



***Skilled Nursing and Home Health Aide Services for For-for-Service Medicaid Beneficiaries 21 Years of Age and Older  
PRIOR AUTHORIZATION PROCESS***

**The procedure codes that will NOW require Prior Authorization are as follows:**

**G0299** – Direct skilled nursing services of a Registered Nurse (RN) in the home health or hospice setting, each 15 minutes

**G0300** – Direct skilled nursing services of a Licensed Practical Nurse (LPN) in the home health or hospice setting, each 15 minutes

**G0156** – Services of Home Health/Hospice Aide in home health or hospice settings, each 15 minutes

All skilled nursing and home health aide services for Fee-for-Service Medicaid beneficiaries who are 21 years of age and older must be approved before the services can be provided. NOTE: *This process does not apply to New Opportunities Waiver beneficiaries receiving home health services.*

**Initial Request (Emergent):**

The process for a home health agency to follow for an initial request that is emergent or for a beneficiary who is pending discharge from a hospital is to call the Molina Home Health Prior Authorization Unit toll-free number to alert Molina staff that the request is time-sensitive. The home health agency is to provide the following information to Molina staff:

- The home health agency's Medicaid provider number
- The beneficiary's Medicaid identification number
- The beneficiary's diagnosis
- Beginning and ending dates of service
- The skilled services being requested
- A home health agency's contact person's name and phone number

The home health agency will then be given a fax number (to use for this purpose only) and the following information is to be sent to the Molina Home Health Prior Authorization Unit:

- If the recipient was seen by a hospitalist, the recipient's certifying physician must co-sign that the encounter occurred;
- Signed prescription or physician's orders that include-
  - The home health services needed;
  - The length of time the services will be needed, and

- The reason the services are needed
- Progress notes or physician's notes
- A copy of the plan of care and face-to-face encounter documentation when it is available (see face-to-face encounter requirements below). A plan of care assessment cannot be done in the hospital. It must be conducted in the recipient's place of residence or where the recipient's normal life activities take place.
  - NOTE: the home health agency must submit the signed plan of care to the Molina Prior Authorization Unit as soon as the signed and dated plan of care is received by the home health agency from the physician
  - If an approval has already been issued by the Molina Prior Authorization Unit, the home health agency may fax the signed and dated plan of care, with the prior authorization number written on the document, to the following fax number: **1-225-216-6481**
- For weekend admission providers are to submit the request via the electronic prior authorization system (ePA) and the request will be reviewed by Molina staff on Monday mornings.

**Initial Request (Non-Emergent):**

The home health agency must submit all non-emergent initial prior authorization requests via the electronic prior authorization (ePA) process. Electronic-PA is a web application that provides a secure web based tool for providers to submit prior authorization requests and to view the status of previously submitted requests.

Providers will select PA-Type 18 (Prior Authorization for Skilled Nursing and Home Health Aide Services for over 21 years of age) from the drop down menu. For more information regarding e-PA, visit the Louisiana Medicaid website ([www.lamedicaid.com](http://www.lamedicaid.com)) or call the Molina Prior Authorization Department at 1-800-807-1320, Option 1.

Non-emergent prior authorization requests for skilled nursing and home health aide services must be submitted with the following documentation:

- Physician's certification/orders to include date of visit, the skilled services needed, and why the services are needed;
- Face-to-Face encounter documentation (see face-to-face encounter requirements below);
- Plan of Care, and
- Any other supporting documents to warrant medical necessity of the treatment, for example, a letter of medical necessity.

***A Prior Authorization request will not be reviewed by the medical staff at Molina until all required documentation is received in the Prior Authorization Department.***

**Recertification/ Continuation of Services Request:**

Prior authorization will be required for each certification of care whether it be an initial request or continuation of services.

The home health agency must submit a new prior authorization request via the ePA process with the following documentation:

- Physician's certification/ orders to include date of visit, the skilled services needed, and why the services are needed;
- A new Plan of Care;
- Progress notes or supporting documentation to warrant medical necessity of the continued treatment, and
- Any other supporting documents to warrant medical necessity of the treatment, for example, a letter of medical necessity.

***A recertification or continuation of services prior authorization request will not be reviewed by the medical staff at Molina until all required documentation is received in the Prior Authorization Unit.***

***Other Requirements***

**Face-to-Face Encounter Documentation**

The Center for Medicare and Medicaid Services (CMS) requires a face-to-face encounter between a beneficiary and their certifying physician or an allowed non-physician practitioner to occur no sooner than 90 days prior to the start of home health services, or no later than 30 days after the start of home health services.

It is the responsibility of the home health agency to acquire the face-to-face encounter documentation and submit it to Molina, as soon as possible for both emergent and non-emergent home health services requests.

Any of the following will be accepted by the Molina Prior Authorization Unit as evidence of a face-to-face encounter between a physician and the beneficiary, or an allowed non-physician practitioner and the beneficiary:

- A written statement on the certifying physician's letterhead or prescription pad attesting to a face-to-face encounter between the physician and the beneficiary or an allowed non-physician practitioner and the beneficiary;
- The home health agency's face-to-face encounter form that recipient's certifying physician the home health agency requires the recipient's certifying physician to complete as a routine business practice.

If the recipient was seen by a hospitalist, the recipient's certifying physician must co-sign that the encounter occurred.

If the face-to-face encounter is between an allowed non-physician practitioner and the beneficiary, the certifying physician must co-sign the document.

**NOTE: Documentation of a face-to-face encounter must be kept in the recipient's record for ALL home health service related requests.**

**Prior Authorization Decisions**

Non-emergent home health prior authorization request decisions are issued within 10-calendar days from the date and time of receipt of the request through ePA at Molina Medicaid Solutions. The home health agency may check for prior authorization approval status at any time through ePA. The home health agency and the Medicaid beneficiary will receive a notification letter via U.S. postal mail with the decision of the review. The beneficiary's letter will include appeal rights.

All notices will contain a nine-digit Prior Authorization (PA) number assigned to that individual request at the time of receipt at Molina.

If the services are approved, the home health agency must put the nine-digit prior authorization number in the appropriate field when filing claims in order to receive payment.

**If you have any questions regarding the Medicaid Fee-for-Service Home Health Services Prior Authorization process, please call the Molina Prior Authorization Unit at 1-800-807-1320, then press Option 1.**