LOUISIANA DEPARTMENT OF HEALTH

HOME HEALTH

Chapter Twenty-Three of the Medicaid Services Manual

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Claims/authorizations for dates of service on or after October 1, 2015 must use the applicable ICD-10 diagnosis code that reflects the policy intent. References in this manual to ICD-9 diagnosis codes only apply to claims/authorizations with dates of service prior to October 1, 2015.

State of Louisiana
Bureau of Health Services Financing

HOME HEALTH

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OVERVIEW

A home health agency (HHA) enrolled in Louisiana Medicaid provides patient care services that are necessary for the diagnosis and treatment of the beneficiary's illness or injury, under the order of an authorized healthcare provider (AHP). An AHP includes a physician, nurse practitioner (NP), clinical nurse specialist, or physician assistant licensed, certified, registered, or otherwise authorized to order home healthcare services consistent with State law.

Services may be provided in the beneficiary's place of residence, which is defined as the place where normal life activities take place, but cannot include a hospital, intermediate care facility for individuals with intellectual disabilities (ICF/IID) or any setting in which payment is or could be made by Medicaid for inpatient services that include room and board.

Such services include part-time skilled nursing services, extended skilled nursing services (for beneficiaries under 21 years of age), home health aide services, physical therapy (PT), speech therapy (ST), occupational therapy (OT) and medical supplies recommended by the AHP as required in the care of the beneficiary and suitable for use in the beneficiary's place of residence.

Medicaid beneficiaries do not have to be homebound in order to receive home health services. The beneficiary cannot receive services in a hospital, nursing home, or ICF/IID (with limited exceptions). The AHP must certify that the beneficiary meets the medical criteria to receive the service in their place of residence and is in need of the home health service on an intermittent basis. This certification and AHP plan of care (POC) must be maintained in the beneficiary's record and on file at the HHA. The AHP must review the POC every 60 days.

A face-to-face encounter is required and it must be related to the primary reason the beneficiary requires home health services. A face-to-face encounter may be conducted by the beneficiary's AHP.

Electronic visit verification (EVV) is required for all home health services.

Refer to Section 23.4 for details regarding face-to-face encounter requirements and for details regarding EVV.

Refer to Section 23.5 for prior authorization (PA) requirements.

Refer to the Minimum Standards for Licensing Home Health Agencies (Louisiana Administrative Code (LAC) 48:1, Chapter 91) for details regarding HHA requirements.

DESCRIPTION OF SERVICES

A home health agency (HHA) enrolled in the Louisiana Medicaid Program provides patient care services in the beneficiary's place of residence, under the order of an authorized healthcare provider (AHP), that are necessary for the diagnosis and treatment of the beneficiary's illness or injury. Such services include part-time skilled nursing services, extended skilled nursing services (for beneficiaries under 21 years of age), home health aide services, physical therapy (PT), speech therapy (ST), occupational therapy (OT), and medical supplies recommended by the AHP as required in the care of the beneficiary and suitable for use in the beneficiary's place of residence.

Home health services are reimbursable only when ordered by a licensed AHP who certifies that the beneficiary meets the medical necessity criteria (refer to section 23.3) to receive services in a beneficiary's place of residence on an intermittent basis. Beneficiaries in an intermediate care facility for individuals with intellectual disabilities (ICF/IID) **may** receive short-term home health care from a registered nurse (RN) during an acute illness to avoid the beneficiary being transferred to a nursing home.

The certification and AHP's plan of care (POC) must be maintained in the beneficiary's record and on file at the HHA. The AHP must review the POC every 60 days. During the home visit, the clinician should define a specific goal or reason for the appointment to substantiate the need for the visit (medical necessity) and the reason it is occurring in the beneficiary's place of residence.

Covered Home Health Services

Covered home health services include the following:

1. **Skilled nursing** (Intermittent or part-time);

2. **Home health aide services** provided in accordance with the POC as recommended by AHP;

3. **Extended skilled nursing services (**also referred to as **extended home health),** as part of early and periodic screening, diagnostic and treatment (EPSDT) services. This service is extended nursing care by an RN or a licensed practical nurse (LPN) and may be provided to beneficiaries under age 21 who are considered "medically fragile";

4. **Rehabilitation services** including PT, OT, and ST, including audiology services; and

5. **Medical supplies, equipment and appliances** as recommended by the AHP, required in the POC for the beneficiary and suitable for use in the place of residence.

Medical supplies, equipment and appliances are covered under the Durable Medical Equipment (DME) program when approved by the Prior Authorization Unit (PAU).

Skilled Nursing Services

Skilled nursing services provided on a part-time or intermittent basis by an RN or LPN that are necessary for the diagnosis and treatment of a beneficiary's illness or injury. Examples of skilled nursing services include, **but are not limited to, the following:**

1. Frequently monitoring blood pressure, fluid status, or blood glucose;
2. More rigorous assessment of symptoms, including pain, dyspnea, or constipation;
3. Management of complex wounds;
4. Patient education around therapy (e.g., home glucose monitoring and insulin administration); and
5. Assessment of medication adherence.

These services shall be consistent with the following:

1. Established Medicaid policy;
2. The nature and severity of the beneficiary's illness or injury;
3. The particular medical needs of the patient; and
4. The accepted standards of medical and nursing practice.

The requested services must meet all of the following:

1. Be ordered and directed by a treating practitioner or specialist (M.D., D.O);
2. Care must be delivered or supervised by a licensed professional in order to obtain a specific medical outcome;
3. Be skilled care, in nature;
4. Be part-time or intermittent ; and

5. Be clinically appropriate and not more costly than an alternative health service.

Psychiatric Services

Home health services provided to beneficiaries whose primary diagnosis is psychiatric must be provided in accordance with state requirements as published in the Minimum Standards for HHAs. One requirement stipulates that only RNs shall make psychiatric nurse visits.

RN qualifications for psychiatric home health visits are taken from the Minimum Standards for Licensing HHAs (Louisiana Administrative Code (LAC) 48:1. Chapter 91). Only RNs who have these credentials shall make psychiatric nurse visits.

Additionally, the RN's experience must have been within the last five years, or they must have documentation must show psychiatric re-training, classes, or continued education units (CEUs) to update their psychiatric knowledge within the last five years.

RN requirements include the following:

1. RN with a master's degree in psychiatric or mental health nursing;

2. RN with a bachelor's degree in nursing with one year of experience in an active treatment unit in a psychiatric or mental health hospital or outpatient clinic; or

3. RN with a diploma or associate degree with two years of experience in an active treatment unit in a psychiatric or mental health hospital or outpatient clinic.

Furthermore, the services must be medically necessary and provided only to beneficiaries who meet Medicaid's medical necessity criteria for home health services.

Home Health Aide Services Only

In some situations, a dually eligible beneficiary (one who has coverage from both Medicare and Medicaid) requires only home health aide visits. Medicare will not pay for this service unless skilled services (skilled nursing service, PT, OT, or speech-language therapy) are also required. However, Medicaid will reimburse for home health aide visits if only home health aide visits are required. Claims of this nature must either have a cover letter attached explaining the reasons for the lack of Medicare coverage or include this explanation in the remarks section of the claim.

Supervision of Home Health Aides

Periodic on-site supervision with the home health aide present is part of the Minimum Standards for HHAs.

