colorado.gov/pacific/hcpf

Provider Bulletin

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Special Home Health Bulletin

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Denver Club Building
518 17th Street, 4th floor
Denver, Colorado 80202

ACS Contacts

Billing and Bulletin Questions
1-800-237-0757 or 1-800-237-0044

ACS Claims and PARs Submission
P.O. Box 30
Denver, CO 80201

ColoradoPAR Program PARs
www.coloradopar.com

Correspondence, Inquiries, and Adjustments
P.O. Box 90
Denver, CO 80201

Enrollment, Changes, Signature authorization and Claim Requisitions
P.O. Box 1100
Denver, CO 80201

Home Health (HH) Providers

Attention Private Duty Nursing (PDN) Providers

On March 19, 2012, the ColoradoPAR Program began processing PDN Prior Authorization Requests (PARs). PDN providers should no longer send PARs to Ascend Management. Ascend Management will forward any PARs they receive to the ColoradoPAR Program until April 1, 2012. After April 1, any PAR sent to Ascend Management will not be processed.

The preferred method for PAR submission is electronically through the ColoradoPAR Web Portal, CareWebQI. Provider registration is required for electronic submission. Registration and submission instructions are available at www.coloradopar.com.

PARs may also be submitted to ColoradoPAR via fax to 1-866-492-3176. Please contact ColoradoPAR with any questions at 1-888-454-7686.

Extraordinary Clarification

In April 2007, the Department of Health Care Policy and Financing (the Department) issued Provider Bulletin B0700231 that listed the criteria that makes a pediatric home health request "extraordinary." If any of the below criteria is met, the "extraordinary home health" box should be checked on the PAR form, and the PAR should be sent to the ColoradoPAR Program for review:

- A pediatric client's medical need for home health exceeds the maximum daily amount;
- Some or all of a pediatric client's medical need for home health services is better met in a setting outside the home;
- A pediatric client has a medical need for unskilled personal care services.

See Attachment A of this bulletin or Appendix D of the Provider Services Billing Manuals section of the Department's Web site for correct reviewing agencies.

Brief Nursing Visit

The following services should be billed as a brief nursing visit:

- All clients seen in the same day by the same home health agency who reside in the same location (two of more clients in one home, two or more clients who reside in the apartment complex, same Assisted Living Facilities, etc.).
- Insulin injections, excluding the first visit of each day, unless insulin administration is the sole reason for all of the visits. If insulin administration is the sole reason for a daily visit or multiple visits per day, bill the first visit of the week at a standard rate and all other visits of the week at the brief rate.
- Any other medication injections (other than insulin), that are required multiple times per day. The first visit of each day may be billed as a standard nursing visit unless administration of the injection is the sole reason for the visits.

If administration of prescribed injections is the sole reason for a daily visit or multiple visits per day, bill the first visit of the week at a standard rate and all other visits of the week at the brief rate.

- Dry wound care dressings are the sole reason for the visit.
- Catheter irrigation is the sole reason for the visit. External catheterization or care, or both, are the sole purposes for the visit.
- Application of over the counter lotions or ointments are the sole reason for the visit, ONLY when a client is completely dependent on others for all of their care.
- Bolus Levin or G-tube feedings of 1 can of prepared formula is the sole purpose of the visit, excluding the first visit of the day, ONLY when there is no able caregiver.
- Simple wound care for up to 2 wounds is the sole purpose of the visit.
- Stage one pressure ulcer wound care is the sole purpose of the visit.
- Medication box refills or changes, following the first refill or the week.
- Foot care, as defined in the Home Health Benefit Policy, is the sole purpose of the visit.

Plan of Care Requirements

All home health services must be ordered in writing by the client's attending physician (or may be signed by another physician who is authorized by the attending physician to care for the patient in the attending physician's absence) as part of a written plan of care. The written plan of care must be updated every 60-calendar days in compliance with Medicare regulations. Colorado Medicaid does not cover nursing visits for the sole purpose of creating the plan of care.

Complete the written plan of care and associated documentation on a HCFA-485 form, or a document that is identical in content, and submit it with the Colorado Medical Assistance Program Home Health PAR form. Providers must maintain copies of the HCFA-485 or other document used to document the plan of care in the client's records and make the documents available upon request to the Department, its reviewing agencies or the Department's designated case management agencies (CMAs).

Below is a list of fields and the information that must be included in those fields to obtain a home health PAR and payment for services provided to Medicaid clients.

