LONG-TERM CARE HOME HEALTH SERVICE PLAN REQUEST

(Please print or type.)

Date: ___/___/_____

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.

Is beneficiary on HCBS waiver?
(Check)
Yes ☐ No ☐

If yes, are PCA services:
(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 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.

Long-Term Care Service Codes

Nursing services – G0156, S0316, T1004, T1023, T1502, 99600, 99601, 99602 **Telehealth** – T1030, T1031

Therapy services – S9128, S9129, S9131, T1021 **Medication management** – T1502

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.

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 documentation submitted must reflect the need for the level and frequency of care requested. The following minimum documentation is required with all requests for home health services. All requests lacking sufficient documentation shall 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

Long Term Care Home Health Service Plan

The Long-Term Care Home Health Service Plan is to be used for beneficiaries who receive frequent and brief intervals of home health services for assistance with monitoring chronic conditions. The beneficiaries often have diagnoses that include asthma, COPD, diabetes, and heart disease. The beneficiaries are relatively stable and require frequent monitoring to prevent exacerbation of symptoms which would warrant emergent care and/or hospitalization. Long-term care home health services often include health maintenance services that the beneficiaries cannot provided for themselves due to cognitive or physical limitations.

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 Long-Term Care Home Health Service Plan. An initial or start of care OASIS assessment should be completed for beneficiaries entering home health services for chronic care management.

The following apply to the provision of long-term care home health services:

- All long-term care home health services are for the provision of reasonable and medically necessary health maintenance tasks to assist beneficiaries in managing chronic health conditions in the home setting and thereby avoiding placement in nursing facilities or other institutions.
- Long-term care home health visits must be reasonable and necessary and must not duplicate other resources available to the beneficiary.
- Providers use procedure codes G0156, S0316, T1004, T1023, T1030, T1031, 99600, 99601, and 99602 for the provision of long-term care home health skilled nursing and home health aide visits.
- Providers use procedure code 99600 for brief skilled nursing visits in accordance with the plan of care.
- Providers use procedure code S0316 for skilled nursing visits of a longer duration, for example, visits that include an assessment and medication set-up. Providers use procedure codes T1030 and T1031 for the provision of telehealth visits under the Long-Term Care Home Health Service Plan. 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.

- Home health aide visits are limited to two visits per beneficiary per week. Home health aide visits under the Long-Term Care 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.
- Long-term skilled nursing visits are per visit and long-term home health aide visits can be prior authorized for up to one hour with documentation to support the service is reasonable and necessary.
- Long-term care home health aide visits must not exceed two visits per beneficiary per week without additional documentation of medical necessity and are subject to other long-term care home health aide limitations.
- Once the acute condition has been resolved or stabilized, the agency can switch the beneficiary back to the Long-Term Care Home Health Service Plan.
- Long-term care home health services can be prior authorized for up to six months for beneficiaries who 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 Long-Term Care Home Health Service Plan and use procedure code T1021 for restorative aide visits.

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