Home Health

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for Telligen on behalf of Wyoming Medicaid

Purpose

- To go over the correct usage of CPT codes
- To discuss how units should be submitted
- To go over the proper documentation

House Keeping

- **Questions**
  - Please enter all questions into the chat
  - Time at the end of the training will be used for answering chat questions
  - Any questions that were not answered from the chat will be posted to the website
- **Content availability**
  - Presentation will be recorded and available to view at https://wymedicaid.telligen.com as well as the slides
  - If you are in need of any one-on-one training, please email ccates@telligen.com
- **Survey**
  - Email from Survey Monkey
  - Feedback on content
  - Constructive feedback
  - Any additional training you would like to see presented in the future

Home Health Service

- Home Health services are intended to be a temporary transitional program to assist Members with the care required after an acute health incident or an institutionalized stay
- Home Health services are to provide medical support education to the member and any caregiver regarding the member's new medical needs.
- For members with long-term needs Home health is available initially while the member and any caregiver are educated on the new medical needs and determine what the long-term solution will be for meeting the needs of the member
  - Long-term solutions may include, additional or alternate caregivers, waiver programs, higher levels of care, nursing facilities

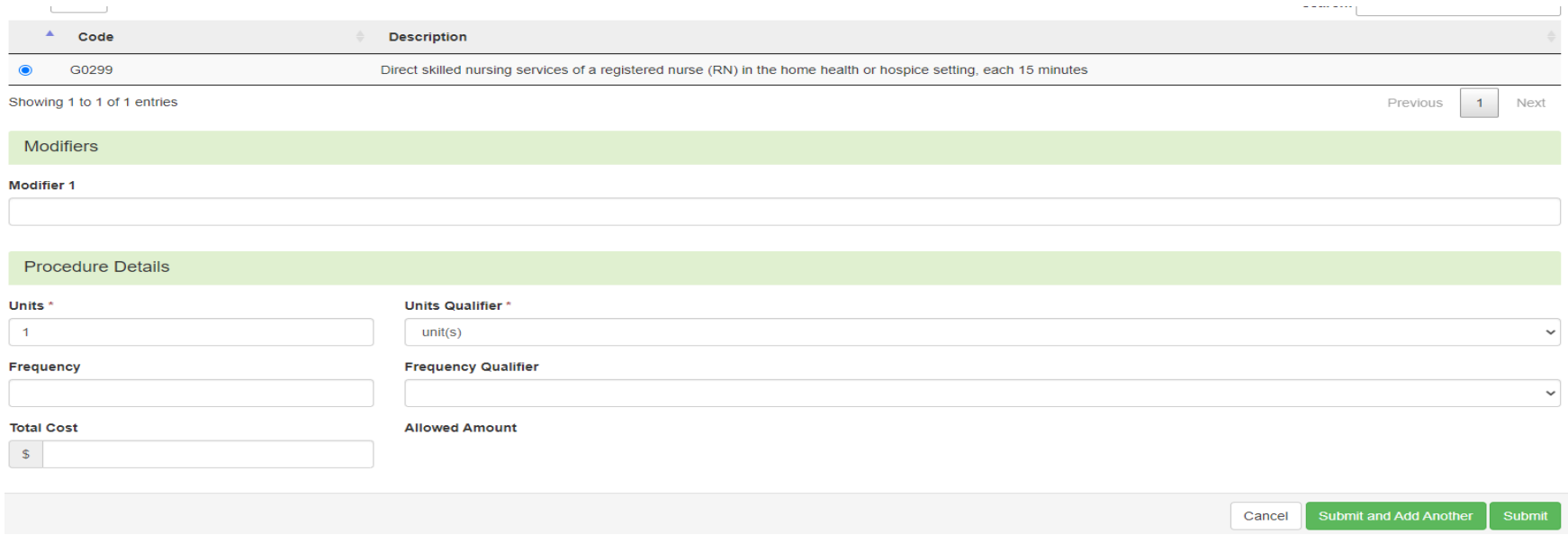
Crosswalk- Codes

Home Health Care requests are billed with rev codes. The G-code must match the associated rev for correct transmission. Only the below list of G-codes are acceptable. And must be associated with the requested service

Home Health Codes			
HCPCS Code	Revenue Code	Code Description	Unit
G0151	0421	Physical therapy	Per visit
G0152	0431	Occupational therapy	Per visit
G0153	0441	Speech therapy	Per visit
G0299 or G0154	0551	Skilled Nursing	Per visit
G0155	0561	Medical Social Services	Per visit
G0156	0571	Home Health Aide	Per Visit

Submitting Units on Case in Qualitrac

- The codes used to request a PA are the procedure codes, but when sent over to BMS they are converted to revenue codes. The revenue codes are all billed on a per-visit basis
- Telligen will not calculate the number of units required
- The total number of units needs to be listed and then the frequency of the visits.



