Optum

Nevada home health prior authorization FAQ

Frequently asked questions

When is Prior Authorization required?

Starting September 1, 2023, Prior Authorization (PA) will be required for all home health services after the initial start of care (SOC) and subsequent visits through day 21 during the 60-day certification period. Notification of admission to services is required (72 hours – verify by market). Please contact:

- Nevada Market: 1-855-893-2297

Prior Authorization will be required for:

- Initial certification period on day 22-60
- Continuation of care
- Resumption of care (ROC)
- Additional visits
- Recertification for all subsequent 60-day episodes

Medicare home health HCPCS – G Codes

To request home health visits, the home health agency must use one of the Medicare appropriate HCPCS codes to represent each visit by each home health care discipline. S Codes will be denied/rejected for incorrect coding. Please refer to the below resources which include a link to the CMS manual on appropriate coding.

Note: Start of Care (initial visit) does not require prior authorization. You can perform a comprehensive evaluation during the initial visit. and are required to provide notification only to Optum Care. After day 21 of episode within first certification period, prior authorization is required. If you do not obtain authorization before services are rendered when required, claims may be denied.

HCPCS code	Description
G0299	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes
G0300	G0300 Direct skilled nursing services of a license practical nurse (LPN) in the home health or hospice setting, each 15 minutes
G0151	G0151 Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes
G0152	G0152 Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes
G0153	G0153 Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes
G0155	G0155 Services of clinical social worker in home health or hospice settings, each 15 minutes
G0156	G0156 Services of home health/hospice aide in home health or hospice settings, each 15 minutes
G0157	Services performed by a qualified physical therapist assistant in the home health or hospice setting, each 15 minutes
G0158	Services performed by a qualified occupational therapist assistant in the home health or hospice setting, each 15 minutes
G0159	Services performed by a qualified physical therapist, in the home health setting, in the establishment or delivery of a safe and effective physical therapy maintenance program, each 15 minutes

Understanding Optum home health approval with the G codes

All home health cases need to be submitted with the appropriate G code for discipline. Each G code will be equivalent to 1 visit. Although the G code is to be used and stated as 15 minutes, billing should be done where one unit corresponds to one visit in its entirety.

Example: G0299 X 9. This means Optum has approved 9 skilled nursing visits.

Home health denials – peer to peer requirement

Peer to Peer can only occur with ordering physician and Optum Medical Director.

What criteria is used for home health medical necessity reviews?

Optum uses Medicare criteria to facilitate medical necessity reviews for home health.

Link to Medicare Manual for Home Health requirements: Medicare Benefit Policy Manual Chapter 7 Home Health Services

Medicare home health conditions coverage

The following criteria for initial and subsequent home health visits will be reviewed and member must meet all three (3) conditions with a Medicare certified agency for initial and subsequent home health visits:

- Member is homebound. This means needs assistance of another person or of a supportive device. Leaving home requires a considerable and taxing effort
    - There is a normal inability to leave the home.
- A physicians order
    - A physician or a recognized non physicism health care professional, had a face-to-face meeting with the member prior to certifying the individuals need for home care.
- Member requires skilled nursing care on an intermittent basis, or skilled physical/occupational therapy, and speech therapy.

How do I request prior authorization?

It is recommended to submit for prior authorization seven days prior to your first visit after Start of Care in order to ensure time for medical necessity review of the authorization. You can request prior authorization visiting the online Optum Provider Portal:

Link: optumcare.linkplatform.com/home

Online portal requests are the preferred method for authorization requests, but if needed, Optum can accept requests by phone call and fax:

Nevada Market: Phone Number: 1-855-893-2297

Fax Number 1-888-992-2809 (PA fax cover sheet and all documentation)

Initial Authorization Process

Regardless of the method of submission, you will be required to submit the following information upon review:

- Ordering Provider demographic information, TAX ID, NPI and office contact name, phone, and fax number
- Servicing Provider (Home Health Agency) demographic information, TAX ID, NPI and office contact name, phone, and fax number.
- Member demographic information
- Attestation to member meeting Centers for Medicare & Medicaid Services (CMS) criteria for home health eligibility
- Home Health Disciple (SN, PT, OT, SP, AIDE) and number of visits requested (Using G codes)
- Member primary diagnosis and secondary diagnosis’s
- CMS-485 form/signed plan of care by ordering physician (or verbal start of care order is accepted)

- Start of Care OASIS will be required within 7 days of initial authorization to support the authorization request
- Initial therapy evaluation within 7 days of the initial authorization request
- Face to face encounter

Recertification: completing request process

All recertifications require prior authorization for the 60-day increment and can be submitted using the same methods as listed above. Regardless of method of submission, you will be required to submit clinical documentation to support medical necessity criteria. This documentation includes:

- 485 form and /or start of care OASIS (if not already submitted)
- Home Health Disciple (SN, PT, OT, SP, AIDE) and number of visits requested (Using G codes)
- Last 2 visit notes per discipline involved
- Any other relevant clinical documentation

Additional discipline visit or add new discipline for certification period is needed?

If there is any modification to members care plan the home health agency is required to submit prior authorization for additional visits or add-on discipline prior to requested service date. The home health agency must submit the following documents: documentation of Physicians order (verbal order accepted), clinical documentation as applicable to support request RN/LPN notes, Physical Therapy notes, Occupational Therapy notes, Speech Therapy notes, Home Health Aid notes, and Medical Social Worker notes.

Compliance

Notice of Medicare Non-Coverage (NOMNC) – preparation and delivery

- Home Health agency must prepare and deliver the NOMNC
- Use the most current Medicare NOMNC (CMS-10123) form
- NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily
- Provider can type or write in the required fields:
    - The patient's name
    - The Medicare patient number

Note: Optum Prior Authorization Department can provide the current NOMNC form.

- The type of coverage (SNF, Home Health, CORF, or Hospice)
- The effective date (last day of coverage), which is always the last day beneficiaries will receive coverage for their services

Who do I call if I have a question?

If you have questions, please call Optum Service Center

Nevada Market: 1-855-893-2297

Optum provider portal and select member state:

Link: optum.com/business/hcp-resources.html

Additional resources

Medicare Claims Processing Manual: Chapter 10- Home Health Agency Billing:
cms.gov/regulations-and-G=guidance/guidance/manuals/downloads/clm104c10.pdf

Benefit Policy Manual, Chapter 7 Home Health Services:

cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c07.pdf

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