Provider Update

Home care services

Summary of update: Amerigroup Iowa, Inc. wants to help our members receive care more efficiently by minimizing the wait time for approval requests and allowing our providers to care for them sooner.

Update to prior authorization requirements
Amerigroup removed the prior authorization requirement for some outpatient services. This applies to in-network providers only. Effective March 1, 2019:

- Prior authorization is not needed for home health aide services (G0156).
- Prior authorization is not needed for the first five visits of home care when the episode of care is provided within 90 days of a prior home care episode.
    - Each new start of care will allow five visits before prior authorization is required.
    - Additional nursing and/or therapy visits within a subsequent episode under the same admission should be preauthorized for medical necessity.

What is the impact of this change?
Other home care services (revenue codes 0551, 0421, 0441, 0431, 0571, 0561) allot five visits (equaling five units) before authorization is required. This allows providers to work with the member to establish an overall plan of care (POC). Once the POC is determined, the request for prior authorization should be made proactively for the total anticipated visits/units, including the five initial visits.

While revenue codes 0570 or 0579 billed with HCPCS code G0156 do not require authorization, they do contribute to the five initial visits allowed to start care and should be included in your planning purposes. For example, if during the first week of care two home health aide visits, two skilled nursing visits, and one physical therapy visit are required, authorization for medical necessity would be required for all additional nursing and/or therapy visits. During this process, the total anticipated visits/units would be included in the authorization, including the five initial visits.

What does this mean to me?
Ensure that authorization requests are made prospectively before the five visits of home care services are completed to establish the overall POC for the total anticipated visits/units.

Amerigroup has been proactively reprocessing home health aide claims (G0156) that were denied for no authorization after March 1, 2019. This project is anticipated to be completed by the end of May. During this time, agencies do not need to appeal these denials and should see adjustments accordingly on future remittances. If after June 1, 2019, your organization finds claims that were inadvertently missed in the adjustment process, claim payment appeals can be made in Availity.

Other home health claims denied for lack of authorization after March 1, 2019, because a prior home care episode occurred within 90 days should be appealed providing documentation that the episode was a new plan of care as outlined in *Chapter 14: Reconsiderations, Disputes, Grievances and Appeals* of the *Provider Manual*.