It is required that if the beneficiary is receiving a skilled service (nursing, PT, OT, or speech-language therapy), the beneficiary shall have an RN or appropriate therapist supervisory visit made **randomly every 14 days.**

Beneficiaries not receiving skilled services must have an RN supervisory visit at the beneficiary's residential setting at least **once every 62 days** while the home health aide is present and providing care. Supervisory visits are not billable services.

Extended Home Health

Extended home health, also known as extended skilled nursing services (a minimum of three or more hours of nursing services per day), may be provided to beneficiaries under the age of 21 by the HHA if determined to be medically necessary, ordered by an AHP, and prior authorized by the PAU. The beneficiary must require skilled nursing care that exceeds the caregiver's ability without the extended home health services.

Rehabilitation Services

PT, OT, and ST services are covered when provided by the HHA. These services are covered with prior authorization (PA).

Physical Therapy

Physical therapy services are rehabilitative services necessary for the treatment of the beneficiary's illness or injury, or restoration and maintenance of function affected by the beneficiary's illness or injury.

These services are provided with the expectation, based on the AHP's assessment of the beneficiary's rehabilitative potential, that:

1. The beneficiary's condition will improve, materially, within a reasonable and generally predictable period of time; or

2. The services are necessary for the establishment of a safe and effective maintenance program.

Physical Therapy Assistants

The use of physical therapy assistants (PTA) is regulated in the Minimum Standards for HHAs. The PTA must be currently licensed by the Louisiana State Board of PT Examiners and must be

supervised by a licensed physical therapist. The PTA must have, at a minimum, one year of experience as a licensed PTA before assuming responsibility for a home health caseload.

The PTA's duties must not include interpretation and implementation of referrals or prescriptions, performance evaluations, or the determination of major modifications of treatment programs.

Occupational Therapy

OT is a medically prescribed treatment to improve or restore a function which has been impaired by illness, injury or, when the function has been permanently lost or reduced, to improve the beneficiary's ability to perform those tasks required for independent functioning.

Speech Therapy

Speech-language therapy services are those services necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of a communication disability.

Medical Supplies

Medical supplies recommended by the AHP, required in the care of the beneficiary and suitable for use in any setting in which normal life activities take place are covered under the DME program when approved by the PAU.

NOTE: HHAs that enroll as DME providers may bill the program for supplies used under that service designation using the DME claim form.

Routine supplies, and supplies that are only covered when provided in conjunction with a home health visit, are listed in Section 23.5.

Chronic Needs Cases

Chronic needs cases pertain to DME, extended home health, personal care services (PCS), and rehabilitation services. The PA process has been altered to allow designation of some beneficiaries as "chronic needs case beneficiaries". Prior authorized services are continuous and are expected to remain at current levels based on the medical condition of these beneficiaries. Once a beneficiary is deemed a "*chronic needs case*", providers must only submit a PA request form accompanied by a statement from an AHP, documenting that the beneficiary's condition has not improved and the services currently approved must be continued at the approved level.

Requests for an increase in these services will be treated as a traditional PA request and are subject to full review.

Beneficiaries meeting the "*chronic needs case"* status will be notified of the designation and the PAU will send a copy of the letter to the provider of services.

SERVICE LIMITATIONS

Service Limitations

Home health services include part-time skilled nursing services, home health aide services, physical therapy (PT), occupational therapy (OT), and speech therapy (ST), and medical supplies and equipment ordered by an authorized healthcare provider (AHP) as required in the care of the beneficiary and suitable for use in the beneficiary's place of residence. The beneficiary cannot receive services in a hospital, nursing home, or intermediate care facility for individuals with intellectual disabilities (ICF/IID) (with limited exceptions). The AHP must certify that the beneficiary meets the medical criteria to receive the service and is in need of the home health service on an intermittent basis.

NOTE: Medicaid prohibits multiple professional disciplines in a beneficiary's residential setting at the same time. This includes but is not limited to nurses, home health aides, and therapists. However, multiple professionals may provide services to multiple beneficiaries in the same residential setting when it is medically necessary. The Bureau of Health Services Financing (BHSF) will determine medical necessity for fee-for-service beneficiaries. Medical necessity will be determined by a beneficiary's managed care organization (MCO) if the beneficiary is enrolled in an MCO.

Service limits for home health services are as follows:

Birth through age 20:

1. No annual service limits;
2. Prior authorization (PA) is required for multiple visits on the same day when medically necessary; and
3. PA is required for extended home health services.

Ages 21 or older:

1. Medicaid will reimburse only one visit per profession, per day; and
2. PA is required for all nursing and rehabilitation services in a residential setting:
    a. Skilled nursing and home health aide services;
    b. PT;

c. OT; and

d. Audiology services.

BENEFICIARY REQUIREMENTS

The Medicaid beneficiary must meet all eligibility requirements in order to qualify for home health services. The home health agency (HHA) providing the service is required to verify beneficiary eligibility, other insurance coverage, and living arrangements before providing services.

General Beneficiary Criteria

The beneficiary cannot be in a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities (ICF/IID), or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

Exception: In accordance with 42 Code of Federal Regulations (CFR) Part 483, Subpart I, there are situations in which a beneficiary residing in an ICF/IID may receive home health services. For example, short-term home health services may be provided to a beneficiary in an ICF/IID during an acute illness to avoid a beneficiary's transfer to a nursing facility.

Medical Necessity Criteria

Medical necessity for home health services must be determined by medical documentation that supports the beneficiary's illness, injury and/or functional limitations. All home health services must be medically reasonable and appropriate. To be considered medically reasonable and appropriate, the care must be necessary to prevent further deterioration of a beneficiary's condition regardless of whether the illness/injury is acute, chronic, or terminal.

The services must be reasonably determined to:

1. Diagnose, cure, correct, or ameliorate defects, physical and mental illnesses, and diagnosed conditions of the effects of such conditions;

2. Prevent the worsening of conditions, or the effects of conditions, that endanger life or cause pain; results in illness or infirmity; or have caused, or threatened to cause a physical or mental dysfunctional impairment, disability or development delay;

3. Effectively reduce the level of direct medical supervision required or reduce the level of medical care or services received in an inpatient setting or provided by the home health program;

4. Restore or improve physical or mental functionality, including developmental functioning, lost or delayed as the result of an illness, injury, or other diagnosed condition or the effects of the illness, injury, or condition; or

5. Provide assistance in gaining access to needed medical, social, educational, and other services required to diagnose, treat, to support a diagnosed condition or the effects of the condition, in order that the beneficiary might attain or retain independence, self-care, dignity, self-determination, personal safety and integration into family, community, facility environments and activities.

Home health skilled nursing and aide services are considered medically reasonable and appropriate when the beneficiary's medical condition and records accurately justify the medical necessity for services to be provided by the home health program rather than in a physician's office, clinic, or other outpatient setting.

Home health services are appropriate when a beneficiary's illness, injury, or disability causes significant medical hardship and will interfere with the effectiveness of the treatment if the beneficiary has to go to a physician's office, clinic, or other outpatient setting for the needed service. Any statement on the plan of care (POC) regarding this medical hardship must be supported by the totality of the beneficiary's medical records.

The following circumstances are not considerations when determining medical necessity for home health services:

1. Inconvenience to the beneficiary or the beneficiary's family;

2. Lack of personal transportation; and

3. Failure or lack of cooperation by the beneficiary or the beneficiary's legal guardians or caregivers to obtain the required medical services in an outpatient setting.

