**PRIOR AUTHORIZATION**

The home health agency (HHA) must submit a plan of care (POC) and request prior authorization for extended skilled nursing services (also referred to as extended home health (EHH)), multiple daily nursing visits for beneficiaries under age 21 who are not receiving extended skilled nursing services, adults age 21 and older, or rehabilitation services (therapies). Prior authorization (PA) approval must be received before services are provided.

**NOTE:** There is no benefit coverage for extended home health services or multiple daily nursing visits for persons age 21 and older. Prior authorization is not required for a single, daily nursing visit for beneficiaries under the age of 21 who are not receiving EHH.

**Requests for Prior Authorization**

For Medicaid fee-for-service beneficiaries, providers must submit requests for PA using the PA forms that can be accessed at <https://www.lamedicaid.com/provweb1/Forms/PAforms.htm>. No other forms or substitutes will be accepted. Completed requests must be sent to the Prior Authorization Unit (PAU).

Electronic prior authorization (e-PA) is a web application that provides a secure web based tool for providers to submit prior authorization requests and to view the status of previously submitted requests. For more information regarding e-PA, visit the Louisiana Medicaid website at [www.lamedicaid.com](file:///C%3A%5CUsers%5Chprett%5CAppData%5CLocal%5CMicrosoft%5CWindows%5CINetCache%5CContent.Outlook%5CNW28V70U%5Cwww.lamedicaid.com) or call the PAU (See Appendix D of this manual chapter).

All PA requests, whether initial or a reconsideration, must be submitted via the e-PA system. A faxed or mailed request will not be accepted.

To ensure that emergency requests are received by PAU, providers must contact the PAU and inform the unit when an emergency PA request is being transmitted via the e-PA.

The appropriate PA form, along with all necessary documentation to substantiate the medical necessity of the requested services, must be submitted to the PAU for approval.

**Prior Authorization Forms**

|  |  |
| --- | --- |
| **Home Health Service** | **Form(s)** |
| Rehabilitation services (physical, occupational and speech therapy) | PA-01  |
| Multiple and extended home health nursing visits for beneficiaries birth through age 20 | PA-07 |
| Home health nursing services for beneficiaries ages 21 and older | PA-18Face-to-Face Encounter Form |

Prior authorization forms can be found in Appendix B of this manual chapter or on the Louisiana Medicaid website at [www.lamedicaid.com](http://www.lamedicaid.com). Prior authorization is required prior to claim submissions. The current procedure codes and descriptions, as well as the revenue codes appropriate to the service necessary to complete the billing process can be found in “Home Health Revenue and Procedure Codes” under the “Fee Schedules” link at [www.lamedicaid.com](http://www.lamedicaid.com).

**NOTE:** A face-to-face encounter form is not required for beneficiaries under the age of 21, for rehabilitation services, or medical equipment and supplies provided through the Durable Medical Equipment (DME) program; however, documentation of the face-to-face encounter for these groups of services is required to be kept in the beneficiary’s record.

For questions concerning the PA process, please contact the PAU (see Appendix D for Contact Information).

**Home Health Services**

Routine skilled nursing and home health aide services for beneficiaries who are age 21 and older require PA. For the initiation of all home health services a face-to-face encounter between the authorized healthcare provider (AHP) and the beneficiary must occur no sooner than 90 days prior to the start of home health services, or no later than 30 days after the start of home health services.

Evidence of the face-to-face encounter is required by the PAU for routine skilled nursing and home health aide services for beneficiaries age 21 and older. If providers do not have this documentation prior to the initiation of services, the initial PA request must be for 30 days only. Providers must submit documentation of the face-to-face encounter with the new PA request in order for services to be approved.

Providers shall refer to section 23.4 - Provider Requirements, for information related to the face-to-face encounter requirements.

