ACUTE CARE HOME HEALTH SERVICE PLAN REQUEST

Fax this completed form with the required documentation to 1-800-913-2229. This form will be returned unprocessed if it is not completed in its entirety.
Notification of a decision will be confirmed with a written letter of determination. Verification of the prior authorization (PA) entry and determination can also be done through the KMAP website.
Please print legibly if using a printed form.

Is beneficiary on an HCBS waiver?
Yes ☐ No ☐
If yes, are PCA services:
Self ☐ or Agency ☐ Directed

Date _____

This request is for:

☐ Initial request/new patient
☐ Reconsideration of a prior request – PA reference #: _____
☐ Renewal of a previously authorized request with changes – PA reference #: _____
☐ Renewal of previously authorized request, no changes – PA reference #: _____
☐ Submission of information requested by PA department: _____
☐ PRN visits – PA reference #: _____
☐ Additional visits due to changed condition – PA reference #: _____
☐ Other _____

Beneficiary name _____ Beneficiary ID # _____

Provider name _____ Provider ID # _____ NPI # _____

Provider contact person _____ Provider phone # _____-_____-_____

Provider fax # _____-_____-_____

If eligible for Medicare, why is Medicare not being used? _____

All fee-for-service home health care must be prior authorized. Refer to prior authorization criteria in the *Home Health Agency Fee-for-Service Provider Manual*. The documentation submitted must reflect the need for the level and frequency of care requested.

Acute Care Services – Nursing services – 99601, 99602, G0156, G0299, G0300, T1002, T1003, T1004, T1023
Therapy services – S9128, S9129, S9131, T1021

Please complete the following for all services being requested.

Code(s) All codes(s) you want to have prior authorized.	**Total units requested** Total number of units you expect to bill for the time period specified in the next column.	**Dates from – to** Date the PA will begin and end. Dates cannot extend more than six months.

The following minimum documentation is required with all requests for home health services. All requests lacking sufficient documentation will be denied.

- Current plan of care (485, 487)
- Request or verbal orders with frequency of visits matching the plan of care
- Wound measurement and staging to justify initial and ongoing care
- Teaching potential of the beneficiary, others living in the home, and other caregivers
- Complete (including the date) Outcome and Assessment Information Set (OASIS) Start of Care form, for initial requests only
- Required diabetes management documentation, if the beneficiary has diabetes (see PA criteria in the *Home Health Agency Fee-for-Service Provider Manual*)

Acute Care Home Health Service Plan

The Acute Care Home Health Service Plan is to be used when a beneficiary is initially admitted for home health services following an acute injury or illness. This level of care could be warranted after a hospitalization or a surgical procedure. The Acute Care Home Health Service Plan is for the provision of services for conditions that have a rapid onset, severe symptoms, have a short course and are medically predictable.

The documentation requirements for acute care home health services have remained unchanged and are documented under the paperwork requirements in Appendix III of the *Home Health Agency Fee-for-Service Provider Manual*. A start of care OASIS assessment and physician certification of the new plan of care are required to initiate an Acute Care Home Health Service Plan.

The following apply for the provision of acute care home health services:

- All acute care home health service codes are limited to a combined total of 120 visits per year per beneficiary.
- Acute care home health limitations are based upon the calendar year.
- Providers use procedure codes 99601, 99602, G0156, G0299, G0300, T1002, T1003, T1004, and T1023 for acute care skilled nursing and home health aide visits. Skilled nursing visits and home health aide visits may be prior authorized for up to one hour with documentation to support the service is reasonable and necessary.
- Home health aide visits are limited to two per week and, when provided through the Acute Care Home Health Service Plan, are counted in the 120 visit per year acute care limitation.
- Providers use code 99602 in extreme circumstances when an IV infusion requires continuous monitoring and cannot be administered in two hours. Providers use 99602 for each additional hour of the IV infusion.
- Providers use code T1023 for skilled nursing visits that include information gathering for OASIS assessments or re-certifications. This code is limited to six visits per calendar year and may be billed under all three home health service plans.
- Should it become evident that home health services are needed long-term, the agency should switch the beneficiary to the Long-Term Care Home Health Service Plan prior to exhausting all acute care units.
- Providers can change a recipient from acute care to long-term care during a certification period or at any time it is determined that services will be needed long-term in an effort to preserve acute care units needed for future acute episodes.
- Home health beneficiaries can have more than one consecutive episode of acute care services.
- Acute care home health services can be prior authorized for up to 60 days.
- Providers use procedure codes S9128, S9129, and S9131 for rehabilitative therapy services rendered under the Acute Care Home Health Service Plan.

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