MDHHS Michigan Department of Health & Human Services

Medical Services Administration

BULLETIN MSA

Bulletin Number: MSA 18-12

Distribution: Medicaid Home Health Agencies, Practitioners

Issued: May 25, 2018

Subject: Prior Authorization Requirements for Home Health Services

Effective: July 1, 2018

Programs Affected: Medicaid

This policy applies to Medicaid Fee-for-Service (FFS). Medicaid Health Plans (MHP) must provide the full range of covered services described in this policy at a minimum and may choose to provide services over and above those specified. For beneficiaries enrolled in an MHP, the provider must check with the beneficiary's health plan for prior authorization requirements.

The purpose of this bulletin is to notify Medicaid Home Health Agencies (HHAs) of changes to Medicaid Home Health policy. Effective July 1, 2018 services provided by a home health aide will require prior authorization (PA) for all Medicaid beneficiaries after the initial 90 days of services, and every 90 days thereafter for continuation of services. The Program Review Division will require submission of PA requests for services provided on or after August 1, 2018. The PA and documentation requirements listed in this bulletin apply to all affected Medicaid beneficiaries.

I. General Information

Home health is a covered Medicaid benefit for beneficiaries who require services on an intermittent basis for treatment of an injury, illness, or disability. An HHA is an organization that provides home health services, such as skilled nursing, physical therapy (PT), occupational therapy (OT), speech therapy (ST), and care by home health aides. Home health services must be medically necessary, ordered by a physician, and provided in any setting in which normal activities take place and does not include services in a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities (ICF/IID). It is the responsibility of the HHA to comply with Medicare Conditions of Participation (42 CFR §484).

At times, the request to begin services will be submitted by the certifying physician; however, a person other than the certifying physician (e.g., physicians who attend to the beneficiary in the acute and post-acute setting) may certify the medical need for home health aide services. The physician attending to the needs of the beneficiary in the acute and post-acute setting certifying medical need for home health aide services must complete the face-to-face encounter and initiate the Plan of Care (POC) for home health services. In the event that the physician in the acute or post-acute setting is certifying the need for home health aide services, the beneficiary's care must "handed off" to the community-based physician to review and sign off on the POC.

II. Definition of Home Health Aide

The home health aide is a covered benefit for health services on an intermittent basis that must be medically necessary and ordered by the attending physician. Consistent with 42 CFR §440, home health aide services are not contingent on the receipt of skilled nursing or therapy services. Also, the qualifications and training provided by the home health aide must comply with regulations outlined in 42 CFR §484.80.

Care provided by the home health aide must be for a specific beneficiary and supervised by a Registered Nurse (RN) or other appropriate skilled professional (e.g., PT, OT, ST) with written care instructions for the beneficiary's care. It is the responsibility of the supervising RN or another appropriate skilled professional to co-sign all documentation completed by the home health aide. The home health aide services and written instructions must be consistent with the home health aide competencies and consistent with the medical needs of the beneficiary. Services provided by the home health aide are not solely to prevent an illness, injury, disability, or based on convenience.

III. Home Health Aide Prior Authorization

Home health aide services for Medicaid beneficiaries must be authorized by the Michigan Department of Health and Human Services (MDHHS) Program Review Division after the initial 90 days, and every 90 days thereafter if continued services are deemed medically necessary.

Effective July 1, 2018, the Program Review Division will require the servicing HHA to submit the MSA-181 form for all services provided on or after August 1, 2018 each time services are requested for:

- continuation of services beyond the initial 90 days;
- continuation of services beyond the end date of the current authorization period (renewal);
- an increase in services; or
- a decrease in services.

After the initial 90 days, home health aide services may be provided up to a maximum of 36 visits within 90 consecutive calendar days. If the beneficiary's attending physician orders home health aide services, the HHA must assess the availability of the family or another entity (e.g., Home Help Program or MI Choice Waiver) to perform the services. Physicians ordering home health aide services must determine that medical services are medically necessary and appropriate for continuation of services beyond the initial 90 days, and for each PA request thereafter.