An AHP’s order must be submitted with the PA request. A POC will be accepted in lieu of a separate AHP’s order if the frequency of visits are specified. If providers are unable to obtain a signed POC for a reconsideration request, an unsigned POC may be submitted for reconsideration requests for a 30-day period only. The signed POC must be submitted with the new PA request in order for services to be approved.

Routine home health services for beneficiaries under the age of 21 must be prescribed by an AHP for only one skilled nursing visit per day. Prior authorization is not required for routine home health visits for beneficiaries under the age of 21. A request for PA of services is required when the prescription of the AHP includes multiple daily visits for a beneficiary under the age of 21. Multiple visits in the same day are usually associated with intravenous (IV) therapy.

**Rehabilitation Services**

All home health rehabilitation services (physical, occupational and speech therapy) require PA.

All rehabilitation services (except for initial evaluations and wheelchair seating evaluations, which are restricted to one evaluation per discipline per beneficiary every 180 days) require PA from the PAU. All evaluations must have an AHP’s prescription that must be kept in the beneficiary’s file.

To request PA for home health rehabilitation services, providers must complete the PA-01 form using the appropriate procedure codes as listed on the fee schedule. Refer to section 23.6 for claims filing information.

All initial PA requests must include a copy of the AHP’s referral and the results of the evaluation of the beneficiary that documents the need for therapy. All renewal PA requests must include a copy of the AHP’s referral and progress notes that document the need for the continuation of therapy.

**Extended Skilled Nursing Services (Extended Home Health)**

Extended skilled nursing services may be provided to a Medicaid beneficiary, birth through age 20, when it is determined to be medically necessary for the beneficiary to receive a minimum of three hours per day of nursing services. Medical necessity for extended skilled nursing services exists when the beneficiary has a medically complex condition characterized by multiple, significant medical problems that require nursing care in accordance with the Louisiana Nurse Practice Act (La. R.S. 37:911, et seq).

When requesting PA for extended home health, all hours of care must be included with the PA request. In addition, the AHP’s prescription and a copy of the POC must be attached to the appropriate PA form. Cases approved for extended home health should be billed using appropriate codes for a registered nurse (RN) and a licensed practical nurse (LPN) in conjunction with the total number of hours provided, indicating the units as hours.

**NOTE:** All extended skilled nursing services for beneficiaries under the age of 21 require PA. Daily nursing visits that are less than three hours per day for beneficiaries under the age of 21 who do not meet medical necessity criteria for extended home health do not require PA.

**Prior Authorization Procedure of Extended Home Health Services at Hospital Discharge**

In order to provide continuity of care for beneficiaries, the following procedure will be used for beneficiaries requiring extended home health care upon discharge from the hospital.

Prior to hospital discharge, the PA process can begin. The following information must be sent to the PAU:

1. A letter of medical necessity from the AHP;
2. A signed prescription indicating the number of hours of extended home health that are being requested;
3. A copy of the admission assessment (history and physical);
4. Progress notes;
5. Discharge orders;
6. A copy of the discharge summary, if available; and
7. A copy of the unsigned POC. The unsigned POC will be accepted only if the beneficiary is being discharged from the hospital and is included with the above information. The POC assessment cannot be done in the hospital but must be done in the beneficiary’s residential setting.

**NOTE**: The HHA must forward the signed POC to the PAU as soon as the signed copy is received from the AHP.

The beneficiary must meet the medically necessary criteria for extended home health services in order for the PAU to approve the services. The extended home health request will be issued a PA number if the service has been approved. The HHA can check the e-PA system or call the PAU to check the status of the request and receive the PA number in order to start immediately approved services.

The beneficiary will be authorized for only six weeks of extended home health services. This is to ensure the signed POC is on file with the PAU. Prior to the end of the six week prior authorized period, all of the requested information including the signed POC must be resubmitted to the PAU. The same information can be resubmitted unless there has been a change in the beneficiary’s condition.

**Home Health Modifiers**

Modifiers are available for routine home health and EHH (beneficiaries age 0 through 20), to reflect specific scenarios as indicated in the chart below. All modifier requests must be submitted with the PA and approved in order to be reimbursed.

