.

(c) Skilled therapies:

(i) Must be provided to the consumer within the therapist's or therapy assistant's scope of practice in accordance with sections 4755.44, 4755.07, and 4753.07 of the Revised Code.

(ii) Must be medically necessary in accordance with rule 5101:3-1-01 of the Administrative Code to care for the consumer's illness or injury.

(iii) Must be provided and documented in the consumer's plan of care in accordance with rule 5101:3-12-03 of the Administrative Code.

(iv) Must be reasonable in their amount, frequency, and duration. Treatment must be considered according to the accepted standards of medical practice to be safe and effective treatment for the consumer's condition.

(v) Must be provided with the expectation of the consumer's rehabilitation potential according to the treating physician's prognosis of illness or injury. The expectation of the consumer's rehabilitation potential is that the condition of the consumer will measurably improve within a reasonable period of time or the services are necessary to the establishment of a safe and effective maintenance program.

(vi) May include treatments, assessments and/or therapeutic exercises but cannot include activities that are for the general welfare of the consumer, including motivational or general activities for the overall fitness of the consumer.