Acentra HEALTH

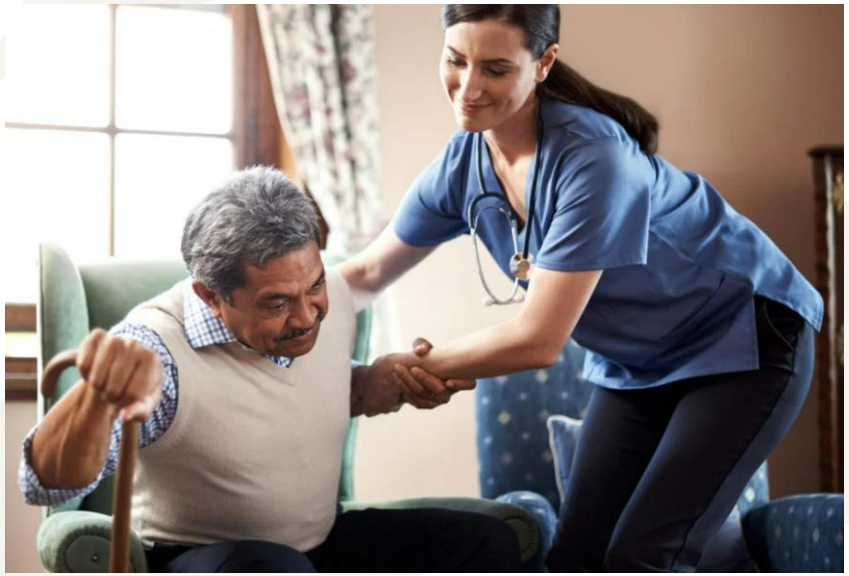
Home Health

Provider Education 2023-2024

Home Health

- Home health services are those services provided by a Home Health Agency or individual provider to eligible Medicaid beneficiaries who are affected by illness or disability. Home health services are based on physician’s orders.

- Home health visits are limited to a total of 50 per recipient 21 years of age and older per state fiscal year. The state fiscal year begins on July 1 and ends June 30 each year. Any medically necessary visits exceeding the yearly maximum will require prior authorization from Acentra Health.
  - Providers may verify the visit count by utilizing the South Carolina Medicaid Web Tool.



Home Health

Covered Services

- Nursing Services
- Pediatric Home Health
- Home Health Aide
- Physical Therapy
- Occupational Therapy
- Speech/Audiology services

Non-Covered Services

- Full-time nursing services
- Drugs and biologicals
- Meals delivered to the home
- Homemaker services
- Care focused primarily on treatment of mental diseases
- Medical rehabilitation facilities
- Routine supplies
- Supervisory nursing visits
- Social work

**detailed program features can be found in the SCDHHS Home Health Services Provider Manual

Prior Authorization Requests

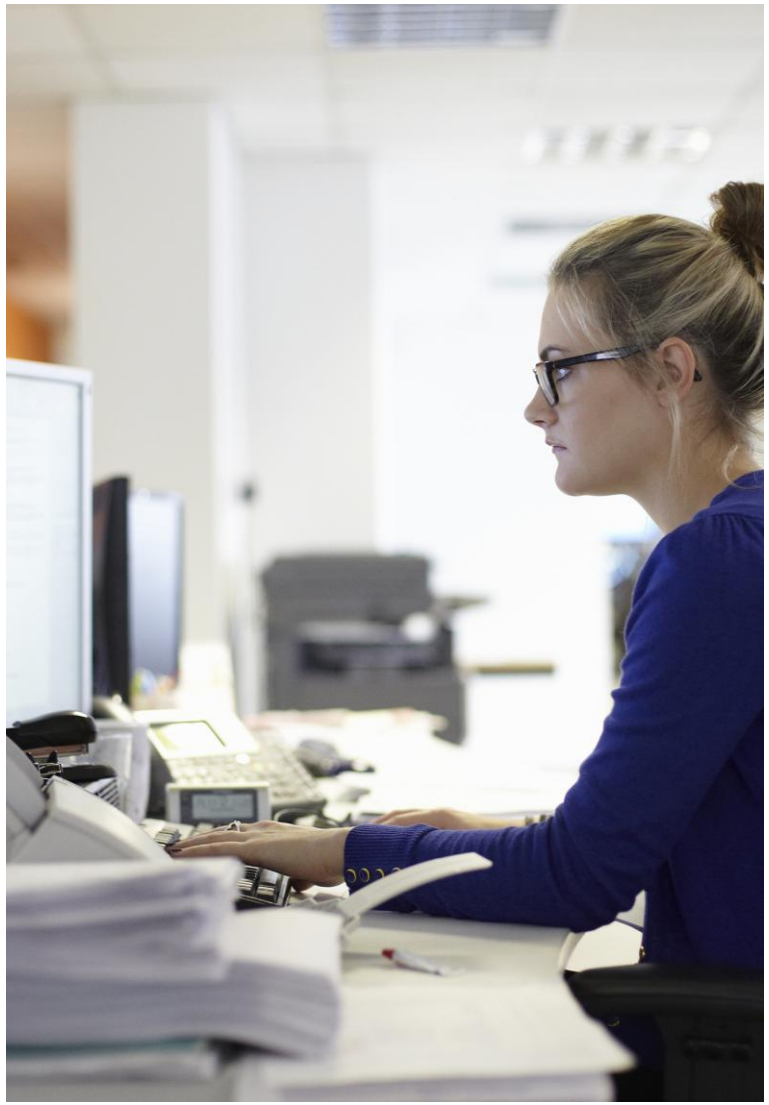
Authorization requests should be submitted prior to services being rendered

