Louisiana

Blue Advantage (HMO) | Blue Advantage (PPO)

The purpose of this form is for a home health care prior authorization request. Contact the Blue Advantage Medical Management department at 1-866-508-7145 if you have questions.

Please complete all applicable areas below.

Request for Home Health Authorization Form

GENERAL INFORMATION

☐ Initial Request ☐ Reauthorization Request	Initial Authorization Date

PATIENT INFORMATION

Patient's Name	
Date of Birth	Blue Advantage Member ID#
Is patient homebound? ☐ Yes *(please explain why)* ☐ No	
Diagnosis	
Surgery ☐ Yes *(please list procedure)* ☐ No	

AGENCY INFORMATION

Agency Name	National Provider Identifier (NPI)
Contact Phone Number	Contact Fax Number

CAREGIVER INFORMATION

Caregiver Name	
Relationship	Type of Assistance
Teachable ☐ Yes ☐ No	Primary Phone Number

MD INFORMATION

Ordering MD	
Date of Face-to-Face Visit	Phone Number
PCP	Date of Next MD Visit

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DME/SUPPLIES/IV/LAB	
Vendor Name	Type

COMMUNITY RESOURCES

CURRENT FUNCTIONAL STATUS				
Cognitive ☐ Alert and Oriented ☐ Impaired ☐ Disoriented	Dress Lower Extremities ☐ Requires Assist ☐ Unable	Bathing ☐ Requires Assist ☐ Unable	Toileting ☐ Requires Assist ☐ Unable	Ambulation ☐ Requires Assist ☐ Unable

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Service Request	From	To	# Of Visits	Frequency	Auth # Visits	Health Plan Auth #
RN						
HHA Visits						
PT						
OT						
ST						
MSW						

MEDICATIONS	
☐ Med List Attached *(must accompany all initial requests)*	Compliant ☐ Yes ☐ No
Teachable Patient/Caregiver ☐ Yes ☐ No	Need for Teaching That is Not Being Met
For Reauthorization: New or Changed Medications	

Name of Person Completing Form	Title	Date

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SKILLED NURSING			
Skilled Nursing: DC Date	☐ Anticipated	☐ Actual	
Clinical Summary			
Reason for Home Health Aide Services			
Wound Care Required	Nutritional Status		
Please describe wound(s): i.e., location, type of wound (pressure ulcer with stage/surgical, etc.), measurement (LxWxD, wound edges), appearance (types of tissue in wound bed: eschar, slough, granulation), drainage (color, amount, odor of drainage), evidence of infection			
Patient/Caregiver Education *(please describe the ability of the patient/caregiver to learn/perform wound care)*			
Care Plan			
Goals/Plan for this Authorization Period			
Barriers to Achieve Goals/Plan			
Interventions			
Signature	Title	Department	Date

OTHER SKILLED DISCIPLINES		
PT: DC Date	☐ Anticipated	☐ Actual
OT: DC Date	☐ Anticipated	☐ Actual
ST: DC Date	☐ Anticipated	☐ Actual
MSW: DC Date	☐ Anticipated	☐ Actual
Reason for Home Health Aide Services		

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Clinical Summary			
Goals/Plan for this Authorization Period			
Barriers to Achieve Goals/Plan			
Interventions			
Signature	Title	Department	Date

Home Health Care Prior Authorization Requirements

Initial Evaluation

- The initial skilled nursing (SN) and/or physical therapy (PT) home care assessment/evaluation visit does not require prior authorization. However a physician's order and certification of homebound status is required.
- Speech therapy, occupational therapy and social work require prior authorization for the initial evaluation when ordered after the Start of Care (SOC) date.

Post Evaluation Visits

- Document the initial evaluation results, evidence of homebound status, individualized member goals and plan of care on our Request for Prior Authorization Form. All documentation is expected to be legible or it will be returned and the authorization process cannot move forward. The Request for Prior Authorization Form, OASIS and any supporting clinical documentation must be faxed to the health plan for review within one business day of the evaluation.
- When the faxed clinical documentation is received from home care agency, it will be reviewed using InterQual Home Care criteria. The types of disciplines, number of visits and dates of service will be determined by the health plan using InterQual criteria as a guide.
- When Home Healthcare (HHC) visits have been approved, a faxed approval will be sent to the agency that includes the number of visits for each discipline approved, dates of coverage and the next review date for requests for continued coverage. An approval letter will also be mailed to the member or the member's legal representative.
- If the clinical documentation does not support the need for HHC services, the case will be sent to the health plan's medical director for review and determination. If the determination by the medical director is unfavorable, a denial letter will be faxed to the HHC agency. Denial will also be mailed to the member or the member's legal representative.

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Ongoing HHC Visits

- Ongoing request must be submitted on the Blue Advantage Request for Home Health Prior Authorization Form with the following information:
    1. Clearly identify goals that are being met and goals that are not being met for each discipline.
    2. Any progress made toward the unmet goal.
    3. Any barriers identified that will impact the member's ability to meet the unmet goals.
    4. The plan to address those barriers, including follow up with the member's attending physician or primary care physician.
    5. Anticipated number of visits needed to meet goals. When any barriers to progress are identified, documentation of physician follow up is required.
- Document the evaluation results, evidence of homebound status, individualized member goals and plan of care on our Request for Prior Authorization Form as listed above. All documentation is expected to be legible or it will be returned and the authorization process cannot move forward. The Authorization Request Form, additional OASIS documentation, if applicable, and any supporting clinical documentation must be faxed to the health plan for review within two business day of the evaluation.
- When the faxed clinical documentation is received from home care agency, it will be sent for review using InterQual Home Care criteria. The types of disciplines, number of visits and dates of service will be determined by the health plan using InterQual criteria as a guide.
- When HHC visits have been approved, a faxed approval will be sent to the agency that includes the number of visits for each discipline approved, dates of coverage and the next review date for requests for continued coverage. An approval letter will also be mailed to the member or the member's legal representative.
- If the clinical documentation does not support HHC services, the case will be sent to the health plan's medical director for review and determination. If the determination by the medical director is unfavorable, a Notice of Medicare Non-Coverage (NOMNC) will be faxed to the HHC agency and mailed to the member or the member's legal representative.
  Note: To prevent a gap in coverage all suggested ongoing visits must be submitted at least **two business days prior to the coverage period end date** (or before the last visit, whichever is sooner).
  A documented face–to-face visit with your attending physician (primary care provider or specialist treating your condition) must take place within 30 days of start of care or within 60 days of any request for recertification of HHC visits.

Discharge Summary

- When members are being discharged from services, the agency will need to submit a completed discharge summary to Medical Management at the time of discharge. The discharge summary should include the number of visits provided, date of last visit, discharge medication list and the disposition for each discipline. A copy of the signed (NOMNC) that was delivered to the member should also be included.

Incomplete/Lack of Information

- If the authorization form is not filled out in its entirety, including defined medical goals and plan of care, it will be rejected as an incomplete request and the authorization request process will not move forward.
- Blue Advantage must receive clinical documentation in a timely manner, generally no later than noon the next business day following the request for authorization. However, in rare circumstances you may be asked to provide information in a shorter timeframe.

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