# HCBS Provider Training
# MyCare

*Home Health*
*Prior Authorizations*

# Training Module Summary

buckeye health plan
MyCareOhio
Connecting Medicare + Medicaid

| | |
|---|---|
| Service Plans & Authorizations | • MyCare Requirements<br>• Knowledge Review |
| Authorization Types | • Waiver<br>• Medicaid<br>• Medicare |
| Review | • Buckeye Basics<br>• Supporting Documentation<br>• Common Denial Reasons |
| Resources | • Helpful Hints<br>• Contacts, Care Management Teams<br>• Contacts, Provider Network Reps |

# Training Module Summary

**Service Plans & Authorizations**

- MyCare Requirements
- Knowledge Review

# MyCare Ohio

Buckeye's 3-way agreement with CMS and ODM guides us the same as it does our providers.

Buckeye follows the prior authorization requirements according to this Provider Agreement.

Buckeye's Quick Reference Guides are a resource for prior authorization and referral procedures.

Quick Reference Guides (QRGs) are available in the Provider Resources, Forms & Resources section of the company website.

- Quick Reference Guide – Medicare (PDF)
- Quick Reference Guide – Medicaid (PDF)
- Quick Reference Guide – MyCare (PDF)

# Service Plan & Authorization Knowledge

- Prior Authorization is required for coverage of services coordinated for beneficiaries of the MyCare Ohio Waiver Program.
- The Service Plan (SP) identifies the services (including Medicaid Home Health Services).
- The provider is responsible to review each Service Plan to assure that you are correctly listed as a provider for an eligible service identified on the SP and that the SP is valid.
- Being listed on the SP will validate approval to begin or continue waiver services within that Service Plan period and is the basis for rendering services.
- The Authorization Confirmation will further validate approval to bill for services.

# Training Module Summary

buckeye health plan
MyCareOhio
Connecting Medicare + Medicaid

**Authorization Types**

- Waiver
- Medicaid
- Medicare

# Waiver, Home Health Authorization

- Services will be based on the member's Services Plan (SP).
- The Waiver Service Coordinator (WSC) will be in contact with both the member and provider.
- Once services are added to the Services Plan (SP), an authorization will be entered into the system by an HCBS Program Coordinator.
  - ➢ The Service Plan (SP) is approval to begin and/or continue waiver services – please do not delay services while awaiting an authorization.
- These are waiver code services (primarily T1019)
- The HCBS Program Coordinator will fax service providers with an authorization number to submit claims for payment along with a copy of the most recent Service Plan.

# Medicaid, Home Health Authorization

- Medicaid (state plan) "chronic/maintenance" services follow a separate authorization process from waiver services.
- Review the Service Plan listing the Medicaid (state plan) paid services and submit an authorization (this is separate from waiver services).
- The 485 and OASIS are required to submit with this request.
- These are services (G0154, G0156,T1000 etc) that are identified as being provided by Medicaid or MHHS (Medicaid Home Health Services)
- Buckeye understands that an efficient prior authorization (PA) process is important to our providers which is why you have 2 submission options:
  1) Manual by fax – form available at http://www.buckeyehealthplan.com > For Providers > Provider Resources > Forms & Reference
  2) Electronic using web portal - https://provider.buckeyehealthplan.com
- IMPORTANT: A request for Medicaid (State Plan) services are reviewed for medical appropriateness before approved. Units and frequency may change.

# Medicare, Home Health Authorization

- Medicare covered "short-term/acute" services follow a separate authorization process from waiver services.
- Authorization requests for services identified as Medicare should be submitted as a 60-day episode of care.
- Supporting documentation should be limited to the note that clearly identifies the reason for increased needs.
- Buckeye understands that an efficient prior authorization (PA) process is important to our providers which is why you have 2 submission options:
  1) Manual by fax – form available at http://www.buckeyehealthplan.com > For Providers > Provider Resources > Forms & Reference
  2) Electronic using web portal - https://provider.buckeyehealthplan.com
- IMPORTANT: A request for Medicare services are reviewed for medical need before approved. Services may be approved differently than requested.

# Training Module Summary

buckeye health plan
MyCareOhio
Connecting Medicare + Medicaid

Review

- Buckeye Basics
- Supporting Documentation
- Common Denial Reasons

# Medicaid vs Medicare

buckeye health plan
MyCareOhio
Connecting Medicare + Medicaid

- A Medicaid authorization submission, once reviewed, may be re-determined as covered by Medicare for the following reasons:
  1) Recent hospital admission
  2) Need for PT/OT
  3) Additional nursing skills needed, i.e. wound care

- A Medicare authorization submissions, once reviewed, may be re-determined as covered by Medicaid (state plan) or waiver for the following reasons:
  1) Condition is chronic
  2) No additional nursing skills are needed
  3) Member not homebound

- For either instance, the Authorization reviewer will transfer the Authorization to the correct payer on behalf of the provider.

