

PRIOR AUTHORIZATION (PA) FAX-FORM INSTRUCTIONS Kentucky Medicaid Home Health Care Services

HHA must justify and validate “Medical Necessity” for all authorization requests for services and supplies and that home health services are appropriate. Pertinent documentation is required.

All information that is requested on the PA FAX form must be provided. If the FAX form is not legible or is not completed in its entirety, the request for Prior Authorization will not be processed; the provider will be notified to re-fax the Map 130. Indicate “N/A” in appropriate space provided if not applicable.

907 KAR 3:130 Medical Necessity Regulation prohibits provisions of services or supplies for the convenience of the individual, the individual’s caregiver, or the health care provider. Services must be provided in the most appropriate location with regards to generally-accepted standards of practice.

All PA FAX requests require the current Physician’s dated order(s) as written or verbal as given.

List the start date of the recipient’s plan of care and the date the CMS 485 Home Health Certification and Plan of Care was completed. **NOTE:** Indicate N/A by the CMS 485 if “supply only” recipient.

Indicate why the PA request is being submitted. (Indicate “**RE-AUTHORIZATION**” if requesting additional services and/or supplies beyond the initial 60 days short term episode of care.)

Indicate if recipient has Medicare, is dual eligible, has private insurance or other third party liability. Medicare recipients who are Medicaid eligible (dual eligible) must have a MAP 34 completed with explanation and Medicare rejection type and placed in recipient’s chart if Medicare rejects payment. **NOTE: Medicaid is always The Payer of Last Resort.**

Recipient Information – Complete pertinent personal information of the Home Health (HH) recipient.

Responsible Party- If the recipient is a child under the age of 18, or an adult that has a responsible party, please enter the required information.

Homebound Status – Consideration of the recipient’s medical and mental condition, functional limitations and degree of difficulty in accessing medical care outside the home, and the services to be provided, shall be considered to determine if it is reasonable to request Medicaid reimbursement for HH services. *Outpatient services, including physician office or clinic visits, should be utilized when the recipient is medically able to do so.*

NOTE: Explanation related to homebound status is not required for “supply only” recipients.

The PA approval period for “supply only” is ninety (90) days.

Recipient Social Support System- Caregiver information - If the recipient is not able to provide self personal care and there is not an able/competent reliable caregiver or family member, describe in detail, the support system available that allows the recipient to stay in his/her home safely. Documentation should include the recipient’s physical and cognitive ability (or inability) for self care, mobility status and the necessity for HH intervention.

Personal Care Home (PCH), Family Care Home, Group Home- Skilled Nursing services for acute care related to illness or injury may be approved if ordered by the recipient’s attending physician.

NOTE: HH Personal Care is not approved for the residents of these homes (Revenue code 570)

EPSDT - If recipient is a child under age 21, services and/or medical supplies appropriate to the EPSDT program should be requested under EPSDT regulatory program requirements.

The Home and Community Waivers including SCL HCB, MII, Michelle P, – If recipients are receiving waiver services and/or supplies, PA requests must follow the appropriate waiver regulatory requirements.

CMHC- If a recipient is receiving CMHC services, Psych meds injections should be received at the Community Mental Health Center, or the Physician’s office.

Agency Information – List the HHA name, address and requestor, *a contact name if different than the requestor*, telephone, fax and provider number. **If recipient has been discharged from your Home Health Agency (HHA), give date of discharge.**

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Primary Physician Information – Complete the information for the physician who is responsible for medical care of the recipient. Include: primary physician name, address, UPIN, telephone number, and verify that there is a physician order for all requested services and/or supplies. Include the most recent date last seen by the primary physician, (According to clinical records or recipient's recollection).

Recipient Diagnosis – It is imperative to list the recipient's pertinent primary and secondary diagnoses code, description and onset date (if known). **List all diagnoses related to the services and supplies requested.**

List - The Home Health Care services you are requesting: explain the type, frequency, duration, number of visits, start and end date of the Plan of Care.

Disposable medical supplies and/or supplements – List the medical supplies and supplements that are an integral part of the plan of care which are required to treat the recipient's illness/injury. List the paper incontinent supplies brief/diapers, chuxs, pads for a "supply only" recipient.

Note: Exclude all administrative supplies.

Supporting Clinical Documentation – List pertinent information for recipient's care needs, services and/or supplies not detailed in any other category.

Provide clinical supporting documentation and appropriate diagnoses to justify and validate "Medical Necessity" for all requests of gloves, nutritional supplements, and paper incontinent supplies.

- **Gloves** – used for the protection of the caregiver, nurse, or aide are **NOT to be authorized**.
Approved coverage examples (not all inclusive): wound care, trach care, IV site care, in & out cath care, immunocompromised (organ replacement therapy, Infection, HIV, undergoing chemo-therapy), new or infected, g-tube, ileostomy, and colostomy site care within the first 60 day plan.
- **Nutritional Supplements** – must be an integral part of the HH Plan of Care/Treatment which includes an approved HH skilled service. Supplements are covered for the diagnoses and/or conditions-disorders of **significant physical or mental health** including trauma, significant weight loss, chronic and/or acute illness which have been determined to require nutritional supplements in order to maintain optimum health status and adequate weight. **(In unusual cases when a recipient is refusing food, sole supplements taken by mouth, may be approved for a short term basis)**
NOTE: Total nutritional products and related supplies must be requested through the DME program.
- **Paper Incontinent supplies** - List the paper incontinent supplies, brief/diapers, chuxs, pads, for a "supply only" recipient. **The recipient must be greater than 36 months of age.**
A diagnosis of incontinence and a diagnosis related to incontinence are required. Also required is a description of the type of incontinence, i.e. Bladder and/or Bowel control problems, Stress, Overflow, Nocturia, Urinary urge and Urinary retention. **Each recipient's unique needs must be evaluated for type and quantity or combination of incontinent supplies.**

PA REQUESTING SKILLED NURSING VISIT (SNV) FOR MEDICATION MANAGEMENT – The HH program will cover medically necessary medication management skilled nursing visits. The HH agency must attempt to teach and coordinate with the recipient, the recipient's primary caregiver and/or family members, pharmacist, and physician to develop independent medication management. The recipient's medical record must document these efforts and the outcome. If independent medication management of the recipient is not possible, DMS will authorize SN visits to fill the medication dispensing systems (medi-planners) every 2 weeks or less frequently. The HH agency documentation must support medical necessity and clearly define the recipient's unique circumstance that justifies provision of this service.

Wound care- Provide the required description(s) of the wound(s)/decubitus. Complete clinical supporting documentation for wound care services and supplies.

DMS and SHPS strongly encourage HH providers to submit the hard-copy MAP-130 PA FAX form for PA reauthorizations, modifications to existing plans (one day prior to any additional visits/supplies), and therapy requests (post evaluations). PA requests that must be called-in: new patients, therapy evaluations, MSW evaluations, PRN visits and also questions from providers concerning the "unreviewed" status of the previous day's PA requests from the Daily Activity Report (DAR).