my choice WISCONSIN	**Medicare Home Health Services Prior Authorization Resource**	Applies to members enrolled in the following My Choice Wisconsin Medicare health plan products: **Partnership and Dual Advantage**

Coverage rationale:
Home health agencies have numerous regulations to abide by when providing care under the Medicare home health benefit. Knowing the regulations for qualifying criteria for home health is important to avoid survey deficiencies and medical review denials. These regulations are found in the Medicare Benefit Policy Manual (CMS Pub. 100-02), Ch. 7.

The following are basic conditions that must always be met before services provided by a home health agency can be covered by Medicare:

- The patient is an active member of My Choice Wisconsin and an eligible Medicare beneficiary;
- The home health agency has a valid agreement to participate in the Medicare program;
- Medicare is the appropriate payer;
- A physician has ordered the service for a skilled need;
- A face-to-face encounter with certifying provider has occurred within 90 days prior to the start of care or 30 days after the start of care;
- Services are documented in a home health plan of care established and periodically reviewed by a physician;
- The member is homebound; and
- The services billed are not excluded from payment.

Home Health Service	Procedure Code- billed in 15 minute increments	Prior Authorization Requirements
Part-time or intermittent skilled nursing (SN) services	G0162 RN for management and evaluation of Plan of Care G0299- Direct skilled services of a RN G0300- Direct skilled services of an LPN G0493- RN for the observation and assessment of the patient's condition G0494- LPN for the observation and assessment of the patient's condition G0495- RN Training and/or education of a patient of family member G0496- LPN Training and/or education of a patient of family member	Prior authorization is required for any combination of these services exceeding 8 visits per episode of care**
Home health aide services	G0156- Home Health Aide	Prior authorization is required for services exceeding 8 visits per episode of care**

Physical therapy (PT)	G0151- Physical Therapy G0157- PT Assistant G0159- PT establish or deliver safe and effective PT maintenance program	Prior authorization is required for any combination of these services exceeding 8 visits per episode of care**
Occupational therapy (OT)	G0152- Occupational Therapy G0158- OT Assistant G0160- OT establish or deliver safe and effective OT maintenance program	Prior authorization is required for any combination of these services exceeding 8 visits per episode of care**
Speech-language pathology (SLP) services	G0153- Speech-Language Pathology G0161- SLP establish and deliver safe and effective SLP maintenance program	Prior authorization is required for any combination of these services exceeding 8 visits per episode of care**
Medical Social Services	G0155- Clinical Social Worker	Prior authorization is required for services exceeding 3 visits per episode of care**

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 for services with measurable time-specific goals
- Fax to 608-210-4050

Definitions:

Homebound- The beneficiary must either:

- Because of illness or injury, need the aid of supportive devises such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence; or,
- Have a condition such that leaving his or her home is medically contraindicated

AND

- There must exist a normal inability to leave home; and.
- Leaving home must require a considerable and taxing effort.

The member may be considered homebound if the absences from the home are infrequent or for periods of relative short durations, or are for the need to receive health care treatment. Examples may be attendance at adult day care centers, ongoing outpatient kidney dialysis or outpatient chemotherapy or radiation therapy.

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.