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~~ extended ~~Home~~ home ~~Health~~ health or 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 prior authorization using the prior authorization forms that can be accessed by the below link. No other forms or substitutes will be accepted. Completed requests must be sent to the Prior Authorization Unit (PAU).

https://www.lamedicaid.com/provweb1/Forms/PAforms.htm

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 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 are asked to 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~~ services (physical, occupational and speech therapy)	PA-01
Multiple and ~~Extended~~ extended ~~Home~~ home ~~Health~~ health ~~Nursing~~ nursing ~~Visits~~ visits for beneficiaries birth through age 20	PA-07
Home ~~Health~~ health ~~Nursing~~ nursing ~~Services~~ services for beneficiaries ages 21 and older	PA-18 Face-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. 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 the Home Health Revenue and Procedure Codes document under the "Fee Schedules" link at 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 physician and the beneficiary, or an ~~allowed~~ authorized non-physician practitioner (NPP) 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. An authorized NPP means a nurse practitioner, clinical nurse specialist, or physician assistant licensed, certified, registered, or otherwise authorized to order home healthcare services consistent with Louisiana law.

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 then 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.

A physician's order or an order from an authorized NPP must be submitted with the PA request. A POC will be accepted in lieu of a separate physician'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 a physician or an authorized NPP 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 prior authorization of services is required whenever the prescription ~~of the physician~~ includes multiple daily visits for a beneficiary under the age of 21. Multiple visits in the same day are usually associated with IV therapy.

Rehabilitation Services

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

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 prior authorization from the PAU. All evaluations must have a ~~physician's~~ prescription by a physician or authorized NPP that must be kept in the beneficiary's file.

To request prior authorization for home health rehabilitation services, providers must complete the PA-01 (Appendix B) 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 ~~physician's~~ referral by the physician or authorized NPP 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 ~~physician's~~ referral by the physician or authorized NPP 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 continuous 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 prior authorization for extended home health, all hours of care must be included with the PA request. In addition, the ~~physician'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 prior authorization.

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:

- A letter of medical necessity from the primary physician or authorized NPP;
- A signed prescription indicating the number of hours of extended home health that are being requested;
- A copy of the admission assessment (history and physical);
- Progress notes;
- Discharge orders;
- A copy of the discharge summary, if available; and
- 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 physician.

The beneficiary must meet the criteria for extended home health services and be determined medically necessary 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 prior 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.

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 orders of the certifying physician~~'s orders~~ or authorized NPP 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 physician or authorized NPP 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 ~~physician's~~ orders from physician or authorized NPP, the HHA must obtain documentation to support the medical need for multiple daily visits along with the POC signed by the physician. 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 Residential Setting on the Same Day

Multiple beneficiaries may been seen in the same residential setting 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.

Each beneficiary must have a PA in order for services to be billed. The procedures for requesting PA established above will work for multiple beneficiaries in the same residential setting. 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 document under the "Fee Schedules" link at www.lamedicaid.com). The TT modifier should be appended to the second and any additional beneficiary requests.

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:

- Repeated seizures requiring treatment, intervention or both;
- Frequent oropharyngeal or tracheostomy suctioning;
- With or without nebulization treatments, repeated administration of percussion physiotherapy, High Frequency Chest Wall Oscillation physiotherapy, or use of a cough assist device;
- Ventilator, CPAP or BIPAP dependence during the nurse's care hours;
- Continuous oxygen dependence with continuous oxygen saturation monitoring and frequent oxygen desaturations requiring intervention;
- Continuous or frequent tube feeding for a beneficiary with gastroesophageal reflux, recurrent aspiration, or recurrent nausea, vomiting or abdominal pain;
- Parenteral nutrition;
- Intravenous therapies; or
- 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 prior authorization 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 prior authorization 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~~ home ~~Health~~ health PA 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 prior authorization 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 prior authorization 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 ~~physician's~~ orders from the physician or authorized NPP 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 should be 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 how 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~~the appropriate 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)	

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, and attach a copy of the ~~doctor's~~ prescription or orders from the physician or authorized NPP 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 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 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 prior authorization 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.