HOME HEALTH AUTHORIZATION PROCESS

FREQUENTLY ASKED QUESTIONS

HOME HEALTH AUTHORIZATION PROCESS PROVIDER QUESTIONS

Recent updates are in *blue italics*: The most recent changes and additions to the frequently asked questions are presented in blue italic text. The revision date in the lower right corner of each page indicates the date those revisions were made.

Q: When were providers notified of the new home health care authorization process change?

A: The initial provider communication was posted online in the Provider Resource Center on March 14, 2016, advising home health care providers that Highmark is simplifying the process for submitting home health care authorization requests. The second provider communication announcing the new training webinar was posted on the Provider Resource Center on July 11, 2016. A corresponding reference guide became available on July 25, 2016.

Q: Will provider reimbursement be affected? *UPDATED*

A: Providers who are reimbursed episodically may experience an impact in the level of payment that they receive with this new process. There are many different factors that are taken into account for the bundled reimbursement methodology. We understand that the number of therapy visits that are provided can change the payment equation used under the case mix model. You should be aware that in the instance that a lesser amount of therapy visits are approved (than what is desired), the bundled payment level will reflect that lesser amount.

Q: What services are excluded from this new process?

A: Any pediatric, private duty nursing, psychiatric, dietician, diagnostic lab, or home infusion services are excluded from this new process and will follow the normal business-as-usual process for authorization requests through NaviNet®.

Q: Can changes be made to an OASIS file after it has been submitted to Highmark?

A: The initial authorization decision will be based on the initial OASIS file submitted. The OASIS file must be completed before submission. If errors are found within the file, the provider will be advised. Once corrected, the file will need to be uploaded again. The capability will not exist for corrections to be made within the authorization request process.

Q: Can an authorization request be saved if it is not completed once started?

A: Yes. One of the new features of this new process allows the provider to save the assessment being created, if it is not completed. The request will not be lost.

Q: Will we now be required to submit OASIS data for commercial patients?

A: Like the Centers for Medicare & Medicaid Services (CMS), Highmark will also require OASIS data for authorizations, as a condition of payment. It's also important for measuring quality outcomes.

Q: How are individual OASIS Assessments pulled into NaviNet?

A: The CMS ZIP file contains multiple XMLs; however, you should be able to search the files in order to pull individual assessments (possibly by patient last name, DOB, etc.). You would use the **Find** feature on your computer.

Q: What is the contingency plan for any issues related to the software and/or data exporting that may arise on or after Aug. 1, 2016?

A: Providers should contact the NaviNet Help Desk if they experience any technical process issues. The contact phone number is 1-888-482-8057. Questions about the authorizations or the changes that were made to the process should be directed to Provider Services at 1-800-242-0514 for (363 Enrollment) or 1-866-803-3708 for (378 Enrollment).

Q: Should we start the new process only with new admissions as of Aug. 1, 2016? How do we handle the current patients (i.e., "transition" patients) who are in the midst of an episode on Aug. 1, 2016?

A: The portal process changes Aug. 1, 2016, for all initial and extension requests. Initial authorization requests (first request for a patient episode) made on or after Aug. 1, 2016, can include new admission or recertification episodes beginning up to 14 days prior. For commercial members, if a start of care was begun prior to Aug. 1, 2016, and your OASIS forms are not available, you may submit those requests via phone to our Care Management department by calling 1-800-547-3627. Medicare member authorization requests should be submitted via the portal with the most recent OASIS forms available.

Q: What if there is a need for additional nursing visits after the initial authorization has been approved?

A: Providers will submit an extension request, which also follows a new process and requires the most recent OASIS assessment (which may be the same as the initial request).

Q: Can we send you the Discharge OASIS files on several patients at one time?

A: Yes. The Discharge OASIS files can be uploaded for individual patients **or** in batch files. Either way, the file format is identical to the CMS required XML format. If submitting a batch of XML files, they must be included in a single Zip file.

Q: Is there a timeframe on the transfer and discharge uploads?

A: Submitting OASIS discharge and transfer assessments in a timely fashion allows home health providers to demonstrate the quality of care provided to Highmark members. While there is no specific requirement, CMS requires OASIS files within 30 days. Highmark believes this to be a reasonable expectation.

Q: The EMR batches the OASIS files, can this be sent as a batch for everything or just the transfer uploads?

A: Any OASIS file type can be included in the batch upload; however, the provider portal will only accept OASIS Transfer/Discharge assessments (M0100 Reason for Assessment = 6, 7, 8, or 9). All other OASIS assessment types will be rejected.