PROVIDER REQUIREMENTS

To participate in the Home Health program, the providing agency must be Medicare-certified for Medicare/Medicaid by the Licensing and Certification Unit of the Health Standards Section (HSS) of the Louisiana Department of Health (LDH). All providers enrolled in the Louisiana Medicaid program must adhere to the conditions of participation as outlined in the provider agreement.

All home health services must be provided by staff employed by or under contract with the home health agency (HHA). (See Louisiana Administrative Code (LAC) 48:I, Chapter 91. Also, refer to 42 Code of Federal Regulations (CFR) 417.416 and Sec 2194 of the State Operations Manual CMS Pub. 7 for specific requirements).

All staff must meet all required licensure requirements in accordance with Medicaid policies, federal, state and other applicable laws.

Provision of Services

Home health services include medically necessary skilled nursing, rehabilitation (physical therapy (PT), occupational therapy (OT), and speech therapy (ST)), home health aide, and medical supplies provided to beneficiaries only if the service is provided in the beneficiary's place of residence.

NOTE: The beneficiary's place of residence cannot be a hospital, nursing home, or an intermediate care facility for individuals with intellectual disabilities (ICF/IID), with limited exceptions, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

Electronic Visit Verification

The HHA shall use an electronic visit verification (EVV) system for time, attendance, and billing tracking.

Home health agencies shall use the following:

1. EVV system designated by LDH; or

2. Alternate system that has successfully passed the data integration process to connect to the designated EVV system, and is approved by LDH.

Reimbursement for services may be withheld or denied a HHA who fails to use the EVV system, or does not use the system in compliance with Medicaid's EVV policies and procedures for.

More resources for EVV may be found here.

Plan of Care

The authorized healthcare provider (AHP) must certify that the beneficiary meets the medical criteria to receive the service in the beneficiary's place of residence and is in need of the home health services on an intermittent basis. The AHP must order all home health services and sign a plan of care (POC) submitted by the HHA. If the HHA is not submitting a CMS-485 form then the POC must meet all the elements provided on the CMS-485 form. For more information on the Form CMS-485, visit the Centers for Medicare and Medicaid Services (CMS) website. (See Appendix D). This certification and the AHP's POC must be maintained in the beneficiary's record and on file at the HHA.

Periodic Review of Plan of Care

The AHP must reauthorize the POC every 60 days.

Face-to-Face Encounter Requirements

For the initiation of home health services, a face-to-face encounter with the AHP and the beneficiary must occur no sooner than 90 days prior to the start of home health services, or no later than 30 days after the start of home health services.

Evidence of the face-to-face encounter is required by Gainwell Technologies' Prior Authorization Unit (PAU) for routine skilled nursing and home health aide services for beneficiaries age 21 and older. If providers do not have this documentation prior to the initiation of services then the initial prior authorization (PA) request must be for 30 days only. Providers must submit documentation of the face-to-face encounter with the new PA request in order for services to be approved.

Providers should refer to **Section 23.5 - Prior Authorization**, for information related to PA requirements.

For the initiation of medical equipment, the face-to-face encounter must be related to the primary reason the beneficiary requires medical equipment and must occur no more than six months prior to the start of services.

Providers should refer to **Section 23.5 – Prior Authorization,** for information related to PA requirements.

Any of the following will be accepted by the PAU as evidence of a face-to-face encounter between an AHP and the beneficiary:

1. A written statement on the certifying AHP's letterhead or prescription pad attesting to a face-to-face encounter between the AHP and the beneficiary;

2. The HHA's face-to-face encounter form that the HHA requires the beneficiary's certifying AHP to complete as a routine business practice; or

3. Medical notes or documentation from the AHP demonstrating evidence of a face-to-face encounter within the required timeframe.

Documentation of a face-to-face encounter as detailed above must be kept in the beneficiary's record for ALL home health service related requests, including therapy services, medical equipment and supplies, and services for beneficiaries under the age of 21.

The face-to-face encounter may be conducted by one of the following practitioners:

1. The beneficiary's AHP;

2. A nurse practitioner (NP) or clinical nurse specialist working in collaboration with the beneficiary's AHP;

3. A physician assistant under the supervision of the beneficiary's AHP;

4. A certified nurse-midwife, as defined in section 1861(gg) of the Social Security Act; or

5. The attending acute or post-acute physician for beneficiaries admitted to home health immediately after an acute or post-acute stay.

Clinical findings must be incorporated into the beneficiary's medical record.

The AHP responsible for ordering the services must:

1. Document that the face-to-face encounter which is related to the primary reason the beneficiary requires home health services, occurred within the required and specified timeframes above;

2. Identify the practitioner who conducted the encounter; and

3. Indicate the date of the face-to-face encounter.

Required Assistance to Beneficiaries

In an effort to assist beneficiaries in locating a provider to submit a PA request for medically necessary home health services, the beneficiary may contact Medicaid for assistance. (See Appendix D for Contact/Referral Information).

In addition, the Bureau of Health Services Financing (BHSF) may conduct surveys with beneficiaries who have been authorized to receive extended home health services. The purpose of these surveys is to ensure that BHSF will contact the appropriate provider to determine what additional assistance may be required to ensure access to the authorized services.

Emergency Preparedness Plan

The HHA must have an emergency preparedness plan that conforms to the current Louisiana Office of Emergency Preparedness (OEP) model plan. The plan is designed to manage the consequences of declared disasters or other emergencies that disrupt the HHAs ability to provide care and treatment or threaten the lives or safety of its clients.

The HHA is responsible for obtaining a copy of the current Home Health Emergency Preparedness Model Plan from OEP. (See Appendix D for Contact/Referral Information).

Additionally, per CMS, the HHA must comply with the reporting requirements of the At-risk Registry. The HHA shall update the "Louisiana At-risk Registry" or other current state-required reporting mechanism as needed or as required.

At a minimum, the HHA must have a written plan that includes:

1. The evacuation procedures for agency clients who require community assistance as well as for those with available caregivers to evacuate to another location;

2. The delivery of essential care and services to agency clients whether they are in a shelter or other locations;

3. The provisions for the management of staff, including distribution and assignment of responsibilities and functions;

4. A plan for coordinating transportation services required for evacuating agency clients to another location; and

5. A declaration that the agency will notify the client's family or caregiver if the client is evacuated to another location.

The HHA must submit the plan to the parish OEP for review. Refer to LAC 48:I.9101 for details regarding the minimum standards for HHA emergency preparedness.

PRIOR AUTHORIZATION

The home health agency (HHA) must submit a plan of care (POC) and request prior authorization (PA) for extended skilled nursing services (also referred to as extended home health), multiple daily nursing visits for beneficiaries under age 21 who are not receiving extended skilled nursing services, adults age 21 and older, or rehabilitation services (therapies). PA approval must be received before services are provided.

NOTE: There is no benefit coverage for extended home health services or multiple daily nursing visits for persons age 21 and older. PA is not required for a single, daily nursing visit for beneficiaries under the age of 21 who are not receiving extended home health.

Requests for Prior Authorization

For Medicaid fee-for-service beneficiaries, providers must submit requests for PA using the PA forms that can be accessed at https://www.lamedicaid.com/provweb1/Forms/PAforms.htm. No other forms or substitutes will be accepted. Completed requests must be sent to the Prior Authorization Unit (PAU).

Electronic prior authorization (e-PA) is a web application that provides a secure web based tool for providers to submit PA requests and to view the status of previously submitted requests. For more information regarding e-PA, visit the Louisiana Medicaid website at www.lamedicaid.com or call the PAU. (See Appendix D for Contact/Referral Information).