In some cases, the beneficiary's attending physician may order home health aide services that extend beyond the maximum of 36 visits within 90 consecutive calendar days. For requests that extend beyond 36 or more visits within 90 consecutive calendar days, the PA request will be reviewed for medical appropriateness, the availability of the family or another entity (e.g., Home Help Program or MI Choice Waiver), and the cost effectiveness of other programs available for the beneficiary.

Following receipt and review of the Home Health Aide Prior Approval Request/ Authorization form (MSA-181) and the required documentation by the Program Review Division, a determination notification is sent to the HHA and beneficiary or primary caregiver indicating the outcome of the review (a copy of the MSA-181 is attached). If approved, the notification letter will contain the PA number and approved authorization dates. It is important to include this PA number on every claim and in all other communications to the MDHHS Program Review Division.

If a beneficiary receiving home health aide services continues to require the services after the initial authorization period, a new MSA-181 must be submitted by the HHA along with the required documentation to support medical necessity for continuation of services beyond the approved authorization dates. This request must be received by the Program Review Division no less than 15 business days before the end of the current authorization period. Failure to do so may result in a delay of authorization for continued services which, in turn, may result in delayed services or no payment for services rendered without authorization. The length of each subsequent authorization period will be determined upon review by the Program Review Division and will be specific to each beneficiary based on several factors, including the beneficiary's medical and functional needs, personal care services through another entity (e.g., Home Help Program, waiver services, or other community services), and family or caregiver support.

IV. Documentation Requirements

The following documentation is required for all initial PA requests for Home Health aide services and must accompany the MSA-181:

- documentation of the Face-to-Face encounter;
- all components of the POC as identified in 42 CFR §484 and MDHHS policy;
- OASIS; and
- other documentation as requested by MDHHS.

The documentation listed above is also required at subsequent 12-month intervals. The anniversary date is the date 12 months from the date services were first provided.

- For services beyond the initial authorized 90 days and for subsequent requests, the MSA-181, an updated POC complete with all components, and other documentation as requested by MDHHS must be submitted to the Program Review Division for review.

- If a beneficiary's condition changes during an authorization period, warranting an increase or decrease in the number of approved hours or discontinuation of services, the HHA must report the change to the Program Review Division. It is important that the HHA report all changes as soon as they occur, as well as properly update the POC and written instructions for the home health aide.

- To request an increase in hours, the following are required:
  - an updated MSA-181 indicating the increase in hours;
  - an updated and signed POC; and
  - documentation from the attending physician.

- To request a decrease in hours, the following are required:
  - an updated MSA-181 indicating the decrease in hours; and
  - an updated and signed POC.

PA and documentation requirements listed in this bulletin apply to all Medicaid beneficiaries.

V. Definition of Medical Necessity

Home health aide services must be reasonable to support the beneficiary's medical and functional needs based on the beneficiary's medical condition and associated symptoms. Documentation to support medical necessity must include the beneficiary's progress or lack of progress, medical condition, functional losses, and treatment goals (e.g., the POC). MDHHS identifies criteria for medical necessity as one or more of the following that directly impact the beneficiary's medical and functional needs:

- New onset or acute exacerbation of diagnosis (supportive documentation must include the date of the new onset or acute exacerbation)
- New or changed prescription medications (e.g., newly prescribed medications within the last thirty days or changed dosage, frequency, or route of administration within the last 60 days; including but not limited to diagnosis such as diabetes or hypertension);
- Recent hospitalizations (must include the date and reason for the hospitalization);
- Recent discharge from an acute or post-acute setting (e.g., skilled nursing facility);
- Change in caregiver status, absence of a caregiver, or unstable caregiving situation; or
- Complicating factors (e.g., presence of Stage III or IV decubiti).

The beneficiary's medical necessity must be clearly identified by the physician and documented in the POC. All PA requests will be considered on an individualized basis to determine medical necessity, reasonableness for home health aide services, and consistency with MDHHS policy.

VI. Personal Care Services

In some cases, the beneficiary may receive home health aide services and personal care services through another entity (e.g., Home Help, MI Choice Waiver). Home health aide services may not be duplicative in nature with other personal care services (e.g., Home Help, MI Choice Waiver) and cannot occur simultaneously with other personal care services on any given day.