For Home Health – authorization requests should be submitted when the member requires visits that will exceed the policy maximum (50) per fiscal year

Authorization requests may be submitted online at https://portal.kepro.com or by fax using the Outpatient Prior Authorization Request form

When requesting authorization for visits that exceed yearly maximum of 50, please include supporting medical documentation that includes the plan of care and clinical notes justifying the medical necessity

Home Health Notes



- Refer to the Home Health Services Provider Manual for detailed program information
- Services are approved for a 60-day period
- Requests submitted close to the end of the Medicaid fiscal year (June 30) will have an end date of June 30 due to the benefit reset on July 1 each year.
- Clinical reviewers will check the SCDHHS Web Tool to verify member visits. Review will not be performed if visits remain.
- Claim note: visits are only deducted after a claim is submitted for payment

Authorization Types

❑ Prior Authorization

Should always be submitted on or before the service begins

❑ Retrospective Authorization "Retro"

Needed when services were performed before the member was eligible for Medicaid and the member has since been granted retrospective eligibility covering the date of service.

- A Retro case is NOT one that is submitted late for any reason other than eligibility.
- Untimely requests will be administratively denied.
- Providers must identify a request as RETRO on the fax request form or by request type in Atrezzo.

Processing Timelines

Acentra Health completes requests for services expeditiously and within contractual timeframes. The review completion timeframe is measured from the date Acentra Health receives a request.

- New Request/Admission review – 5 business days
- Retrospective Reviews – 5 business days

Review Process

Administrative Requirements

- Member eligibility verified
- Provider eligibility verified
- Medicaid Guidelines applied

Nurse Review

- InterQual® or State defined criteria applied
- May pend for additional clinical information
- Approve if criteria met
- Refer to physician reviewer if documentation does not support medical necessity.

Physician Review

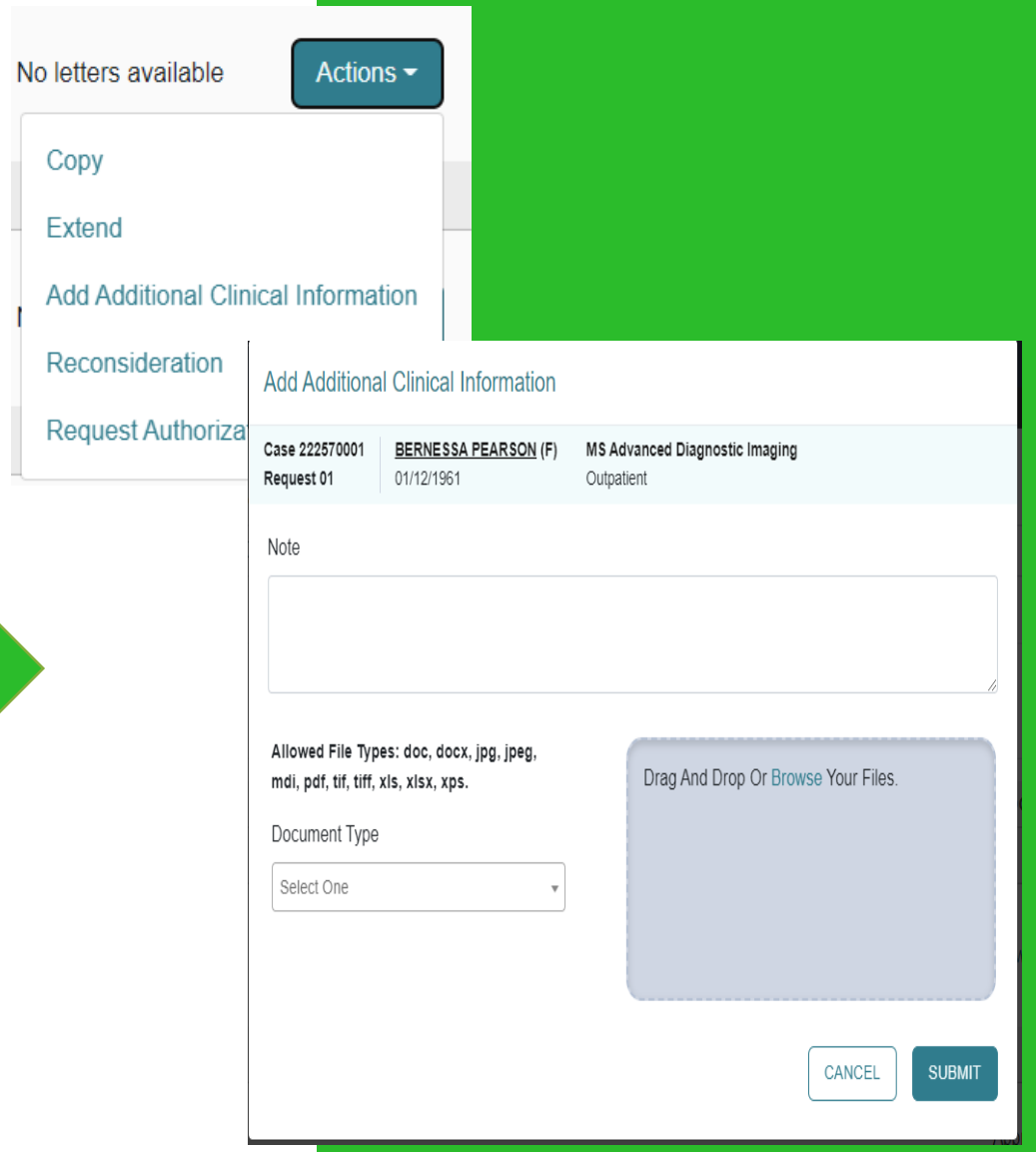
- The medical director, or another qualified physician reviewer will review the case against InterQual® or State defined criteria and national standards to provide a decision
- The physician or qualified practitioner may approve or deny the review

