Neighborhood Health Plan OF RHODE ISLAND™

Home Care Services
Prior Authorization Form

Please return completed form to the Utilization Management Department at (401)459 -6023.
Please refer to Neighborhood's Clinical Medical Policies, which are available on our web site, www.nhpri.org for more detailed information about these benefits, authorization requirements, and coverage criteria.

*Indicates required field(s)

Member Information* (All fields are required)		
Member's Name:	Member's ID #:	Member's DOB:
Provider Information* (All fields are required)		**Physician Info* (All fields are required)**
Agency's Name:	Agency's NPI:	Ordering Physician:
Agency's Phone:	Agency Contact Person:	Ordering Physician's Phone:
Agency's Fax:		Ordering Physician's Fax:

***Choose One:**

☐ **Initial Request** ☐ **Continuation of Services** ☐ **Correction:** Previous Authorization or E-form Reference #: _____

***PLEASE CHOOSE SERVICE TYPE & COMPLETE THE APPLICABLE SECTION BELOW:**

Section A ☐ Skilled Intermittent Home Health
Section B ☐ Non-Skilled Home Care (CNA, Homemaker, and/or Combination Services)
Section C ☐ Private Duty Nursing

SECTION A: SKILLED INTERMITTENT HOME HEALTH

Agency Start of Care Date:_____ **Date of D/C from facility** *(if applicable)*: _____

***REQUIRED INFORMATION:**

New Start of Care & Evaluations:

- Referral from physician/facility, **or** discharge summary from facility

>Only applies to one (1) visit for nursing, physical therapy, and/or occupational therapy

Continuation of Care after Evaluation:

- Current completed OASIS with documentation of verbal orders received for all requested visits; **and/or**
- Current CMS-485 Home Health Certification and Plan of Care signed by agency clinician that received verbal orders for the plan of care and/or signed by the Physician; **and**
- Supporting documentation of the member's need for skilled home health services, such as evaluations/assessments and progress notes for each requested discipline

Recertification of Existing Services:

- Applicable CMS-485 Home Health Certification and Plan of Care signed by agency clinical that received verbal orders for the plan of care and/or signed by the Physician; **and**
- Recertification assessment/evaluation for each requested discipline that addresses progress towards meeting goals with objective measurements, response/barriers to education/managing care, and adherence issues.

***Dates of Service** *(Dates cannot overlap certification periods)* From: To:	***Primary Diagnosis Code(s):**

Select the Discipline(s) Requested and Quantity of Visits with Physician Orders *(not units)

Requested Service(s)	Check for Eval Only	Requested # of Visits	# of Requested Visits that were already completed
☐ **Skilled Nursing** ***Circle all that are needed: T1030 T1031 S9097**			
☐ **Physical Therapy (G0151)**			
☐ **Occupational Therapy (G0152)**			
☐ **Speech Therapy (G0153)**			
☐ **Social Worker (S9127)**			
☐ **Home Health Aide** ***Choose one:G0156 (MED or MMP) S5125 (Commercial)**			

SECTION B: HOME CARE (CNA, Homemaker, and/or Combination Services)

***Indicate if the HHA hours are requested for:**

☐ **Work** ☐ **School or Daycare** ☐ **Before/After School or Daycare**

***REQUIRED INFORMATION:**

INTEGRITY (MMP): Clinical documentation is not required but the requested hours and services must match the hours and services the member's care manager approved as medically necessary.

Medicaid (RHE, RHP, MED, CSN, SUB):

If transferring hours between agencies, then a Release of Hours Letter is preferred from the agency releasing the hours advising the number of hours released to the new agency, the start date of the transfer, and the end date of the transfer (if applicable)

New Start of Care or Increased Services:

- Documentation that the services are part of a physician's plan of care, such as doctor's orders, letter of medical necessity, referral, etc., **AND**
- If not completing the ADL grid below, then provide documentation indicating the level of assistance the member needs with each Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), such as a completed Minimum Data Set (MDS) for Home Care or a completed Provider Medical Statement (PM1) from the member's physician within the last year. **AND**
- Current aide plan of care

Continuation of Services:

- If not completing the ADL grid below, see the second bullet point in the **New Start of Care or Increased Services** section above. **AND**
- Current aide plan of care

