Care Wisconsin Community Partners Since 1976	Prior Authorization Guide: **Medicaid Home Health Services**	Applies to members enrolled in the following Care Wisconsin Medicaid health plan products: **Partnership, Family Care, SSI Managed Care**

Home health agencies have numerous regulations to abide by when providing care under the Medicaid home health benefit. Knowing the regulations for qualifying criteria for home health is important to avoid medical review denials. These regulations are found in the Chapter DHS 107.11 of the Wisconsin Administrative Code.

The following are basic conditions that must always be met before services provided by a home health agency can be covered by Medicaid (SSI Managed Care, Family Care, and Partnership Program):

- The patient is an active member of Care Wisconsin's SSI Managed Care, Partnership, or Family Care Program;
- Services are provided by an agency certified under s. DHS 105.16 which are covered by Medicaid,
- Medicaid is the appropriate payer (Federal law prohibits home health services that are covered by Medicare to be paid by Medicaid);
- A physician has ordered the service for a skilled need;
- Services are documented on a home health plan of care established and signed by the physician within 20 working days following the admission for care; and
- The services billed are not excluded from payment.

Home Health Service	Procedure Code	Prior Authorization Requirements
Part-time or intermittent skilled nursing (SN) services and medication management	99600 — Unlisted home visit service or procedure [per visit] T1502 — Administration of oral, intramuscular and/or subcutaneous medication by health care agency/professional, per visit	Prior authorization is required for any combination of these two services exceeding 8 visits per episode of care**
Home health aide services	T1021 — Home health aide, per visit (when part of a POC that includes regularly scheduled skilled services)	Prior authorization is required for services exceeding 8 visits per episode of care** NOTE: Prior Authorization requests for Personal Care Services and 50-60 day RN supervisory visits- T1001 — Nursing assessment/evaluation [per visit] must be submitted to the Care Team for Partnership and Family Care members.
Physical therapy (PT)	97799 — Unlisted physical medicine/rehabilitation service or procedure [per visit]	Prior authorization is required for services exceeding 8 visits per episode of care**
Occupational therapy (OT)	97139 — Unlisted therapeutic procedure (specify) [per visit]	Prior authorization is required services exceeding 8 visits per episode of care**
Speech-language pathology (SLP) services	92507 — Treatment of speech, language, voice, communication, and/or auditory processing disorder;	Prior authorization is required services exceeding 8 visits per episode of care**

	individual [per visit]	
Private Duty Nursing	99504 — Home visit for mechanical ventilation care [per hour] S9123 — Nursing care, in the home; by registered nurse, per hour S9124 — Nursing care, in the home; by licensed practical nurse, per hour	Prior authorization is required before these services are provided. The physician's orders for PDN should be written in hours per day and days per week. Medically necessary services will be authorized for a maximum of 13 weeks.

Requests for PRN “as needed” visits: Providers may request PRN, or "as needed," visits only when service is likely to vary due to changes in the member's need for services. If the use of PRN visits is anticipated, the specific number of PRN visits must be included with rationale in the plan of care. PRN visits must be added to the regularly scheduled number of visits requested for a particular procedure code.

Requesting prior authorization:

- Complete the Home Health Prior Authorization Form
- Include current Plan of Care, physicians order, and documentation demonstrating continued needs (beyond the amounts listed above) for services with measurable time-specific goals
- Fax to 608-210-4050

DEFINITIONS:

****Episode of Care** is defined as the time that a specific medical problem or condition or specific illness is being managed by the home health agency. A new episode of care may be initiated 30 days following the discharge of the member from services. Readmissions prior to the 30 days are subject to the prior authorization requirements based upon the most recent home health service plan.