DIABETES MANAGEMENT HOME HEALTH SERVICE PLAN REQUEST

(Please print.)

Date: ___/___/_____

Fax the 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.

Is beneficiary on HCBS waiver?
(Circle or check)
Yes ___ No ___
If yes, are PCA services:
(Circle or check)
Self ___ or Agency ___ Directed

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 unit: _____
_____ 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 billed? _____

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

Diabetes Management Service Codes

Nursing Services – S0315, 99601, 99602, S9460, G0156, T1004 **,** T1023, T1502

Therapy services – S9128, S9129, S9131, T1021

Please complete the following for all services being requested:

Code(s) All codes(s) that 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.

What is the reason(s) the beneficiary cannot provide these services for self? _____
_____

What is the reason(s) primary caregiver or attendant cannot be taught to provide these services? _____
_____

Have options for obtaining these services through other resources in the community been explored and exhausted? What was done?_____
_____

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 (see PA criteria in the *Home Health Agency Provider Manual*)

Diabetes Management Home Health Service Plan

The Diabetes Management Home Health Service Plan is to be used for a beneficiary who receives frequent and brief intervals of home health services for assistance with managing his or her diabetes. The beneficiaries and their unpaid caregivers are unable to self-manage the diabetes due to cognitive or physical limitations.
The beneficiaries are relatively stable but require frequent skilled nursing visits for diabetes management, which includes blood glucose monitoring and insulin administration. Home health services are provided to assist the beneficiary in maintaining stable blood glucose levels and obtaining periodic assessments according to current best practice guidelines to prevent or delay costly complications associated with diabetes.

The basic documentation requirements remain unchanged and are noted under the paperwork requirements in Appendix III of the *Home Health Agency Provider Manual*. Providers can submit the most current OASIS assessment and all other required documents to initiate the Diabetes Management Home Health Service Plan. An initial or start of care OASIS assessment should be completed for beneficiaries entering home health services for diabetes management.

The following apply for the provision of diabetes management home health services:

- All diabetes management home health services are for the provision of reasonable and medically necessary health maintenance tasks to assist beneficiaries in managing their diabetes in the home setting and thereby avoiding placement in nursing facilities or other institutions.
- Diabetes management home health visits must be reasonable and necessary and must not duplicate other resources available to the beneficiary.
- Providers use procedure codes S0315, S9460, 99601, 99602, T1023, T1030, and T1031 for the provision of skilled nursing visits to render diabetes management tasks. Home health aide service codes are G0156 and T1004.
- Providers use codes 99601, 99602, S0315, S9460, T1023, T1030 and T1031 for the provision of skilled nursing visits to render diabetes management services. Use G0156 and T1004 for home health aide services.
- Providers use code S0315 for skilled nursing visits of a longer duration, for example, visits that include an assessment and medication set-up and periodic assessments in accordance with current best practices for the treatment of diabetes. This is a per visit code.
- Providers use code S9460 for brief skilled nursing visits in accordance with the plan of care for blood glucose monitoring and insulin administration. This is a per visit code.
- Providers use codes T1030 and T1031 for the provision of telehealth visits to assist beneficiaries in managing their diabetes. Please see specific provider requirements for the provision of telehealth services.
- Providers use code 99602 in extreme circumstances when an IV infusion requires continuous monitoring and cannot be administered in two hours. 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, certifications, or re-certifications. This code is limited to six visits per calendar year and may be billed under all three home health service plans.
- Diabetes management home health aide visits must not exceed two visits per beneficiary per week. Home health aide visits under the Diabetes Management Home Health Service Plan are not included in the 120 visits per calendar year acute care limitation. Providers must submit additional documentation to support medical necessity to exceed two visits per week. This will be considered on a case-by-case basis.
- Providers use code T1502 for medication administration. This is to be used when nonskilled nursing visits are provided by licensed nurses to assist beneficiaries who have cognitive and physical impairments with care, such as but not limited to oral medication administration and nebulizer treatments (treatments that are generally self-administered), when the service cannot be received through other resources.
- Diabetes management home health services can be prior authorized for up to six months for beneficiaries who will require this level of care until placement in a nursing facility.
- Providers use procedure codes S9128, S9129, and S9131 for rehabilitative therapy services rendered under the Diabetes Management Home Health Service Plan and use T1020 for restorative aide visits.
- Providers use procedure code T1021 for restorative aide visits.

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