All PA requests, whether initial or a reconsideration, must be submitted via the e-PA system. A faxed or mailed request will not be accepted.

To ensure that emergency requests are received by PAU, providers must contact the PAU and inform the unit when an emergency PA request is being transmitted via the e-PA.

The appropriate PA form, along with all necessary documentation to substantiate the medical necessity of the requested services, must be submitted to the PAU for approval.

Prior Authorization Forms

Home Health Service	Form(s)
Rehabilitation services (physical therapy (PT), occupational therapy (OT), and speech therapy (ST))	PA-01
Multiple and extended home health nursing visits for beneficiaries birth through age 20	PA-07
Home health nursing services for beneficiaries ages 21 and older	PA-18 Face-to-Face Encounter Form

PA forms can be found in Appendix B of this manual chapter or on the Louisiana Medicaid website at www.lamedicaid.com. PA is required prior to claim submissions. The current procedure codes and descriptions, as well as the revenue codes appropriate to the service necessary to complete the billing process can be found in "Home Health Revenue and Procedure Codes" under the "Fee Schedules" link at www.lamedicaid.com.

NOTE: A face-to-face encounter form is not required for beneficiaries under the age of 21, for rehabilitation services, or medical equipment and supplies provided through the Durable Medical Equipment (DME) program; however, documentation of the face-to-face encounter for these groups of services is required to be kept in the beneficiary's record.

For questions concerning the PA process, please contact the PAU. (See Appendix D for Contact/Referral Information).

Home Health Services

Routine skilled nursing and home health aide services for beneficiaries who are age 21 and older require PA. For the initiation of all home health services, a face-to-face encounter between the authorized healthcare provider (AHP) and the beneficiary must occur no sooner than 90 days prior to the start of home health services, or no later than 30 days after the start of home health services.

Evidence of the face-to-face encounter is required by the PAU for routine skilled nursing and home health aide services for beneficiaries age 21 and older. If providers do not have this documentation prior to the initiation of services, the initial PA request must be for 30 days only. Providers must submit documentation of the face-to-face encounter with the new PA request in order for services to be approved.

Providers shall refer to section 23.4 - Provider Requirements, for information related to the face-to-face encounter requirements.

An AHP's order must be submitted with the PA request. A POC will be accepted in lieu of a separate AHP's order if the frequency of visits are specified. If providers are unable to obtain a signed POC for a reconsideration request, an unsigned POC may be submitted for reconsideration requests for a 30-day period only. The signed POC must be submitted with the new PA request in order for services to be approved.

Routine home health services for beneficiaries under the age of 21 must be prescribed by an AHP for only one skilled nursing visit per day. PA is not required for routine home health visits for beneficiaries under the age of 21. A request for PA of services is required when the prescription of the AHP includes multiple daily visits for a beneficiary under the age of 21. Multiple visits in the same day are usually associated with intravenous (IV) therapy.

Rehabilitation Services

All home health rehabilitation services (PT, OT, and ST) require PA.

All rehabilitation services (except for initial evaluations and wheelchair seating evaluations, which are restricted to one evaluation per discipline per beneficiary every 180 days) require PA from the PAU. All evaluations must have an AHP's prescription that must be kept in the beneficiary's file.

To request PA for home health rehabilitation services, providers must complete the PA-01 form using the appropriate procedure codes as listed on the fee schedule. Refer to section 23.6 for claims filing information.

All initial PA requests must include a copy of the AHP's referral and the results of the evaluation of the beneficiary that documents the need for therapy. All renewal PA requests must include a copy of the AHP's referral and progress notes that document the need for the continuation of therapy.

Extended Skilled Nursing Services (Extended Home Health)

Extended skilled nursing services may be provided to a Medicaid beneficiary, birth through age 20, when it is determined to be medically necessary for the beneficiary to receive a minimum of three hours per day of nursing services. Medical necessity for extended skilled nursing services exists when the beneficiary has a medically complex condition characterized by multiple, significant medical problems that require nursing care in accordance with the Louisiana Nurse Practice Act (La. R.S. 37:911, et seq).

When requesting PA for extended home health, all hours of care must be included with the PA request. In addition, the AHP's prescription and a copy of the POC must be attached to the appropriate PA form. Cases approved for extended home health should be billed using appropriate

codes for a registered nurse (RN) and a licensed practical nurse (LPN) in conjunction with the total number of hours provided, indicating the units as hours.

NOTE: All extended skilled nursing services for beneficiaries under the age of 21 require PA. Daily nursing visits that are less than three hours per day for beneficiaries under the age of 21 who do not meet medical necessity criteria for extended home health do not require PA.

Prior Authorization Procedure of Extended Home Health Services at Hospital Discharge

In order to provide continuity of care for beneficiaries, the following procedure will be used for beneficiaries requiring extended home health care upon discharge from the hospital.

Prior to hospital discharge, the PA process can begin. The following information must be sent to the PAU:

1. A letter of medical necessity from the AHP;
2. A signed prescription indicating the number of hours of extended home health that are being requested;
3. A copy of the admission assessment (history and physical);
4. Progress notes;
5. Discharge orders;
6. A copy of the discharge summary, if available; and
7. A copy of the unsigned POC. The unsigned POC will be accepted only if the beneficiary is being discharged from the hospital and is included with the above information. The POC assessment cannot be done in the hospital but must be done in the beneficiary's residential setting.

NOTE: The HHA must forward the signed POC to the PAU as soon as the signed copy is received from the AHP.

The beneficiary must meet the medically necessary criteria for extended home health services in order for the PAU to approve the services. The extended home health request will be issued a PA number if the service has been approved. The HHA can check the e-PA system or call the PAU to check the status of the request and receive the PA number in order to start immediately approved services.

The beneficiary will be authorized for only six weeks of extended home health services. This is to ensure the signed POC is on file with the PAU. Prior to the end of the six week prior authorized period, all of the requested information including the signed POC must be resubmitted to the PAU. The same information can be resubmitted unless there has been a change in the beneficiary's condition.

Home Health Modifiers

Modifiers are available for routine home health and extended home health (beneficiaries age 0 through 20), to reflect specific scenarios as indicated in the chart below. All modifier requests must be submitted with the PA and approved in order to be reimbursed.

Providers shall refer to the Louisiana Medicaid Home Health Revenue and Procedure Codes document under the "Fee Schedules" link at www.lamedicaid.com.

Modifier	Modifier Name
U2	Second daily visit
U3	Third daily visit
TT	Multiple beneficiaries in the same setting
TG	High complexity
TN	Rural/outside area
TV	Weekends and holidays
UH	Services provided in the evening
UJ	Services provided at night
TU	Overtime (DOES NOT REQUIRE PA)

Multiple Same Day Visits

Multiple nursing visits on the same date of service may be provided to a beneficiary age birth through 20 when the medical necessity criteria is met and these services cannot be provided during the course of one visit. Multiple same day visits must be prior authorized before services begin.

Extended and multiple daily visits must be authorized in accordance with the certifying AHP's orders and home health POC. All nursing services shall be provided in accordance with the Louisiana Nurse Practice (La. R.S. 37:911, et seq).

The AHP must issue orders detailing how many visits should be provided per day and the duration of time to provide the multiple visits, (i.e., 10 days, 2 weeks, 45 days, etc.).