Providers shall refer to the Louisiana Medicaid Home Health Revenue and Procedure Codes document under the “Fee Schedules” link at [www.lamedicaid.com](http://www.lamedicaid.com).

|  |  |
| --- | --- |
| **Modifier**  | **Modifier Name** |
| U2 | Second daily visit |
| U3 | Third daily visit |
| TT | Multiple beneficiaries in the same setting |
| TG | High complexity  |
| TN | Rural/outside area |
| TV | Weekends and holidays  |
| UH | Services provided in the evening |
| UJ | Services provided at night |
| TU | Overtime (DOES NOT REQUIRE PA) |

**Multiple Same Day Visits**

Multiple nursing visits on the same date of service may be provided to a beneficiary age birth through 20 when the medical necessity criteria is met and these services cannot be provided during the course of one visit. Multiple same day visits must be prior authorized before services begin.

Extended and multiple daily visits must be authorized in accordance with the certifying AHP’s orders and home health POC. All nursing services shall be provided in accordance with the Louisiana Nurse Practice (La. R.S. 37:911, et seq).

The AHP must issue orders detailing how many visits should be provided per day and the duration of time to provide the multiple visits, (i.e., 10 days, 2 weeks, 45 days, etc.).

When the HHA receives the AHP’s orders, the HHA must obtain documentation to support the medical need for multiple daily visits along with the POC signed by the AHP. A completed PA-07 form must be submitted to the PAU indicating the additional visits requested for the same date of service. Appropriate service code indicators, procedure codes and modifier codes, when applicable, must be used on PA requests and claims to designate additional visits on the same date. Modifier code U2 is to be used for second visits, and code U3 for third visits.

**Visits for Multiple Beneficiaries in the Same Place of Residence on the Same Day**

Multiple beneficiaries may been seen in the same place of residence by the same provider, on the same day when medically necessary. Medical necessity will be determined by review of the clinical documentation for each beneficiary receiving services.

Services furnished by one nurse or home health aide to two or more beneficiaries within the same setting on the same day is reimbursed as follows:

1. For the first beneficiary, Medicaid reimburses the service at the established Medicaid rate for the prior authorized CPT code/modifier combination; and
2. For the second beneficiary, Medicaid reimburses the service at 50 percent of the established Medicaid rate.

The TT modifier must be added to the home health procedure code billed on the claim to identify the service provided to more than one beneficiary in the same setting. Providers are prohibited from billing for providing services to two beneficiaries concurrently without appending the TT modifier.

Each beneficiary must have a PA in order for services to be billed. The procedures for requesting the PA established above will work for multiple beneficiaries in the same place of residence. The TT modifier can be attached to routine and EHH codes to allow the correct payment to be made for this authorized service (see ‘Louisiana Medicaid Home Health Revenue and Procedure Codes’ under the “Fee Schedules” link at [www.lamedicaid.com](http://www.lamedicaid.com)).

**High Complexity Needs**

The TG modifier may be authorized for beneficiaries aged birth through 20 with highly complex needs requiring EHH services. The HHA shall submit all necessary documentation to the PAU, as well as additional documentation to support the highly complex nature of the beneficiary. The TG modifier shall be attached to the relevant number of hours being requested.

Examples of high complexity may include, but are not limited to:

1. Repeated seizures requiring treatment, intervention or both;
2. Frequent oropharyngeal or tracheostomy suctioning;
3. With or without nebulization treatments, repeated administration of percussion physiotherapy, high frequency chest wall oscillation physiotherapy, or use of a cough assist device;
4. Ventilator, CPAP or BIPAP dependence during the nurse’s care hours;
5. Continuous oxygen dependence with continuous oxygen saturation monitoring and frequent oxygen desaturations requiring intervention;
6. Continuous or frequent tube feeding for a beneficiary with gastroesophageal reflux, recurrent aspiration, or recurrent nausea, vomiting or abdominal pain;
7. Parenteral nutrition;
8. Intravenous therapies; or
9. Repeated or extensive care of complex wounds.