Q: When we request initial authorization from Highmark, now that they will all be an episode of care, do we continue to pick the strongest discipline to obtain the episode authorization or do we enter clinical for each discipline?

A: All medically necessary and justified disciplines should be submitted together on the initial authorization whenever possible. Additional disciplines can always be requested at a later date.

Q: Will we be required to "stack" additional requests for authorization on the commercial plans?

A: Subsequent authorization requests for the same discipline within the same episode will be pended for nurse review, regardless of the plan.

Q: If the orders change during the course of the "episode," would we upload the new order?

A: Any change in patient condition that requires a request for additional visits can be documented and included within the request for additional visits (Continued Stay Review).

Q: Are these authorizations provided in G codes? If so, can the RN and LPN designation be used under G0299, or is a separate authorization required for the LPN?

A: G0299 should be used for skilled nursing requests regardless of RN or LPN designation.

Q: Will the system deny authorizations if the criteria are not met?

A: No. The new authorization process is not designed to deny authorizations. Only Highmark medical directors have the authority and capability to deny authorization requests. The new process will pend the request and notify a Highmark nurse reviewer when criteria are not met and additional review is necessary. The nurse reviewer will contact the home health provider to request additional information.

Q: What software exists for providers to be able to save or regenerate OASIS files once they have already been submitted to CMS?

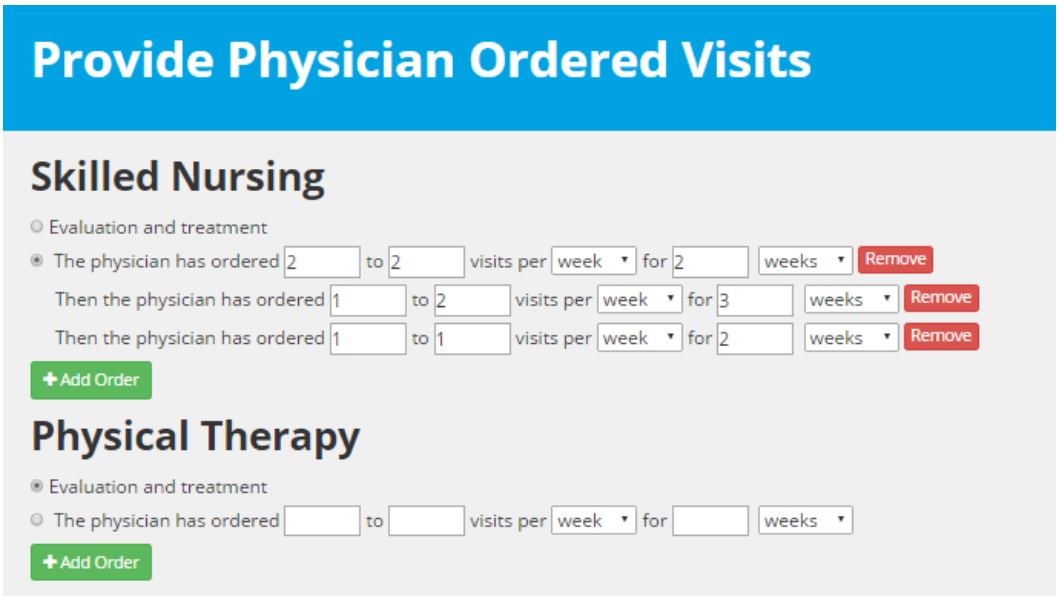
A: Cerner, McKesson, and Homecare Homebase are three of the market leaders in the home health software arena. Files can easily be filtered and generated by patient, date range, etc. Some capabilities also exist for files to be rechecked and recreated as needed.

Q: Can agencies submit discharge or transfer assessments for patients that Highmark may not have a start of care (SOC), resumption of care (ROC) or recertification? This would affect patients who were already on service prior to Aug. 1, and did not previously require an OASIS.

A: Yes.

Q: The NaviNet system only allows for one visiting pattern per discipline and typically, the agencies write multiple visiting patterns per discipline. In other words, the physician might order SN 3w4, 2w2 and NaviNet just offers a range of _ to _ for _ weeks. How should agencies enter this information? Can the software be edited to allow multiple fields for this question?

A: We have enhanced our software. The following screen within the process will now allow providers to add additional orders:



Q: Are agencies able to "split" authorized therapy visits among disciplines? For instance, if the agency was approved for six physical therapy visits and six occupational therapy visits, and the physical therapist saw the patient for eight visits and the occupational therapist saw the patient for four, would the extra two physical therapy visits still be paid even though the authorization specified only six physical therapy visits?