For Approval the requested service must be:

- Ordered by a Physician
- Documented in a signed and Dated plan of care/ Medicare 485 form that is reviewed and revised as medically necessary by the attending physician every 60 days
- Expected to last six months or less
- Three or fewer encounters per day for any combination of home health aide and skilled nursing services
  - An encounter is defined as all home health services provided in a single day that could be provided in a single visit to the member, regardless of how many actual visits to the Member are completed. A separate encounter is not to be billed due to the convenience of the provider or due to scheduling issues or conflicts. A separate encounter can be billed when services must be separated due to orders or medical necessity.

Covered Services

- Skilled nursing services provided by a Registered Nurse (RN) for Member's condition while in the acute phase.
- Home Health aide services delegated and supervised by a Registered Nurse (RN).
  - Each Home Health Aide visit MUST include at least one (1) or more of the following:
    - Bath (bed, sponge, tub, shower, or shampooing hair)
    - Nail or skin care (applying lotion does not constitutes personal care
    - Oral Hygiene
    - Toileting and Elimination
    - Safe Transfers/Assisted Ambulation
    - Assist with dressing (not grooming alone)
    - Assisted range of motion/positioning
    - Assisted nutrition or fluid intake (meal set-up or prep or feeding assist/supervision).
- NOTE: Home Health Aide services must be related to the Member's skilled need (SN, PT, OT, ST). Without a related skilled need, HHA services are not covered.

Covered Services continued

- Physical therapy services provided by a qualified licensed physical therapist.
- Speech therapy services provided by a qualified licensed therapist
- Occupational therapy services provided by a qualified registered or certified therapist
- Personal care services (PCS) provided to children and adolescents under the age of 21 years under EPSDT
- Medical social services provided by a qualified licensed Master of Social Work (MSW) or Bachelor of Social Work (BSW) -prepared person supervised by an MSW.

Non-Covered Services

- Long-term custodial care
- Homemaker services
- Respite Care
- Home Delivered Meals
- Services for Members who are hospital patients or residents of skilled nursing facilities
- Services for members that are inappropriate in the Member's home setting
- Services for Members that are extensive or for long periods of time and/or are not cost-effective
- Services for Members where the desired outcome could be better or faster accomplished in another setting
- Services for Members where the member must be compliant to achieve measured success and the Member is not compliant.

Documentation Requirements

- If the member is receiving home health services only, visit notes must state home health services and detail the specific services provided
- If the member is receiving both home health services and waiver services, visit notes must state either home health services or waiver services as appropriate and detail the specific services provided
- The Plan of Care/ Medicare 485 Form must list all services the member is receiving, regardless of pay source. This includes a waiver, private duty nursing, etc., and frequency of the services to portray a clear picture of all services the member is receiving
- Adequate documentation justifying medical necessity must be kept. Any plans extending past 120 days (two consecutive 60-day plan periods) will be reviewed
- New members ordered to home health care must have documentation of a face-to-face visit with the ordering practitioner within the 90 days preceding the beginning of home health
  - This face-to-face visit can be in the hospital, clinic, nursing home, or other clinical settings

Regarding Prior Authorization for services

- Services can be requested up to 10 days after the service has been rendered
- Telligen has 1 business day turnaround time from the day of submission
  - This will be extended if there is documentation missing and a request for information will be sent out
- Request submitted without a signed and dated 485 or physicians detailed order will not be processed
- For wound care-related requests, be sure to include current detailed wound-specific information including frequency of care, drainage, wound measurements
- For IV medication-related requests, include current medication orders with frequency and duration and how often administration is to be completed

Common Reasons for Technical Denial

- No signed/dated Plan of Care form (485) or physician's orders
- Failure of the Provider to respond to a request for additional information
- Incorrectly submitted codes
- Incomplete or missing forms and documentation

Appeals Process

- If the initial request for prior authorization is denied or reduced, a request for reconsideration can be submitted through Telligen, including any additional clinical information that supports the request for services
- If the reconsideration request is upheld the original denial or reduction in services, an appeal can be made to the state by sending a written appeal via e-mail to the Benefits Quality Control Manager, Brenda Stout (Brenda.stout1@wyo.gov)
  - The appeal needs to include an explanation of the reason for the disagreement with the decision and the reference number from Telligen's system. The appeal will be reviewed in conjunction with the documentation uploaded into Telligen's system

Billing requirement for Medicare Primary

- In the patient's medical records, it should state why the member does not meet the requirements for Medicare payment as the member is homebound
- When billing Wyoming Medicaid for members who have Medicare primary, the following Medicare information must be reported on the claim
  - Applicable value codes
  - Occurrence codes
  - Occurrence span codes
  - Claim adjustment reason codes (CARCs)
  - Remittance advice reason codes (RARCs)
  - Condition codes
  - Claim filing indicator
  - Revenue codes
  - Source codes
    - XA- Condition Stable
    - XB- Not Homebound
    - XC- Maintenance Care
    - XD- No Skilled Service

Helpful Tips/Links

Links-

- Provider Manual
- CMS 1500 Manual
- Provider Manual
- Condition Code Bulletin
- Fee Schedules
- CMS Home Health Plan of Care (485 Form)

Tips

- Be sure to upload all documentation for a prompt review
- Plan of Care is required for the review

Q & A