When the HHA receives the AHP's orders, the HHA must obtain documentation to support the medical need for multiple daily visits along with the POC signed by the AHP. A completed PA-07 form must be submitted to the PAU indicating the additional visits requested for the same date of service. Appropriate service code indicators, procedure codes and modifier codes, when applicable, must be used on PA requests and claims to designate additional visits on the same date. Modifier code U2 is to be used for second visits, and code U3 for third visits.

Visits for Multiple Beneficiaries in the Same Place of Residence on the Same Day

Multiple beneficiaries may been seen in the same place of residence by the same provider, on the same day when medically necessary. Medical necessity will be determined by review of the clinical documentation for each beneficiary receiving services.

Services furnished by one nurse or home health aide to two or more beneficiaries within the same setting on the same day is reimbursed as follows:

1. For the first beneficiary, Medicaid reimburses the service at the established Medicaid rate for the prior authorized Current Procedural Terminology (CPT) code/modifier combination; and

2. For the second beneficiary, Medicaid reimburses the service at 50 percent of the established Medicaid rate.

The TT modifier must be added to the home health procedure code billed on the claim to identify the service provided to more than one beneficiary in the same setting. Providers are prohibited from billing for providing services to two beneficiaries concurrently without appending the TT modifier.

Each beneficiary must have a PA in order for services to be billed. The procedures for requesting the PA established above will work for multiple beneficiaries in the same place of residence. The TT modifier can be attached to routine and extended home health codes to allow the correct payment to be made for this authorized service. (See 'Louisiana Medicaid Home Health Revenue and Procedure Codes' under the "Fee Schedules" link at www.lamedicaid.com).

High Complexity Needs

The TG modifier may be authorized for beneficiaries aged birth through 20 with highly complex needs requiring extended home health services. The HHA shall submit all necessary documentation to the PAU, as well as additional documentation to support the highly complex

nature of the beneficiary. The TG modifier shall be attached to the relevant number of hours being requested.

Examples of high complexity may include, but are not limited to:

1. Repeated seizures requiring treatment, intervention or both;
2. Frequent oropharyngeal or tracheostomy suctioning;
3. With or without nebulization treatments, repeated administration of percussion physiotherapy, high frequency chest wall oscillation physiotherapy, or use of a cough assist device;
4. Ventilator, Continuous Positive Airway Pressure (CPAP), or Bi-level Positive Airway Pressure (BiPAP) dependence during the nurse's care hours;
5. Continuous oxygen dependence with continuous oxygen saturation monitoring and frequent oxygen desaturations requiring intervention;
6. Continuous or frequent tube feeding for a beneficiary with gastroesophageal reflux, recurrent aspiration, or recurrent nausea, vomiting or abdominal pain;
7. Parenteral nutrition;
8. IV therapies; or
9. Repeated or extensive care of complex wounds.

It is the responsibility of the provider and the RN or LPN to ensure they are working within their scope of practice and licensure.

This list does not guarantee authorization. Each request will be considered on an individual basis, and reviewed based on medical necessity and documentation provided. Approved hours for this modifier will be paid at the TG modifier rate.

Rural or Outside Area

The HHA may submit PA requests using the TN modifier to identify travel to extended home health beneficiaries who live in a rural area, or outside the providers' usual service area. A geographical area will be considered rural as defined by the United States Department of Commerce, Census Bureau as non-urbanized.

The HHA shall submit all necessary documentation to the PAU to support the use of this modifier. The TN modifier can be requested for up to two units or hours per day, and can therefore be used in conjunction with other necessary modifiers. For example:

Description	Procedure Code	Modifier Code	Requested Units
Skilled Nursing Visit	S9124	TN	10
Skilled Nursing Visit	S9124	TG	30

Approved hours for this modifier will be paid at the TN modifier rate.

Holiday and Weekend Visits

The HHA may submit PA requests using the TV modifier to identify hours for an extended home health beneficiary that are required during a weekend (12 a.m. Saturday through midnight on Sunday) or on designated state holidays, as indicated in La. R.S 1:55. The TV modifier must be requested on the home health PA, form which covers the certification period in which the state recognized holiday(s) occur.

The HHA shall submit all necessary documentation to the PAU, as well as additional documentation to support the use of this modifier. This shall include an explanation and documentation as to why services are required at those times. Services will not be provided in circumstances of inconvenience to the beneficiary or the beneficiary's family.

The TV modifier shall be attached to the relevant number of hours being requested. For example, if 37 hours are being requested and 10 of those are proposed to be on a weekend, then the TV modifier shall be attached to those 10 hours on the PA request. Approved hours for this modifier will be paid at the TV modifier rate.

Evening and Night Visits

The HHA may submit PA requests using the UH or UJ modifier(s) to identify hours for an extended home health beneficiary that are required during evening or night hours. The HHA shall submit all necessary documentation to the PAU, as well as additional documentation to support the use of this modifier. This shall include an explanation and documentation as to why services are required at those times. Services will not be provided in circumstances of inconvenience to the beneficiary or the beneficiary's family.

Modifier Code	Procedure Code
UH	Evening (6 p.m. to 11:59 p.m.)
UJ	Night (12 a.m. to 5:59 a.m.)

Providers shall submit authorizations and claims using the modifier UH (evening) and/or UJ (night), for the hours that are required at these times. For example, if a beneficiary is requiring services between 5 p.m. and 5 a.m. (12 hours total), then six hours would be requested with the UH modifier and five hours requested with the UJ modifier.

Providers may request more than one modifier over the total number of hours, if the hours ordered are divided up and stipulate the appropriate modifier; however, only one modifier may be requested per line.

For example:

Description	Procedure Code	Modifier Code	Requested Units
Skilled Nursing Visit	S9124		45
Skilled Nursing Visit	S9124	TV	24
Skilled Nursing Visit	S9124	UH	15

For one week, this would be a total number of 84 hours; 24 of those hours are on a weekend and 15 hours are during the evening.

All PA requests shall be reviewed for medical necessity and when a decision is rendered a notice of the decision will be sent to the HHA and the beneficiary. If the PA is approved, a PA number will be assigned and included in the PA notice.

Home Health Supplies

Home health supplies are reimbursable under the DME Program. Approval of payment for covered supplies provided under the DME program must be obtained from the PAU.

Providers may either obtain these non-reimbursable supplies through a DME provider or provide the supplies through the DME program. Providers who opt to have the supplies provided by a DME provider must give the DME provider a copy of the AHP's orders for the supplies. The request must include the quantity and period of time the supplies are to cover. Home health providers who choose to provide these supplies can have their home health provider file updated to allow billing for these supplies.

A written request is submitted to the Provider Enrollment Unit to have the provider type for DME added to the home health provider numbers. The forms and instructions required to obtain PA approval are contained in Appendix B.

HHAs often train beneficiaries or their caregivers to administer medications, or use certain equipment/supplies, in the provider's absence. DME covered IV, or other home health supplies, may be provided to the HHA for use in the beneficiary's residential setting when administration is monitored and home health services are provided.

When normal usage amounts are exceeded, a request for approval must be submitted with documentation of medical necessity to justify the greater quantity.

Certain supplies for wound care and dressing will be covered under DME, but will be authorized exclusively for the use of HHAs when delivering a home health service.