It is the responsibility of the HHA to identify other services the beneficiary may be receiving to ensure the services of the home health aide and personal care services through another entity (e.g., Home Help, MI Choice Waiver) are not duplicative in nature, nor occur simultaneously. There must be coordination between the two providers and documentation in the POC to verify there is no duplication, or simultaneous receipt of personal care services.

VII. Reminders Regarding Prior Authorization

A. Retroactive Prior Authorization

Services provided before PA is approved will not be covered unless the beneficiary was not Medicaid eligible on the date of service but became eligible retroactively. If MDHHS eligibility information does not demonstrate retroactive eligibility, then the request for retroactive PA will be denied.

B. Beneficiary Eligibility

Approval of the MSA-181 confirms that the service is authorized for the beneficiary. The approval does not guarantee that the beneficiary is eligible for Medicaid. If the beneficiary is not eligible on the date of service, MDHHS will not reimburse the provider for services provided and billed. To assure payment, the HHA must verify beneficiary eligibility monthly at a minimum.

Public Comment

The public comment portion of the policy promulgation process is being conducted concurrently with the implementation of the change noted in this bulletin. Any interested party wishing to comment on the change may do so by submitting comments in writing to:

Attn: Michelle Tyus
MDHHS/MSA
PO Box 30479
Lansing, Michigan 48909-7979
Or
E-mail: TyusM@michigan.gov

If responding by e-mail, please include "Prior Authorization Requirements for Home Health Services" in the subject line.

Comments received will be considered for revisions to the change implemented by this bulletin.

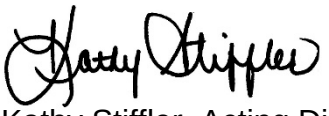
Manual Maintenance

Retain this bulletin until the information is incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved



Kathy Stiffler, Acting Director
Medical Services Administration

Michigan Department of Health and Human Services
Completion Instructions for MSA-181
Home Health Aide Prior Approval Request/Authorization

General Instructions

The MSA-181 must be used by Medicaid enrolled and home health agencies to request Prior Authorization (PA) for home health aide services. MDHHS requires that the MSA-181 be typewritten; handwritten forms will not be accepted. A Word fill-in enabled version of this form can be downloaded from the MDHHS website www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Forms.

This form must be used to request Prior Authorization (PA) for home health aide services for beneficiaries with Medicaid. A request to begin services may be submitted by a person other than the home health agency such as the hospital Discharge Planner or physician. When this is the case, the person submitting the request must do so in consultation with the beneficiary (parent or guardian if applicable), and home health agency who will be assuming responsibility for the care of the beneficiary.

PA may be authorized for a period not to exceed ninety days. If need for home health aide services are medically necessary, a subsequent request for PA must be submitted. The provider should retain a copy of the PA form until the approval or denial is returned.

Refer to the Medicaid Provider Manual, Home Health Chapter, Prior Authorization Subsection, for the listing of required documentation to accompany each request.

Completion of this form is as follows:

Item#	Instructions
1	Prior Authorization Number. MDHHS use only.
2	The Home Health Agency Provider Name.
3	The Medicaid enrolled provider's name and National Provider Identifier (NPI).
4-9	The Home Health Agency provider's telephone number (including area code), address and fax number (including area code).
10	**Initial:** The authorization request is the initial prior authorization request for the beneficiary under this treatment plan. **Continuing:** The treatment authorization request is to continue treatment for additional calendar month(s) of service under this treatment plan.
11-19	Beneficiary information. Provide complete name, sex, mi health card number, date of birth, complete address (including city, state, and zip code), and phone number.
20-21	Enter the beneficiary's diagnosis(es) code(s) and and onset date that relate to the service being requested.
22	The beneficiary's most recent hospital discharge date for the requesting prior authorization period.
23-25	Hospital information including complete address and phone number, anticipated discharge date, and name and contact information of Discharge Planner, if beneficiary is currently hospitalized.
26	The date MDHHS signed the last approved prior authorization request for the given diagnosis.
27	The total number of visits the service is to be provided during the requested prior authorization period.
28	The date home health services was started for the given diagnosis (if home health aide services were previously provided).
29	The previous total number of visits rendered since the initiation this treatment plan.
30	The authorization request is an increase or decrease from previous authorization request.
31	List the beneficiary's current medications relevant to the medical diagnosis.
32	Documentation of the beneficiary's cognitive status.
33	Identify the beneficiary's ability to complete range of motion for upper and lower extremities.
34	Evaluation includes OASIS coding of the beneficiary. **OASIS Coding** 06 **Independent** – Patient completes the activity by him/herself with no assistance from a helper. 05 **Setup or clean-up assistance** – Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity. 04 **Supervision or touching assistance** – Helper providers VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently. 03 **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.