A: Claims are matched based on authorization number and dates of service. Providers should feel free to allocate therapy visits as the member needs. However, we do not recommend interchanging nursing and medical social worker visits.

Q: When performing a ROC OASIS assessment for a patient who is not also receiving a recertification, the agency will not have a 485 to submit along with the OASIS. In this instance, would it be appropriate to submit the ROC OASIS and the physician orders for the resumption of home health services?

A: Yes.

Q: If new orders are received in the middle of an episode for disciplines not already in the current authorization, should an agency send the OASIS and orders, or just the orders?

A: Updates with OASIS are required for the following:

- Provider requests extension of visits (additional disciplines) within the 60-day certification period (in this case, it would be the most recent OASIS)
- Resumptions of care
- Recertification
- Transfer of care
- Discharges

Q: Do agencies need an OASIS and 485 for a one-time visit, since there is not a plan for continued care?

A: No. A one-time visit is considered an evaluation visit. No authorization is required.

Q: Some providers have noticed transposed numbers of visits in NaviNet. Should I be concerned?

A: No. This issue has been resolved with NaviNet and the Highmark technical developers. There should be no claims impact.

Q: What should the provider do when they are attempting to answer the Skilled Need/Homebound questions but are not able to find the appropriate reason that applies to the patient?

A: When verifying the patient's homebound status or skilled need justification, there are multiple reasons to choose from. The list can be filtered based on the domains at the top of the screen. Choose all that apply. Multiple options can be selected on this screen. If the appropriate reason is not listed, choose **Reason Not Listed** and enter text to support this status. **Please note**: The field is limited to 250 characters.

Q: What is the difference between an initial visit and a continued stay review (CSR) (extension)?

A: There is a very important distinction between initial versus continuation requests. As each authorization is for a 60-day episode, the **first** request for any services within an episode of care should be submitted as "Initial." For example, if you are submitting a new request for nursing and physical therapy, you would choose "Initial." Later on during the 60-day episode, if you are submitting a request to add occupational therapy, for example, you would also choose "Initial," since it is the first request for that discipline during this episode.

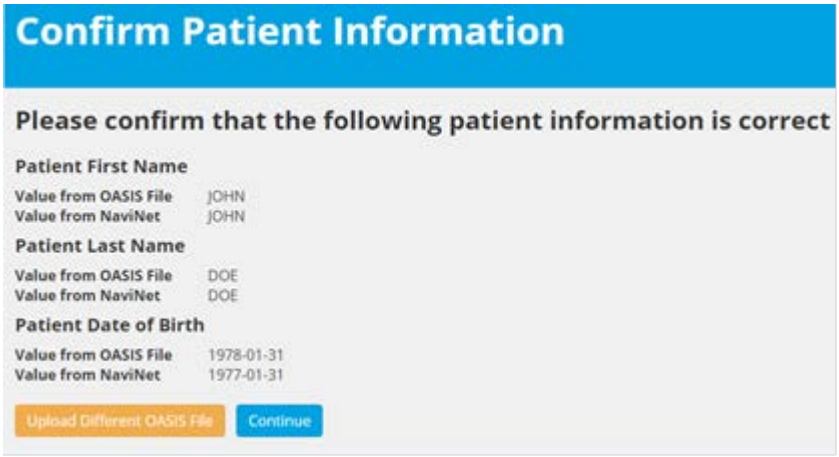
The same would be true for resumptions of care (following an inpatient stay) and recertification requests, meaning requests for a new 60-day episode. For resumptions of care during a 60-day episode, your request covers the balance of the 60-day episode. However, if the resumption occurs during the last 5 days of a 60-day episode, your request will automatically be submitted for the next 60-day episode period.

An "Initial" request is for any new service. For example, the SOC date was Aug. 1, and a physical therapist or occupational therapist provided a service. On Aug. 5, the member needs registered nurse visits. The registered nurse visits are considered initial and should auto approve for your agency.

A CSR is defined as a service that the member has previously received within the 60-day certification period. For example, 20 registered nurse visits were allocated and now additional registered nurse visits are needed.

Q: ***What should the provider do if they notice that they uploaded the incorrect OASIS file for a patient?***

A: *Please be sure to double check the patient name shown on the screen once the OASIS file is uploaded. If the name is incorrect, the provider should cancel the case and start over to avoid erroneous authorizations being processed. In the event that the case is submitted incorrectly, you will be prompted to confirm the patient information. See screen below.*



Q: ***What will happen to the case that was submitted incorrectly?***

A: *If the case was submitted incorrectly and processed in error, you may receive a notice that the authorization was canceled by an administrator. The discipline requested as well as the overall status will both be reflected as canceled. See screens below.*