Routine Supplies for which Reimbursement is Included as Part of the Reimbursement Rate for the Home Health Visit	
Blood drawing supplies	Specimen containers
Sterile specimen containers	Vacutainer used for drawing blood
Tourniquet	Tubex holder
Alcohol preps-swabs	Surgical masks
Bandage scissors	Culturettes
Disposable gloves-non-sterile	Adhesive tape
Paper tape	Emesis basins
Oral swabs/toothettes	Alcohol
Tape measure, all types	Non-sterile cotton balls, buds
Disposable gowns (plastic, paper)	Disposable masks
Goggles	Disposable wash clothes
Water soluble lubricant	Thermometer with holder
Thermometer cover	Sharps container
Self–assistive devices (long handle tongs and shoehorn stocking aide)	

Supplies Covered only when Provided in Conjunction with a Home Health Visit	
Inflatable Cushion (Softcare mattress)	Douche – Betadine
Enema – disposable enema administering kit	Enema – Fleets, mineral oil
Fracture pan, plastic	Bed pan, plastic
Urinal, plastic, male	Female urinal
Commode urinary disposable collection device (HAT)	Toppers, sterile

Steri-strips	Reston
Telfa	Skin staple remover
Sterile Applicators (tongue blades, sterile q-tips)	Suture removal kit
Sitz bath, portable, disposable	Elastoplast
Foam tape	Pericare kit/supplies
Bile bags	Therabands/putty
Sterile irrigation solutions (Genitourinary (GU) irrigant, acetic acid and normal saline)	Lymphedema pumps

Supplies through the Durable Medical Equipment Program

When requesting approval of payment for supplies, providers must complete the PA-01 form, and attach a copy of the doctor's prescription or orders along with the home health POC and submit these documents to the PAU.

The date on the prescription should be the same date as the PA-01 form's date of signature. When DME requests are approved under home health, a PA number will be issued within 25 working days from the date the PAU receives the prescription and PA request. A letter containing the PA number, a listing of the approved supplies and the time-period for which approval is given will be mailed to the provider and the beneficiary.

If additional supplies are required for this period, the provider is required to submit a PA-01 form for reconsideration with a new prescription and documentation of medical necessity to the PAU. If approved, these supplies will be added to the list of supplies covered by the existing PA number.

The PAU may authorize a 30-day increment of supplies by phone if a beneficiary is pending discharge from a hospital or on an emergency basis. A request for additional supplies must be submitted via e-PA.

Prior Authorization Decisions

Home health PA decisions are issued within 10 days by letter to the provider, beneficiary and support coordinator, if applicable. Approval letters contain a nine-digit PA number. Denial letters include beneficiary appeal rights.

CLAIMS RELATED INFORMATION

Reimbursement requires compliance with all Medicaid guidelines.

Claim Related Responsibilities

All providers are responsible for including the correct billing codes on a claim. If a licensed practical nurse (LPN) provides services, the provider must submit the appropriate LPN code for payment. Likewise, if a registered nurse (RN) delivers the service, the claim must identify the code associated with the appropriate service. Home health providers should perform a self-audit to identify claims paid incorrectly and report any overpayments to the fiscal intermediary (FI). All providers are responsible for assuring that their professional employees (i.e. RNs, LPNs, aides, etc.) are practicing within the limitations established by their licensing boards.

The home health agency (HHA) must provide the supporting documentation used to document medical necessity criteria (i.e. medical doctor's prescription, etc.) which must be met in order to receive home health services upon request.

Claim Type

HHAs can submit claims either by paper or electronically. Home health providers who choose to submit their claims on paper forms must use the Centers for Medicare and Medicaid Services (CMS) standard **UB-04** claim form.

The HHA must bill using its own Medicaid provider number and National Provider Identifier (NPI).

Diagnosis Codes to Support Medical Necessity

Providers must bill using the appropriate International Classification of Diseases (ICD), Tenth Edition, Clinical Modification, Tenth Revision (ICD-10-CM) diagnosis code(s), or its successor, that best describes the beneficiary's illness, injury or medical condition.

Billing Codes

The procedure codes and revenue codes to be used for billing covered home health services can be found in "Louisiana Medicaid Home Health Revenue and Procedure Codes" under the "Fee Schedules" link at www.lamedicaid.com.

Billing Instructions for Home Health Services

The UB-04 claim form (hard copy) or 837I electronic transaction is required when filing for Medicaid reimbursement of services. All information, handwritten or computer generated, must be legible and completely contained in the designated area of the claim form.

As a reminder, the beneficiary's authorized healthcare provider's (AHP's) name and provider number is always required when submitting for reimbursement of services. Please see the chart below for the correct placement of this information on the UB-04 Claim Form and 837I electronic format.

UB-04 Claim Form	837I Electronic Format
Form Locator 76 – Attending Provider (Required) Enter the name or seven-digit Medicaid provider number of the AHP ordering the plan of care (POC).	**Loop 2310A, REF02 segment OR Loop 2420A, REF02 segment** Enter the name or seven-digit Medicaid provider number of the AHP ordering the POC.

Billing Instructions for Extended Home Health Services Including Modifiers

Prior authorization (PA) must be obtained from the Prior Authorization Unit (PAU) for extended home health services, and any modifiers. When billing for the approved number of hours, providers should include the relevant modifier related to that procedure code.

For example, if four units are approved without a modifier and four units are approved with the UJ modifier, these must be billed **individually** on a separate line of the claim form. Providers shall use the correct procedure code and modifier for each line item.

Description	HCPCS	Modifier Code(s)	Service Date	Units
Nurse Care in Home - LPN	S9214		12/15/2099	4
Nurse Care in Home - LPN	S9124	UJ	12/15/2099	4

Providers shall refer to Section 23.5 - Prior Authorization for the application and use of modifiers.

Billing Instructions for Multiple Same Day Visits

PA **must** be obtained from the PAU before any multiple same day visits are provided for beneficiaries under the age of 21 who are not receiving extended home health. When billing for the multiple daily visits, the claim form should have each visit listed on a separate line with the correct procedure code and modifier codes to reflect the multiple day visits. (See "Louisiana Medicaid Home Health Revenue and Procedure Codes" under the "Fee Schedules" link at www.lamedicaid.com).

Example:

Jane Doe needs a nurse to visit her three times a day, one RN and two LPNs. The beneficiary will need these services on December 15, 2099.

A PA-07 request is completed by the provider requesting approval for the two additional visits per day and then that request is submitted to the PAU. Documentation, including the AHP's orders and the POC signed by the AHP, is submitted to substantiate the medical necessity of the additional visits.

When the PA is approved, a PA number is assigned and included in the notice authorizing the additional daily visits.

The nine-digit PA number assigned by the PAU must be included in Form Locator 63 A of the UB-04 claim form or in the PA Loop for Electronic Data Interchange (EDI) transmissions. (See EDI Companion Guide for details).

A standard unit of service is 15 minutes. **Each unit** must be billed **individually** on a separate line of the claim form. Please be sure to use the correct procedure code and modifier (if applicable) for each line item. (See sample below).

Please refer to the Louisiana Medicaid Home Health Revenue and Procedure Codes document and fee schedule at www.lamedicaid.com for the current modifiers, Healthcare Common Procedure Coding System (HCPCS) and revenue codes.

Description	HCPCS	Modifier Code(s)	Service Date	Units
Skilled Nurse Visit - RN	G0299		12/15/2099	1
Skilled Nurse Visit - RN	G0300	U2	12/15/2099	1
Skilled Nurse Visit - RN	G0300	U3	12/15/2099	1

Only one PA number may be entered per UB-04 claim form. Use of an incorrect PA number will cause the claim to deny.

