Home Care Prior Authorization Form Guide

The purpose of this form is to streamline the authorization process and standardize all the information needed in one easy-to-use format. This form is designed to support you with requesting a complete and accurate prior authorization (PA), allowing for timely processing of your request so that you can focus on our shared priority - providing high quality care to your Neighborhood patients.

All supporting documents must be attached to the request. Failure to include supporting documentation or respond to requests for additional documentation may result in a delay in processing or denial.

Avoid the most common errors that can result in processing delays or denial of PA requests:

- Insufficient or missing supporting documentation review. Please note that a Letter of Medical Necessity alone is often not sufficient supporting documentation.
- Illegible or incomplete request form and/or supporting documentation.
- Requesting services without physician's orders and supporting medical necessity.
- Requesting excessive authorization time frames. The requested time frame should comply with the guidance in the applicable section of the form.
- Requesting authorization for more hours or visits than what has been ordered and/or being fulfilled by the agency.

Be sure to write legibly.

1. **Member Information:** This section must be filled out completely.
2. **Provider Information:** This section must be filled out completely. Ensure the fax number is the number where the authorization approval/denial can be faxed to.
3. **Physician Information:** This section must be filled out completely. Ensure the fax number is the number where the authorization approval/denial can be faxed to. The only exception is when requesting Section B only for MMP members; for these requests you can enter the Neighborhood Case Manager's information.
4. **Type of Request:** This section must be filled out.
    a. **Initial:** Check this box when the authorization is the initial authorization request.
    b. **Continuation of Services:** Check this box when the authorization is for continuation of previously authorized services.
    c. **Correction:** Check this box when correcting an error or making a change on a previously submitted authorization request. Be sure to include the previous authorization or E-form reference number.
5. **Choose the Service Type(s):** This section must be filled out completely. Then complete the associated section. For example: If Section A is checked, then only complete Section A of the form.
6. **Section A: Skilled Intermittent Home Health -** This section must be filled out if requested.
    a. **Agency Start of Care Date:** This is the date the Home Health Agency admits the patient.
    b. **Date of D/C from facility:** This is the date the member is discharged home from an inpatient facility (i.e., a hospital, rehab, etc.), if applicable
    c. **Required Information:** Specifies the supporting documentation to submit with the authorization request depending on request type.
    d. **Dates of Service:** This section must be filled out. Dates cannot overlap certification periods.
    e. **Primary Diagnosis Code(s):** Primary diagnosis and related secondary diagnosis associated with the reason for the home health care admission.
    f. **Disciplines Requested and Quantity of Visits:**

i. Check off which discipline(s) are needed. For Skilled Nursing and Home Health Aide, also circle the needed code(s).
ii. **Check for Eval Only:** Check this box if only one evaluation visit is being requested for the associated discipline. If this box is checked, the *Requested # of Visits* column should be blank.
iii. **Requested # of Visits:** Indicate the number of visits (not units) being requested based on the physician's orders in the member's plan of care. The number of visits requested should not exceed the plan of care.
iv. **# of Requested Visits that were already completed:** *If the requested dates of service include dates prior to the authorization submission date*, then indicate the number of requested visits that were already completed between the starting date of service requested and the date the prior authorization request was submitted to Neighborhood. For example, requesting starting date of service of 4/1, but prior authorization request is being submitted to Neighborhood on 4/4, then indicate how many visits were provided between 4/1-4/3.
v. Units that Neighborhood will approve per visit:
    1. Skilled Nursing and Medical Social Worker: 1 visit = 1 unit
    2. Home Health Aide: 1 visit = 4 units
    3. Therapies – Physical, Occupational, & Speech: 1 visit = 8 units

7. **Section B: Home Care -** This section must be filled out if requested.
    a. Indicate if the HHA hours are being provided somewhere other than home.
    b. **Required Information:** Specifies the supporting documentation to submit with the authorization request depending on request type.
    c. **Dates of Service:** This section must be filled out. Date span cannot exceed 26 weeks.
    d. **Primary Diagnosis Code(s):** Primary diagnosis and related secondary diagnosis driving the need for home care services.
    e. **Service(s) Requested and Number of Hours per Week:** Check off the type(s) of service being requested. For each checked service, indicate the number of hours per week (not units) being requested.
    f. **Assessment of Member's Activities of Daily Living (ADL) Function:** Complete only if the member is in the Medicaid only line of business (Rite Care, RHP, RHE, SUB, CSN) **and** a completed Home Care MDS or PM1 is not attached to the authorization request.
    g. **Durable Medical Equipment (DME) Related to ADL Care:** Indicate DME needed to complete ADLs (i.e., walker, wheelchair, shower chair, Hoyer lift, etc.).
    h. **Additional Information:** Provide any additional member information that may impact the outcome of the review.
8. **Section C: Private Duty Nursing -** This section must be filled out if requested.
    a. Indicate if the HHA hours are being provided somewhere other than home.
    b. **Required Information:** Specifies the supporting documentation to submit with the authorization request depending on request type.
    c. **Dates of Service:** This section must be filled out. Date span cannot exceed 13 weeks.
    d. **Primary Diagnosis Code(s):** Primary diagnosis and related secondary diagnosis driving the need for PDN services.
    e. **Requested Hours per Week: I**ndicate the number of hours per week (not units) being requested.
    f. Circle the needed code(s)