# The Buckeye Basics

The following basic information is required for all Authorization requests for home health (state plan) services (non-waiver):

1. Verify member eligibility with Buckeye.
2. Complete the appropriate authorization form (Medicare, Medicaid, MyCare) or submit your request electronically through our secure provider portal .
3. Attach supporting documentation required for home health services when submitting.

****Remember, authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.*

# Supporting Documentation

buckeye health plan
MyCareOhio
Connecting Medicare + Medicaid

| Start of Care and Continuing Care Requests | |
|---|---|
| ❑ Supporting documentation of the patients need for home health services. | ❑ Date of last face to face encounter with physician. |
| ❑ Written physician's order for continuing home health services from the attending physician actively treating the patient. | ❑ All Home Health requests require ongoing supervision of the treating physician. The treating physician must order recertification and document the clinical need for continuation of services. |

| Clinical Information | |
|---|---|
| ❑ Current diagnosis and co-morbidities | ❑ Current medical status |
| ❑ Medication list and compliance | ❑ Recent hospitalization information |
| ❑ DME currently utilized | ❑ Latest 485 form, when available |
| ❑ If requesting home health nurse visits, indicate the specific skilled nursing need to support the request | ❑ Provide a complete description of any wounds: size, depth, type and frequency of dressings. |
| ❑ Daily home health notes for the last 2 weeks for continuing care. | |

# Common Reasons for Claim Denials

- No Authorization on file.
- No Authorization on file for dates of service.
- Authorization ended – no new request.
- Member eligibility ended.
- Member not eligible for services billed.
- Member Medicaid-only and not eligible for waiver services.
- Member not eligible for services billed for dates of service.
- Billing an incorrect service code (i.e. Billing G0156/G0154 instead of T1019/T1002 per the service plan - existing authorization).
- Provider left network.

# Training Module Summary

buckeye health plan
MyCareOhio
Connecting Medicare + Medicaid

**Resources**

- Helpful Hints
- Contacts, Care Management Teams
- Contacts, Provider Network Reps

# Helpful Hints

buckeye health plan
MyCareOhio
Connecting Medicare + Medicaid

These hints will help ensure that your Authorization requests contain all of the necessary information for review the first time they are submitted.

- Fax your Authorization requests, including all clinical documentation (485 and OASIS) to the appropriate fax number.
- Allow 2 days for:
  1) Authorization to be listed in the Web Portal, or
  2) FAXBACK response that may request resubmission after correcting identified errors or missing information
- Contact Care Management when scenario 1) or 2) does NOT occur

Care Management (866) 549-8289 option 3

(Leave a message that will be returned within 2 business days)

# Helpful Hints

buckeye health plan
MyCareOhio
Connecting Medicare + Medicaid

- Maximum time requested is 60 days for start of care and continuing care per request.
- No more than a combined total of 14 hours (56 units) per week of home health nursing and home health aide services will be approved.
- The main purpose of home health services cannot be to provide incidental services. Incidental services include light chores, light house cleaning, preparing of meals and/or taking out the trash. These incidental services cannot increase the total number of hours requested.

# Helpful Hints

- The fax notice confirmation and/or verbal notice of approved services provides the cert period date of service coverage, fax # and person who sent the fax. We recommend keeping this document as a reminder to resubmit a request when the end date is approaching.
- Cert period is also viewable on the web portal.
- It is the provider's responsibility to notify Care Management of requested additional and/or concurrent services.
- Avoid the most common reasons for delay or denial of Authorization requests:

| | |
|---|---|
| ✓ Insufficient or missing clinical information necessary for review of the home health services. | ✓ Provider not contracted to provide Medicaid/Medicare services. |
| ✓ Lack of progress notes | ✓ Illegible documentation |

# Contacts, Care Management Teams

Service Plan & Waiver Authorization Requests
(866) 246-4356 ext 24365

Medicare & Medicaid Authorization Questions
(866) 296-8731 Choose Option for Authorization Request/Status

Care Management (866) 549-8289 option 3
(Leave a message that will be returned within 2 business days)

# Contacts, Provider Network

For questions related to claims or billing, please contact:

Provider Services MyCare Concierge Team at 1-866-296-8731

or your regional HCBS Provider Network Specialist:

**Northeast Area (Cuyahoga, Geauga, Lake, Lorain & Medina counties)**

Anne Marie Hillton ♦ 866.246.4356 x24367 ♦ ahillton@centene.com

**Northwest Area (Fulton, Lucas, Ottawa and Wood counties)**

Laura Anaple ♦ 866.246.4356 x24816 ♦ lanaple@centene.com

**West Central Area (Clark, Greene and Montgomery counties)**

Derek Goode ♦ 866.246.4356 x24162 ♦ dgoode@centene.com

buckeye health plan

MyCareOhio
Connecting Medicare + Medicaid

# Thank You!