Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MassHealth
Home Health Agency Bulletin 51
February 2016

TO: Home Health Agencies Participating in MassHealth

FROM: Daniel Tsai, Assistant Secretary for MassHealth

RE: **New Prior Authorization (PA) Policy for Home Health Services**
New Physician Referral Procedure/Face-to-Face Requirement
New Requirement to Inform MassHealth of Member Transfers
Update on Referral Procedures to Aging Service Access Points (ASAPs)

Background

This bulletin provides guidance to MassHealth providers of Home Health services regarding:

1. New prior authorization requirements for intermittent skilled nursing services and home health aide services effective March 1, 2016.
2. New physician referral procedures and face-to-face requirement, effective as of March 1, 2016.
3. Member transfers to alternate home health agencies.
4. Update on referral procedures to Aging Service Access Points (ASAPS).

MassHealth Home Health Agency providers should consult MassHealth regulations at 130 CMR 403.000 for further information about coverage, limitations, and conditions of payment for home health services. Additionally, providers should review the MassHealth guidelines on medical necessity for home health services and the Request and Justification forms for home health services.

Prior Authorization Requirements

General information

As of March 1, 2016, prior authorization is required for all Home Health services (skilled nursing, physical therapy, occupational therapy, speech-language therapy, and home health aide services) and as described below. See also 130 CMR 403.413. MassHealth reviews requests for prior authorization on the basis of medical necessity. If MassHealth approves a request for prior authorization, payment for the provision of the requested service is subject to all applicable MassHealth conditions of payment, including member eligibility, other insurance, and program restrictions. Prior authorization determinations are made on an individual, case-by-case basis, and in accordance with 130 CMR 403.000 and 130 CMR 450.303(A).

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Prior Authorization Requirements (cont.)

General information

For intermittent skilled nursing services and home health aide services provided pursuant to intermittent skilled nursing services, prior authorization is required whenever the services provided exceed one or more of the following:

1. More than 30 skilled nursing visits in a 90 day period;
2. More than 240 home health aide units in a 90 day period.

For continuous skilled nursing services, prior authorization is required before such services are provided to the member.

For therapy services and home health services provided pursuant to therapy services, prior authorization is required as follows:

1. Physical therapy: After 20 visits in a 12 month period
2. Occupational therapy: After 20 visits in a 12 month period
3. Speech-language therapy: After 35 visits in a 12 month period
4. Home Health Aide services provided pursuant to physical or occupational therapy: After 20 physical or occupational therapy visits
5. Home Health Aide services provided pursuant to speech-language therapy: After 35 speech-language therapy visits

In conducting prior authorization, the MassHealth agency or its designee may refer the member for an independent clinical assessment to inform the determination of medical necessity for Home Health services.

Submitting clinical documentation

Requests for prior authorization must be submitted by a home health provider and accompanied by clinical documentation including the individual plan of care certifying the medical necessity for the service from the referring physician, who must not be on the staff of or under contract with the requesting home health agency. Providers should not wait until service thresholds are met before submitting a prior authorization request for continuing services. Providers should submit requests for prior authorization as soon as they determine that the member needs services which require prior authorization. The MassHealth agency may take up to 14 days to act on a request for prior authorization for continuous skilled nursing services, and up to 21 days to act on a request for prior authorization for all other services. See 130 CMR 450.303(A). If there is an urgent need for prior authorization, the provider should contact the MassHealth Customer Service Center at 1-800-841-2900 for information on how to submit a request for an expedited prior authorization.

Providers must submit all information pertinent to the diagnosis using the appropriate Request and Justification forms through the Provider Online Service Center (POSC) or by completing a MassHealth Prior Authorization Request form (using the PA-1 paper form and the Request and Justification Form found in the MassHealth Provider Forms section of the MassHealth website) and attaching pertinent documentation. The PA-1 form and documentation should be mailed to the address on the back of the form.

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Physician Referral and Face-to-Face Requirement

As of March 1, 2016, the following requirements apply to physician referrals.

1. The physician providing the certification of medical necessity and submitting the plan of care for home health services must not be a physician on the staff of, or under contract with, the home health agency.
2. The plan of care must document that the physician conducted a face-to-face encounter with the member related to the primary reason the member requires home health services no more than 90 days before or 30 days after the start of home health services.

Member Transfers to Alternate Home Health Agencies

If a home health agency assists a member to transfer from one home health agency to an alternate home health agency, the transferring home health agency must inform MassHealth within 10 days of the transfer and the receiving home health agency must complete an initial member assessment.

When informing MassHealth of the transfer, the transferring home health agency must include the following information:

1. Member Name;
2. Member ID;
3. Member Care Plan;
4. Receiving home health agency;
5. Date of transfer; and,
6. Reason for transfer.

Information on member transfers should be submitted to:

Program Manager, Home Health Services
MassHealth Office of Long Term Services and Supports
One Ashburton Place, 5th Floor
Boston, Massachusetts 02108

Update on Referral Procedures to Aging Service Access Points

Home health agencies must complete an Aging Service Access Point (ASAP) referral form in the form and format as specified by MassHealth for those MassHealth members aged 60 and older. *See* 651 CMR 14.00: *Aging Services Access Points,* for a description and definition of ASAP. Home health agencies must complete this referral form upon assessment or reassessment for home health services or discharge from home health services. Home health agencies must forward the completed referral form to the Executive Office of Elder Affairs (EOEA) designee specified by MassHealth. Home health agencies must keep a copy of the completed ASAP referral form in the member's record for all MassHealth members aged 60 and older.

Questions

If you have any questions about the information in this bulletin, please contact the MassHealth Customer Service Center at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.

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