It is the responsibility of the provider and the RN or LPN to ensure they are working within their scope of practice and licensure.

This list does not guarantee authorization. Each request will be considered on an individual basis, and reviewed based on medical necessity and documentation provided. Approved hours for this modifier will be paid at the TG modifier rate.

**Rural or Outside Area**

The HHA may submit PA requests using the TN modifier to identify travel to EHH beneficiaries who live in a rural area, or outside the providers’ usual service area. A geographical area will be considered rural as defined by the United States Department of Commerce, Census Bureau as non-urbanized.

The HHA shall submit all necessary documentation to the PAU to support the use of this modifier. The TN modifier can be requested for up to two units or hours per day, and can therefore be used in conjunction with other necessary modifiers. For example:

|  |  |  |  |
| --- | --- | --- | --- |
| **Description** | **Procedure Code** | **Modifier Code** | **Requested Units** |
| Skilled Nursing Visit | S9124 | TN | 10 |
| Skilled Nursing Visit | S9124 | TG | 30 |

Approved hours for this modifier will be paid at the TN modifier rate.

**Holiday and Weekend Visits**

The HHA may submit PA requests using the TV modifier to identify hours for an EHH beneficiary that are required during a weekend (12 a.m. Saturday through midnight on Sunday) or on designated state holidays, as indicated in La. R.S 1:55. The TV modifier must be requested on the home health PA, form which covers the certification period in which the state recognized holiday(s) occur.

The HHA shall submit all necessary documentation to the PAU, as well as additional documentation to support the use of this modifier. This shall include an explanation and documentation as to why services are required at those times. Services will not be provided in circumstances of inconvenience to the beneficiary or the beneficiary’s family.

The TV modifier shall be attached to the relevant number of hours being requested. For example, if 37 hours are being requested and 10 of those are proposed to be on a weekend, then the TV modifier shall be attached to those 10 hours on the PA request. Approved hours for this modifier will be paid at the TV modifier rate.

**Evening and Night Visits**

The HHA may submit PA requests using the UH or UJ modifier(s) to identify hours for an EHH beneficiary that are required during evening or night hours. The HHA shall submit all necessary documentation to the PAU, as well as additional documentation to support the use of this modifier. This shall include an explanation and documentation as to why services are required at those times. Services will not be provided in circumstances of inconvenience to the beneficiary or the beneficiary’s family.

|  |  |
| --- | --- |
| **Modifier Code** | **Procedure Code** |
| UH | Evening (6 p.m. to 11:59 p.m.) |
| UJ | Night (12 a.m. to 5:59 a.m.) |

Providers shall submit authorizations and claims using the modifier UH (evening) and/or UJ (night), for the hours that are required at these times. For example, if a beneficiary is requiring services between 5 p.m. and 5 a.m. (12 hours total), then six hours would be requested with the UH modifier and 5 hours requested with the UJ modifier.

Providers may request more than one modifier over the total number of hours, if the hours ordered are divided up and stipulate the appropriate modifier; however, only one modifier may be requested per line.

For example:

|  |  |  |  |
| --- | --- | --- | --- |
| **Description** | **Procedure Code** | **Modifier Code** | **Requested Units** |
| Skilled Nursing Visit | S9124 |  | 45 |
| Skilled Nursing Visit | S9124 | TV | 24 |
| Skilled Nursing Visit | S9124 | UH | 15 |

For one week, this would be a total number of 84 hours; 24 of those hours are on a weekend and 15 hours are during the evening.

All PA requests shall be reviewed for medical necessity and when a decision is rendered a notice of the decision will be sent to the HHA and the beneficiary. If the PA is approved, a PA number will be assigned and included in the PA notice.

**Home Health Supplies**

Home health supplies are reimbursable under the DME Program. Approval of payment for covered supplies provided under the DME program must be obtained from the PAU.