Billing Instructions for Overtime Modifier

A HHA may also submit claims using the overtime (TU) modifier to identify hours for an extended home health beneficiary that were paid as overtime to the nurse delivering the care. This modifier shall not require a PA, but must be for hours already authorized for the beneficiary. When billing, this modifier may be used in addition to any other authorized modifiers (e.g., TG) for procedure codes S9123 and S9124. The payable amount shall be paid at 1.5 times the rate of the procedure code after factoring in any other modifiers.

The use of this modifier is subject to post payment review. The HHA should maintain all necessary documentation to support the use of this modifier. Non-compliance with written policy may result in recoupment and additional sanctions, as deemed appropriate by Louisiana Medicaid.

Billing Instructions for Rehabilitation Services

The Medicaid program provides coverage for physical therapy (PT), occupational therapy (OT), and speech therapy (ST) through the home health program. These services require PA.

The service codes used for billing as well as the corresponding procedure codes are listed in "Louisiana Medicaid Home Health Revenue and Procedure Code" under the "Fee Schedules" link at www.lamedicaid.com. Reimbursement will be made at a flat fee-for-service.

Cardiac and pulmonary/respiratory therapy are not covered under the Medicaid program. These services should not be prior authorized or billed using covered rehabilitation codes.

NOTE: HHAs are not to bill Medicaid for rehabilitation services rendered in nursing homes. Per 42 Code of Federal Regulations (CFR) 440.70(c), "A beneficiary's place of residence, for home health services, does not include a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities (ICF/IID)..."

Wheelchair Seating Evaluation

When billing for a wheelchair seating evaluation, a paper claim **must** be submitted with a copy of the AHP's prescription attached to the claim, (8 ½ x 11 sheet), and the original prescription **must** be kept in the beneficiary's file.

Rehabilitation Services Rendered To Dual Eligible Beneficiaries

If a particular beneficiary is eligible for both Medicaid and Medicare services, the rehabilitation provider rendering services to the beneficiary must be willing to accept the Medicare assignment in order for Medicaid to make crossover payment on the claim.

Rehabilitation providers must bill for Medicare/Medicaid crossovers on the UB-04 claim form and file the claim with Medicare first, ensuring that the beneficiary's Medicaid identification (ID) number has been entered on the claim form. Once Medicare has processed the Medicare portion of the claim, the claim payment information must be sent to the PAU for processing.

Providers should receive Medicaid payment within six weeks after receiving payment from Medicare. If payment is not received from Medicaid, providers should submit the UB-04 claim form, along with the Medicare Explanation of Benefits (EOB), to the FI for processing.

Billing for Supplies through the Durable Medical Equipment Program

Foley and indwelling catheters may not be billed through the Durable Medical Equipment (DME) program.

Reimbursement for supplies that are considered "routine supplies" are included as part of the home health visit rate and may not be billed to Medicaid nor to the beneficiary. The appropriate procedure code should be used for each supply requested.

Supplies included in the reimbursement for a Home Health Visit

Routine supplies, as determined by Medicaid, that are not reimbursed through the DME program are considered included in the home health visit rate and will not be separately reimbursed.

ACRONYMS

AHP – Authorized healthcare provider

CEUs – Continuing education units

CFR – Code of federal regulations

DME – Durable medical equipment

EVV – Electronic visit verification

HHA – Home health agency

HIPAA – Health Insurance Portability and Accountability Act

RN – Registered nurse

LPN – Licensed practical nurse

MST – Multi-systemic therapy

OASIS – Outcome and Assessment Information Set

OT – Occupational therapy

PA – Prior authorization

PAU – Prior authorization unit

PCS – Personal care services

POC – Plan of care

PT – Physical therapy

PTA – Physical therapy assistant

ST – Speech therapy

REGULATORY REQUIREMENTS
OUTCOME AND ASSESSMENT INFORMATION SET

The Outcome and Assessment Information Set (OASIS) is a group of standard data elements developed, tested, and refined through a research and demonstration program funded primarily by the Centers for Medicare & Medicaid Services (CMS) and co-funded by the Robert Wood Johnson Foundation. The OASIS is a key component of Medicare's partnership with the home care industry to foster and monitor improved home health care outcomes and is an integral part of the Conditions of Participation (COP) for Medicare-certified home health agencies (HHAs).

For the most recent and accurate OASIS regulations please visit the website at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/index.html

NOTE: CMS rules for OASIS are published in the Federal Registers.

An online OASIS training program for providers and their employees is available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/Training.html.

jHAVEN

HHAs must encode and transmit data using software available from CMS or software that conforms to CMS standard electronic record layout, edit specifications, and data dictionary, and must include the required OASIS data set. jHAVEN is software provided free from CMS for HHAs to use to submit their OASIS data. More information regarding jHAVEN software can be found at:
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/HAVEN.html.

For questions about jHAVEN, please call the jHAVEN Help Desk at 1-877-201-4721 or send an e-mail to help@qtso.com.

HHAs can also use other software vendors for encoding and transmitting data.

STATE AGENCY OASIS

State agency OASIS staff may be contacted by telephone or facsimile (FAX) for assistance with clinical questions and/or OASIS data submissions. The OASIS education coordinator may be contacted at the following numbers: 225-342-6446 or by FAX at 225-342-0157.

MAIL TO:
Molina / LA. MEDICAID
P.O. BOX 14919
BATON ROUGE, LA. 70898-4919

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
Bureau of Health Services Financing Medical Assistance Program
REQUEST FOR PRIOR AUTHORIZATION

P.A. NUMBER

FAX TO: (225) 929-6803

CONTINUATION OF SERVICES ____YES ____ NO

PRIOR AUTHORIZATION TYPE: (1)
___ 01-Outpatient Surgery Performed Inpatient Hospital
___ 05 Rehabilitation Therapy
___ 09 DME equipment & Supplies
___ 99 Outpatient Surgery Performed Inpatient (CPT Procedures) & All other specialized CPT Procedures

RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER (2)

Social Security No. (3)

RECIPIENT LAST NAME | FIRST | MI (4)

DATE OF BIRTH (5)

MEDICAID PROVIDER NUMBER (7- DIGIT) (6)

BEGIN DATE OF SERVICE (7) (MMDDYYYY)

END DATE OF SERVICE (MMDDYYYY)

P. A. NURSE AND / OR PHYSICIAN REVIEWER'S SIGNATURE: & DATE

DIAGNOSIS : (8)
PRIMARY CODE & DESCRIPTION

SECONDARY CODE & DESCRIPTION

PRESCRIPTION DATE (9) (MMDDYYYY)

STATUS CODES:
2 = APPROVED
3 = DENIED

PRESCRIBING PHYSICIAN'S NAME AND/ OR NUMBER: (10)

DESCRIPTION OF SERVICES

FOR INTERNAL USE ONLY

PROCEDURE CODE (11)	MODIFIERS (11A) Mod 1	Mod 2	Mod 3	Mod 4	DESCRIPTION (11B)	REQUESTED UNITS (11C)	REQUESTED AMOUNT (11D)	AUTHORIZED UNITS	AUTHORIZED AMOUNT	STATUS	P.A. MESSAGE/ DENIAL CODE (S)	

(12)
PLACE OF TREATMENT: ___ RECIPIENT'S HOME ___ NURSING HOME ___ ICF-MR FACILITY ___ OUTPATIENT HOSPITAL / CLINIC

(13)
PROVIDER NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIPCODE _____
TELEPHONE: (___) ___ ___ FAX NUMBER: (___) ___ ___

(14) CASE MANAGER INFORMATION:
NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIPCODE _____
TELEPHONE (___) ___ ___ FAX NUMBER: (___) ___ ___