	02 **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. 01 **Dependent** – Helper does ALL the effort. Patient does noon of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity. **If activity was not attempted, code reason:** 07 **Patient refused** 09 **Not applicable** 88 Not attempted due to **medical condition or safety concerns**
35	Indicate the service and frequency of the service for this authorization request.
36	Identify the medical need for additional services. Service request must be specific, include supportive documentation of the beneficiary's current level of function and the medical necessity of requested service(s).
37	List all other services in the home. Must include the frequency of the service(s) and payer(s). Failure to disclose all services in the home may result in recoupment of Medicaid dollars for home health aide reimbursement.
38	Signature certifies that Parent/Guardian of beneficiary attests that information provided on this form is accurate and complete to the best of their ability. All unsigned requests will be returned for signature.
39	The Physician's signature certifies that (1) the Home Health agency requesting the services understands the medical necessity for obtaining prior authorization for Home Health services and; (2) the information provided on this form is accurate and complete. All unsigned requests will be returned for signature.
40	The licensed supervising professional's signature certifies that (1) the licensed, registered nurse, physical therapist, occupational therapist, or speech/language therapist provides supervision of the home health aide; (2) the services are medically necessary for obtaining prior authorization for Home Health aide services and; (2) the information provided on this form is accurate and complete. All unsigned requests will be returned for signature.
41-42	MDHHS use only

RETURN COMPLETED FORM AND REQUIRED DOCUMENTATION TO:

MDHHS
Program Review Division
PO Box 30170
Lansing, MI 48909

OR

Fax to: 517-335-0075

Questions should be directed to MDHHS - Medical Services Administration, Program Review Division via telephone at **1-800-622-0276.**

Authority: Title XIX of the Social Security Act.	**Completion**: Is voluntary but is required if payment from applicable programs is sought.
The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs, or disability.	

HOME HEALTH AIDE
PRIOR APPROVAL REQUEST/AUTHORIZATION

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

The provider is responsible for eligibility verification.
Approval does not guarantee beneficiary eligibility or payment.

1. Prior Authorization Number (MDHHS USE ONLY)

MDHHS requires this form to be typewritten; handwritten forms will not be accepted.

2. Home Health Agency Provider Name	3. Provider NPI Number	4. Provider Phone Number	5. Provider Fax Number

6. Home Health Agency Provider Address (Number, Street, Building, Suite Number, etc.)	7. City	8. State	9. Zip Code

10. Home Health Aide Authorization Request ☐ Initial ☐ Continuing

11. Beneficiary Name (Last, First, Middle Initial)	12. Beneficiary Date of Birth	13. Sex	14. mi health ID Number	15. Beneficiary Telephone Number
		☐ M ☐ F		- -

16. Beneficiary Address (Number, Street, Apt/Lot, etc.)	17. City	18. State	19. ZIP Code

20. Medical ICD Diagnosis(es) Code(s) Requiring Home Health Services	21. Onset Date	22. Most Recent Hospital Discharge Date

23. Primary Caregiver(s)	24. Relationship(s) to Beneficiary	25. Primary Caregiver(s) Phone Number(s)
		- -
		- -

26. Date of Last Authorization	27. Date of Request	28. Date Home Health Aide Service(s) Started	29. Number of Previous Visits	30. Number of Visits Requested compared to Last Authorization
	Start Date: End Date: Frequency:			☐ Increase ☐ Decrease

