GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Senior Deputy Director/Medicaid Director

Transmittal # 16-08

TO: Home Health Agency Providers and DME Suppliers

FROM: Claudia Schlosberg, J.D.
Senior Deputy Director and State Medicaid Director

DATE: March 30, 2016

SUBJECT: **Clarifying procedures for obtaining prior authorizations for Home Health Services beyond the thirty six (36) visits established under the Medicaid State Plan**

The Department of Health Care Finance (DHCF) is developing new State Plan Amendments (SPAs) and Regulations for Home Health Services.

In the interim, DHCF is clarifying *existing* federal regulation and State Plan requirements by notifying Home Health Agencies (HHAs) of their responsibility when Home Health Services are provided under the District's Medicaid State Plan. Until the new SPAs and Regulations are finalized, DHCF expects Home Health Agencies (HHAs) to comply with existing requirements.

Home Health Services Defined

In accordance with the federal rule *(see* 42 CFR § 440.70), Home Health Services consist of the following: Skilled Nursing, Home Health Aide services, Durable Medical Equipment and Supplies, Physical Therapy, Occupational Therapy and Speech Pathology and audiology services. These services must be provided to a beneficiary:

(1) At his/her place of residence; and

(2) Based upon the beneficiary's physician's orders as part of a written plan of care that is developed by the R.N. and reviewed by the physician every sixty (60) days.

Effective July 1, 2016, per the new federal requirements (*see* 42 CFR § 440.70 (f) (1-2) and (5) (i-ii)) for initiating Home Health Services, the ordering physician must:

(1) Document that a face-to-face encounter ,related to the primary reason the patient requires home health services, occurred between the beneficiary and the practitioner, as defined below, within the ninety (90) days before or within the thirty (30) days after the start of services; and

(2) Indicate the practitioner who conducted the face-to-face encounter, and the date of the encounter.

In accordance with the federal regulations (*see* 42 CFR § 440.70 (f) (3)), a **practitioner** who conducts the face-to-face encounters may include: (1) the ordering doctor; (2) a nurse practitioner or clinical nurse specialist; (3) a certified nurse mid-wife as authorized under District law; (4) a physician assistant acting under the supervision of the ordering physician; or (5) the attending acute or post-acute physician for those beneficiaries admitted to home health immediately after an acute or post-acute stay.

Per the federal regulations (*see* 42 CFR § 440.70 (f) (1-3)), the following new requirements are also applicable to durable medical equipment and supplies:

(1) For the initiation of durable medical equipment and supplies, the face-to-face encounter must be related to the primary reason the beneficiary requires medical equipment, and must occur no more than six (6) months prior to the start of services; and

(2) The initial order and the face-to-face encounter for durable medical equipment and supplies may be conducted by a physician or any of the non-physician practitioners allowed to conduct face-to-face encounters referenced above, with the exception of nurse-midwifes.

The Home Health Services section of the DHCF Medicaid State Plan amendment, Supplement 1 to Attachment 3.1-A and 3.1-B, Section 7 states:

Services provided by Home Health Agencies which are covered under the State Plan and authorized in the patient treatment plan may not exceed in total 36 visits per year per recipient, unless prior authorization is given by the State Agency.

The 36 visit limitation includes services performed by all disciplines included in the Medicare certification of a home health agency which are certified by a physician as medically necessary in the patient's treatment plan.

One visit is any healthcare encounter with any Home Health Services provider during a calendar year.

In other words, the 36 visit limitation includes all home health service visits provided to a beneficiary in a calendar year. All Skilled Nursing, Home Health Aide, Occupational Therapy, Physical Therapy, Speech and Audiology services visits will all be counted towards the 36 visit

cap per year. The 36 visit limitation is not applicable to Durable Medical Equipment and Supplies.

Beneficiaries enrolled in the Individuals with Intellectual and Developmental Disabilities Waiver (ID/DD Waiver) may access additional skilled nursing hours under the Waiver after exhaustion of the 36 visit limitation under the State Plan.

To ensure that home health agency providers of Home Health services comply with federal rules, and the Medicaid State Plan requirements, the provider must:

- Receive an order (inclusive of the new federal requirements for documenting the face-to-face encounters referenced within) for skilled nursing or other Home Health services from a physician;
- Ensure that an R.N. conducts an initial assessment to develop a plan of care for services;
- Submit the plan of care to the physician initially, and every sixty (60) calendar days;
- Ensure that the physician reviews the initial and subsequent plan of care and affixes is/her signature on the plan of care within thirty (30) calendar days of its development;
- Ensure that new or revised physician orders have been obtained from the treating physician, as needed, and every sixty (60) calendar days, to promote continuity of care; and
- Document the actions taken to ensure that the processes are available for review by DHCF's LTC Administration or upon audit by DHCF.

In all cases where a beneficiary needs more than 36 visits of home health services per year, the provider must receive a prior authorization, by adhering to the following steps:

- Receive an order for skilled nursing or other Home Health services from a physician;
- Ensure that the order incorporates the new federal requirements, effective July 1, 2016, for documenting that a face-to-face encounter occurred within the timeframes referenced in the preceding paragraphs;
- Upload the order, 719A, inclusive of the face-to-face documentation by visiting the Qualis Health Provider Portal at www.qualishealth.org. Then select "DC Medicaid" from the Healthcare Professional Drop-Down Menu, and upload the form electronically;
- Ensure that new or revised physician orders have been obtained from the treating physician initially, and every sixty (60) calendar days or as needed, to promote continuity of care; and
- Document the actions taken to ensure that the processes are available for review by DHCF's LTC Administration or upon audit by DHCF.

It is important that providers comply with the federal rules, and aforementioned procedures to ensure access to services and prevent any gaps in receiving needed Home Health services.

Please Note- In accordance with the federal rules, no payment will be made for any Home Health Services for new admissions on or after July 1, 2016 unless the ordering doctor documents that there was a face-to-face encounter with the beneficiary within the required timeframes referenced in the preceding paragraphs.

MCO's are subject to all the requirements in the transmittal with the exception of the new federal requirements pertaining to face-to-face encounters effective on or after July 1, 2016.

You can obtain additional assistance in registering for the Qualis Health Provider Portal by contacting ProviderPortalHelp@qualishealth.org. If you have any questions about this transmittal, please contact Ieisha Gray, Director, Long Term Care Administration (DHCF), 202-442-5818, Ieisha.Gray@dc.gov.