Providers may either obtain these non-reimbursable supplies through a DME provider or provide the supplies through the DME program. Providers who opt to have the supplies provided by a DME provider must give the DME provider a copy of the AHP’s orders for the supplies. The request must include the quantity and period of time the supplies are to cover. Home health providers who choose to provide these supplies can have their home health provider file updated to allow billing for these supplies.

A written request is submitted to the Provider Enrollment Unit to have the provider type for DME added to the home health provider numbers. The forms and instructions required to obtain PA approval are contained in Appendix B.

HHAs often train beneficiaries or their caregivers to administer medications, or use certain equipment/supplies, in the provider’s absence. DME covered IV, or other home health supplies, may be provided to the HHA for use in the beneficiary’s residential setting when administration is monitored and home health services are provided.

When normal usage amounts are exceeded, a request for approval must be submitted with documentation of medical necessity to justify the greater quantity.

Certain supplies for wound care and dressing will be covered under DME, but will be authorized exclusively for the use of HHAs when delivering a home health service.

|  |
| --- |
| **Routine Supplies for which Reimbursement is Included as Part of the Reimbursement Rate for the Home Health Visit** |
| Blood drawing supplies | Specimen containers |
| Sterile specimen containers | Vacutainer used for drawing blood |
| Tourniquet | Tubex holder |
| Alcohol preps-swabs | Surgical masks |
| Bandage scissors | Culturettes |
| Disposable gloves-non-sterile | Adhesive tape |
| Paper tape | Emesis basins |
| Oral swabs/toothettes | Alcohol |
| Tape measure, all types | Non-sterile cotton balls, buds |
| Disposable gowns (plastic, paper) | Disposable masks |
| Goggles | Disposable wash clothes |
| Water soluble lubricant | Thermometer with holder |
| Thermometer cover | Sharps container |
| Self–assistive devices (long handle tongs and shoehorn stocking aide) |  |

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| **Supplies Covered only when Provided in Conjunction with a Home Health Visit** |
| Inflatable Cushion (Softcare mattress) | Douche – Betadine |
| Enema – disposable enema administering kit  | Enema – Fleets, mineral oil |
| Fracture pan, plastic | Bed pan, plastic |
| Urinal, plastic, male | Female urinal |
| Commode urinary disposable collection device (HAT) | Toppers, sterile |
| Steri-strips | Reston |
| Telfa | Skin staple remover |
| Sterile Applicators (tongue blades, sterile q-tips)  | Suture removal kit |
| Sitz bath, portable, disposable | Elastoplast |
| Foam tape | Pericare kit/supplies |
| Bile bags | Therabands/putty |
| Sterile irrigation solutions (GU irrigant, acetic acid and normal saline) | Lymphedema pumps |

**Supplies through the Durable Medical Equipment Program**

When requesting approval of payment for supplies, providers must complete the PA-01 form, and attach a copy of the doctor’s prescription or orders along with the home health POC and submit these documents to the PAU.

The date on the prescription should be the same date as the PA-01 form’s date of signature. When DME requests are approved under home health, a PA number will be issued within 25 working days from the date the PAU receives the prescription and PA request. A letter containing the PA number, a listing of the approved supplies and the time-period for which approval is given will be mailed to the provider and the beneficiary.

If additional supplies are required for this period, the provider is required to submit a PA-01 form for reconsideration with a new prescription and documentation of medical necessity to the PAU. If approved, these supplies will be added to the list of supplies covered by the existing PA number.

The PAU may authorize a 30-day increment of supplies by phone if a beneficiary is pending discharge from a hospital or on an emergency basis. A request for additional supplies must be submitted via e-PA.

**Prior Authorization Decisions**

Home health PA decisions are issued within 10 days by letter to the provider, beneficiary and support coordinator, if applicable. Approval letters contain a nine-digit PA number. Denial letters include beneficiary appeal rights.