Beneficiary's Current Functional Level and Services

31. List Current Medications:

32. Cognitive: ☐ Alert/oriented ☐ Able to Direct Care ☐ Impaired/Developmental Delay ☐ Disoriented ☐ Unresponsive

33. Range of Motion Exercises: Upper Extremity: ☐ Independent ☐ Requires Assistance / Dependent

Lower Extremity: ☐ Independent ☐ Requires Assistance / Dependent

34. SCORE: (see instructions)	06	05	04	03	02	01	07	09	88	35. Services & frequency to be performed by aide
Bathing/Skin Care	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Toileting	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Grooming	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Oral Hygiene	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Eating	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Transfers	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Positioning	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ambulation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Medication Management, if applicable	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Laundry	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Shopping	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Vital Signs										☐

36. Other Services (Must specify service(s) include documentation of current level of function and medical necessity for each)

See pg. 2

Beneficiary Name: _____ mi health ID Number: _____

37. Other Services Currently Received By Beneficiary (Check All)				Frequency	Payer
Skilled Nursing Visits	☐ No	☐ Yes			
Private Duty Nursing	☐ No	☐ Yes			
Physical Therapy	☐ No ☐ Home	☐ Yes ☐ School	☐ Outpatient		
Occupational Therapy	☐ No ☐ Home	☐ Yes ☐ School	☐ Outpatient		
Speech Therapy	☐ No ☐ Home	☐ Yes ☐ School	☐ Outpatient		
Home Help	☐ No	☐ Yes			
Community Living Services (CLS)	☐ No	☐ Yes			
Other Behavioral Health Services	☐ No	☐ Yes	Specify:		
Waiver Services	☐ No	☐ Yes	Specify:		
Hospice	☐ No	☐ Yes			
Other Services	☐ No	☐ Yes	Specify:		

☐ Home Health Agency Plan of Care Attached (Most Recent Plan Of Care Must Accompany Request)

☐ Copy of Oasis Must Be Attached With Initial Request And Annually Thereafter

38. PATIENT (PARENT / GUARDIAN IF APPLICABLE) CERTIFICATION	39. PHYSICIAN CERTIFICATION	40. LICENSED SUPERVISING PROFESSIONAL CERTIFICATION
I, the patient (parent/guardian) named above, understand the necessity to request prior authorization for the medically necessary services indicated. I understand that services requested herein require prior authorization and, if approved and submitted by the agency on the appropriate invoice, payment of authorized services will be from general and/or state funds. I understand that any false claims, statements or documents, or concealment of a material fact may lead to prosecution under applicable federal and/or state law. I hereby attest that information provided on this form is accurate and complete to the best of my ability.	I certify that I have examined the patient named above and have determined that home health aide services are medically necessary, as supervised by a licensed, registered nurse or other authorized licensed professional. I understand that home health aide services require prior authorization to validate that such services are deemed medically necessary in accordance with Michigan Medicaid Provider Manual policy. I understand that any false claims, statements or documents, or concealment of a material fact may lead to prosecution under applicable federal and/or state law. I hereby attest that information provided on this form is accurate and complete to the best of my ability.	I hereby attest as a licensed professional (registered nurse, physical therapist, occupational therapist, or speech/language pathologist) that supervision of the home health aide is under my authority and deemed medically necessary. I understand that services requested herein require prior approval and, if approved and submitted on the appropriate invoice, payment of approved services will be from federal and/or state funds. I understand that any false claims, statements or documents, or concealment of a material fact may lead to prosecution under applicable federal and/or state law. I hereby attest that information provided on this form is accurate and complete to the best of my ability.
PATIENT NAME (PARENT / GUARDIAN) PRINTED SIGNATURE DATE	PHYSICIAN NAME PRINTED SIGNATURE DATE	SUPERVISING PROFESSIONAL NAME PRINTED SIGNATURE / CREDENTIALS DATE

MDHHS USE ONLY

41. REVIEW ACTION:
☐ APPROVED ☐ DENIED
☐ RETURN ☐ NO ACTION
☐ APPROVED AS AMENDED

42. CONSULTANT REMARKS AND AUTHORIZATION PERIOD IF APPROVED:
☐ See CHAMPS ☐ KEEP IN FILE

☐ KEEP IN FILE

☐ KEEP IN FILE

CONSULTANT SIGNATURE / DATE