***Dates of Service** *(not to exceed 26 weeks)* From: To:	***Primary Diagnosis Code(s):**

***Select the Service(s) Requested and Number of Hours per Week (*not units*)**

☐ **Combination Services (S5125 U1):** Personal care & homemaking services performed by an HHA/CNA during the same visit. **Number of hours per week: _____**	☐ **High Acuity Combination Services (S5125 U1 U9):** **Please note:** You must complete the Home Care MDS form if choosing this option. **Number of hours per week: _____**
☐ **Homemaker Services Only (S5130):** **Number of hours per week: _____**	☐ **CNA Services Only (S5125):** **Number of hours per week: _____**

***For Medicaid Member's Only: Assessment of Member's Activities of Daily Living (ADL) Function:**

Independent: No help or oversight, **OR** help/oversight provided 1-2 times over past week
Supervision: Oversight or cueing provided 3 or more times **OR** physical assistance less than 3 times over past week
Minimal Assistance: Member highly involved in activity, provide physical help in guided maneurvering of limbs or other non-weight bearing assistance 3 or more times over past week
Moderate or Maximum Assistance: Member participated but weight bearing support or full assistance given 3 or more times over past week
Total Dependence: Full performance of activity completed by another over entire past week
Does Not Occur: Activity did not occur over entire past week regardless of ability

	Independent	Supervision	Minimal Assistance	Moderate or Maximum Assistance	Total Dependence	Does Not Occur
Ambulation						
Transfer						
Bathing						
Grooming						
Dressing						
Eating						
Toileting						

Incontinence (3 years old and older): ☐YES ☐ NO	**Falls within the last 6 months:** ☐ YES ☐ NO
***In addition to personal care needs*, does member require assistance with Instrumental Activities of Daily Living, such as meal preparation, cleaning, shopping, laundry, etc.?** ☐YES ☐ NO	
Durable Medical Equipment (DME) Related to ADL Care:	
Provide any additional information and documentation to support member's requested hours	

SECTION C: PRIVATE DUTY NURSING (PDN)

***Indicate if the requetsed PDN hours are requested for:**

☐ **Work** ☐ **School or Daycare** ☐ **Before/After School or Daycare**

***REQUIRED INFORMATION:**
If transferring hours between agencies, then a Release of Hours Letter is needed from the agency releasing the hours that includes: the number of hours released to the new agency, the start date of the transfer, and the end date of the transfer (if applicable)

New Start of Care and Continuation of Care:

- Current, comprehensive Plan of Care (POC) signed by agency clinician that received verbal orders for the plan of care and/or signed by the Physician. All PDN requests require ongoing supervision by the treating physician.
- Up to two (2) weeks of the most recent nursing notes detailing all nursing interventions and care provided during the nurses' shift.
- If applicable, provide a complete description of any wounds: size, depth, drainage, type, and wound care orders.
- If a member has a change in condition or caregiver status that requires additional PDN coverage, you can submit a request to increase hours at any time with supporting documentation to be reviewed.

***Dates of Service** *(not to exceed 13 weeks)* From: To:	***Primary Diagnosis Code(s):**
***Requested Number of Hour per Week:**	***Circle the needed code(s): T1002 T1003**

ATTENTION: Please complete all fields on the form and submit all clinical documents. Documentation may include MD orders, physician office notes, consults and all other evaluations, results of diagnostic testing, previous treatment outcomes, and patient's clinical information. This will help us process your request without delay. Failure to provide sufficient information will delay your request as it will be returned.

Requests submitted without clinical information cannot be processed as they are incomplete.

NOTE: THIS FORM MUST BE SIGNED BY PROVIDER (RN, MD, Administrator/Equivalent, where applicable)
PER EOHHS, Neighborhood cannot pay for services provided by individuals legally responsible for the member. I attest that contracted services provided to this member will not be rendered by a person that is legally responsible for the member.

***Signature and Title of Treating Provider:**	***Date:**

Authorization is not a guarantee of payment.

Authorization #:	**Dates of Service:**	**Services Approved:**
UM Initials:	**Notification Date:**	☐ **Not Approved – Letter to Follow**

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