(15)
PROVIDER SIGNATURE: _____

(16)
DATE OF REQUEST: _____

PA-01 FORM

MAIL TO:
Molina / LA. MEDICAID
P.O. BOX 14919
BATON ROUGE, LA. 70898-4919

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
Bureau of Health Services Financing Medical Assistance Program
REQUEST FOR PRIOR AUTHORIZATION

P.A. NUMBER

FAX TO: (225) 237-3342

CONTINUATION OF SERVICES _____YES _____NO

PRIOR AUTHORIZATION TYPE: (1)	RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER (2)	Social Security No. (3)
06 - Home Health Services	RECIPIENT LAST NAME FIRST MI (4)	DATE OF BIRTH (5)
MEDICAID PROVIDER NUMBER (7- DIGIT) (6)	SERVICE TREATMENT PLAN (7) BEGIN DATE (MMDDYYYY) / END DATE (MMDDYYYY)	IS RECIPIENT CURRENTLY RECEIVING THESE SERVICES (8) _____ YES _____ NO
		P. A. NURSE AND / OR PHYSICIAN REVIEWER'S SIGNATURE: & DATE

DIAGNOSIS : (9)
PRIMARY CODE & DESCRIPTION

SECONDARY CODE & DESCRIPTION

PRESCRIPTION DATE (10) (MMDDYYYY)

STATUS CODES:
2 = APPROVED
3 = DENIED

PRESCRIBING PHYSICIAN'S NAME AND/ OR NUMBER: (11)

DESCRIPTION OF SERVICES

FOR INTERNAL USE ONLY

PROCEDURE CODE (12)	MODIFIERS (12A) Mod 1	Mod 2	Mod 3	Mod 4	DESCRIPTION (12B)	REQUESTED UNITS (12C)	REQUESTED AMOUNT	AUTHORIZED UNITS	AUTHORIZED AMOUNT	STATUS	P.A. MESSAGE/ DENIAL CODE (S)

(13)
PROVIDER NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIPCODE _____
TELEPHONE: (___) _____ _____ FAX NUMBER: (___) _____ _____

(14) CASE MANAGER INFORMATION:
NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIPCODE: _____
TELEPHONE (___) _____ _____ FAX NUMBER: (___) _____ _____

(15)
PROVIDER SIGNATURE: _____

(16)
DATE OF REQUEST: _____

PA-07 FORM

BILLING CODES

Information on procedure codes and the current rates is available at:
https://www.lamedicaid.com/provweb1/fee_schedules/feeschedulesindex.htm.

CONTACT/REFERRAL INFORMATION

Gainwell Technologies

TYPE OF ASSISTANCE	CONTACT INFORMATION
e-CDI technical support	Gainwell Technologies (877) 598-8753 (Toll Free)
Electronic Media Interchange (EDI) Electronic Claims testing and assistance	P.O. Box 91025 Baton Rouge, LA 70898 Phone: (225) 216-6000 Fax: (225) 216-6335
Pharmacy Point of Sale (POS)	P.O. Box 91019 Baton Rouge, LA 70821 Phone: (800) 648-0790 (Toll Free) Phone: (225) 216-6381 (Local) **After hours, please call REVS*
Prior Authorization Unit (PAU)	Gainwell Technologies – Prior Authorization P.O. Box 14919 Baton Rouge, LA 70898-4919 (800) 488-6334
Provider Enrollment Unit	Gainwell Technologies - Provider Enrollment P. O. Box 80159 Baton Rouge, LA 70898-0159 (225) 216-6370 (225) 216-6392 Fax
Provider Relations Unit	Gainwell Technologies – Provider Relations Unit P. O. Box 91024 Baton Rouge, LA 70821 Phone: (225) 924-5040 or (800) 473-2783 Fax: (225) 216-6334
Recipient Eligibility Verification (REVS)	Phone: (800) 766-6323 (Toll Free) Phone: (225) 216-7387 (Local)

Louisiana Department of Health (LDH)

TYPE OF ASSISTANCE	CONTACT INFORMATION
General Medicaid Hotline (Customer Service)	(888) 342-6207 (Toll Free) http://ldh.la.gov/index.cfm/subhome/1/n/10 MedWeb@la.gov
General Medicaid Information for Providers	www.lamedicaid.com
Health Standards Section (HHS)	P.O. Box 3767 Baton Rouge, LA 70821 Phone: (225) 342-0138 Fax: (225) 342-5073 HSS.Mail@la.gov
Louisiana Children's Health Insurance Program (LaCHIP)	(225) 342-0555 (Local) (877) 252-2447 (Toll Free) http://ldh.la.gov/index.cfm/page/222
Office of Aging and Adult Services (OAAS)	P.O. Box 2031 Baton Rouge, LA 70821 Phone: (866) 758-5035Fax: (225) 219-0202 OAAS.Inquiries@la.gov http://ldh.la.gov/index.cfm/subhome/12
Office of Management and Finance (Bureau of Health Services Financing (BHFS))	P.O. Box 91030 Baton Rouge, LA 70821 http://ldh.la.gov/index.cfm/page/23
Office for Citizens with Developmental Disabilities (OCDD)	628 N. Fourth Street Baton Rouge, LA 70802 Phone: (225) 342-0095 (Local) Phone: (866) 783-5553 (Toll-free) E-mail: ocddinfo@la.gov

TYPE OF ASSISTANCE	CONTACT INFORMATION
Rate Setting and Audit Hospital Services	P.O. Box 91030 Baton Rouge, LA 70821 Phone: 225-342-0127 225-342-9462
Beneficiary Assistance for Authorized Services	Phone: (888) 342-6207 (Toll Free)
Recovery and Premium Assistance Third-Party Liability (TPL) Recovery, Trauma	P.O. Box 3588 Baton Rouge, LA 70821 Phone: (225) 342-1376 Fax: (225) 342-5292

Fraud hotline

TYPE OF ASSISTANCE	CONTACT INFORMATION
To report fraud	Program Integrity (PI) Section P.O. Box 91030 Baton Rouge, LA 70821-9030 Fraud and Abuse Hotline: (800) 488-2917 Fax: (225) 219-4155 http://dhh.louisiana.gov/index.cfm/page/219

Appeals

TYPE OF ASSISTANCE	CONTACT INFORMATION
To file an appeal	Division of Administrative Law (DAL) - Health and Hospitals Section Post Office Box 4189 Baton Rouge, LA 70821-4189 (225) 342-0443 (225) 219-9823 (Fax)

Other Helpful Contact Information:

TYPE OF ASSISTANCE	CONTACT INFORMATION
Centers for Medicare and Medicaid Services OASIS, CMS-485 Form	https://www.cms.gov
Governor's Office of Homeland Security and Emergency Preparedness (GOSHEP) **See: Louisiana Model Plans for Home Health Template**	http://gohsep.la.gov/PREPARE/PLANNING-OVERVIEW
Southeastrans Transportation Inc. Transportation Call Center	Phone: (855) 325-7576

UB-04 FORM AND INSTRUCTIONS

Claims for home health services must be filed by electronic claims submission 837I or on the UB-04 claim form.

The most recent instructions for completing the UB-04 form along with samples of UB-04 claim forms for home health services routine billing are located on the home page of the Louisiana Medicaid website at www.lamedicaid.com.

The billing instructions and examples for completing the UB-04 form may also be accessed at:
http://www.lamedicaid.com/provweb1/billing_information/Home_Health_UB04.pdf.