Pended Reviews

- A review may be pended for one of the following reasons:
  - Missing required information such as plan of care or provider number
  - Additional information or clarification is needed before a decision can be made
- Notifications are sent via fax or web portal
- A provider has 2 business days to respond to the additional information request
  - If the case contains no clinical information, the case will be administratively denied.
  - If the case has insufficient clinical information and there is no response to the pended, the case will move to the physician reviewer for a determination.
- If a review is administratively denied, the provider may submit a new request once they have all the necessary information.

Responding to Pended Reviews

- If you submitted the request online thru the Portal:
  - Log into the Portal and open the pended case
  - ACTION TAB – additional Clinical Information
  - Upload the requested documents or type the information in the note section.



Denials and Reconsiderations

Administrative Denial

- When any portion of the review is denied because it does not comply with Medicaid regulations
- Example: untimely, eligibility, insufficient information
- Provider may submit a new case for the service if an administrative denial is received. This does not apply to those cases that were denied for untimely submission.

Clinical Denial

- Occurs when any portion of the requested service is denied by a physician reviewer due to medical necessity
- Does not meet state Medicaid criteria with information submitted or does not meet other national evidence-based criteria

Reconsideration

- May only be requested for clinically denied cases
- Not used for Administrative Denials

Reconsiderations

- May be submitted within 30 days of the **clinical** denial date
  - This is your opportunity to provide more detailed clinicals
- May be submitted via
  - Web portal *preferred
  - Fax
  - phone *least preferred (will still require additional information to be faxed)
- A clinical reviewer will review any additional information submitted. If unable to meet InterQual® or State approved criteria, it will be referred to the physician reviewer.
- A physician reviewer – a different physician from the one who originally reviewed the case - will look at the case and any new information submitted to support the reconsideration
- The physician reviewer may
  - Uphold original decision (no change made)
  - Overturn the original decision (approve the case)
- If original decision is upheld, provider may appeal the decision to SCDHHS.

Appeals

- If a reconsideration is upheld, an appeal may be requested. Specific instructions will be included in the reconsideration determination letter.
- SCDHHS will review the provider's request and conduct a Fair hearing.
- Members may request an appeal within 30 calendar days from the reconsideration determination notice:
  - online at www.scdhhs.gov/appeals,
  - Fax 803 255 8206
  - Email appeals@scdhhs.gov
  - Mail Office of Appeals and Hearings

    PO BOX 8206

    Columbia, SC 29202

Resources and Education

- SCDHHS Home Health Services Provider Manual
- Provider Training Resources | SCDHHS
- SC Acentra Health website
- Acentra Health Customer Service
  - 1-855-326-5219
  - scproviderissues@kepro.com generic questions please, do not include PHI