Field	Field Title	Information That Must Be Present
1	Patient's HI Claim No.	Client's Medicaid Number, if the client is eligible for Medicare and Medicaid, this number may be the client's Medicare number.
2	SOC (Start of Care) Date	Enter the first day home health services were provided to the client.
3	Certification Period	Enter the first date of services for the current 60-day plan of care (MMDDYY) and the date of the 60th day of care as the "To:" date in this field. • "To" date can be up to, but never exceed, two calendar months and mathematically never exceed 62 days. • Always repeat the "To" date on a subsequent recertification as the next sequential "From" date. • Services delivered on the "To" date are covered in the next certification period. EXAMPLE: Initial certification "From" date is 061512 then the initial certification "To" date would be 081412. Then the recertification would have the "From" date as 081512 and the "To" date as 101412. The 485-certification period must encompass the start of care date on the Colorado Medical Assistance Program HH PAR form.
5	Provider Number	Enter the provider's Medicaid ID number.
6	Patient's Name & Address	Enter the patient's last name, first name and middle initial followed by the street address, city, state and ZIP code. The address noted may be the client's temporary residence.

Field	Field Title	Information That Must Be Present
7	Provider's Name/Address/ Telephone Number	Enter the provider's name and/or branch office (if applicable), street address (or other legal address), city, state, and ZIP code. The provider's telephone number should be the Branch office number and may include the branch's fax number as well.
8	Date of Birth	Enter the client's date of birth in a 6-digit format. (MMDDYY)
9	Sex	Enter the client's gender.
10	Medications	Enter every prescription drug, over-the-counter medicines & natural products used by the client along with the dose, the frequency of the dosing and the means in which the medication is taken (route). • Use the addendum HCFA-487/addendum to the plan of care for client's who have medication lists that exceed the space allotted on the HCFA-485 • Use the letter "N" after the medication(s) that are "new" orders. • Use the letter "C" after the medication(s) that have been "changed" since the client's start of care.
11	Principal Diagnosis, ICD-9 code and date of onset or exacerbation	Enter the principal diagnosis on all HCFA-485 forms. The principal diagnosis is the diagnosis most related to the current plan of treatment. It may or may not be related to the patient's most recent hospital stay, but must relate to the services rendered. If more than one diagnosis is treated concurrently, enter the diagnosis that represents the most acute condition and requires the most intensive services. Enter the appropriate diagnosis code for the diagnosis in the space provided. The code must be the full diagnosis code including all digits. V codes are acceptable as both primary and secondary diagnosis. In many instances, the V code more accurately reflects the care provided. However, do not use the V code when the acute diagnosis code is more specific to the exact nature of the patient's condition. EXAMPLE: Patient is surgically treated for a malignant neoplasm of the colon (code 153.2) with exteriorization of the colon. Admission to home care is for instruction in care of colostomy (V55.3). Use V55.3 as the primary diagnosis since it is more specific to the nature of the proposed home health services. The following is a **partial** list of acceptable V codes: • V24.2—Routine Postpartum Follow-Up Care • V46.0—Dependence on Aspirator • V46.1X—Dependence on Respirator • V53.5X—Fitting and Adjustment of Other Intestinal Appliance • V53.6—Fitting and Adjustment of Urinary Devices • V55.0—Attention to Tracheostomy • V55.1—Attention to Gastrostomy • V55.2—Attention to Ileostomy • V55.3—Attention to Colostomy • V55.4—Attention to Other Artificial Opening of Urinary Tract The principal diagnosis may change on subsequent forms only if the patient develops an acute condition or an exacerbation of a secondary diagnosis requiring intensive services different from those on the established plan of care. List the actual medical diagnostic term next to the diagnosis code. Do not describe in narrative format any symptoms or explanations. Do not use surgical procedure codes.

Field	Field Title	Information That Must Be Present
11 (continued)	Principal Diagnosis, ICD-9 code and date of onset or exacerbation	The date is always represented by six digits (MMDDYY) and if the exact day is not known, use 00 in the middle section. The date of onset is specific to the medical reason for home health care services. If a condition is chronic or long term in nature, use the date of exacerbation. Use one or the other, not both. Always use the latest date. Enter all dates as close as possible to the actual date.
12	Surgical Procedure, ICD-9 code and the date of most recent surgery	Enter the surgical procedure relevant to the care rendered. For example, if the diagnosis in item is "Fractured Left Hip", note the diagnosis code, the surgical procedure, and date (e.g., 81.62, Insertion of Austin Moore Prosthesis, 060904). If a surgical procedure was not performed or is not relevant to the plan of care, do not leave the box blank, instead enter N/A. Use the addendum (HCFA-487/addendum to the plan of care) for additional relevant surgical procedures. At a minimum, the month and year must be present for the date of surgery. Use 00 if the day is unknown.
13	Other Pertinent Diagnoses, ICD-9 code and date of onset or exacerbation	Enter all pertinent diagnoses, both narrative and diagnosis codes, relevant to the care rendered. Other pertinent diagnoses are all conditions that coexisted at the time the plan of care was established or subsequently developed. Exclude diagnoses that relate to an earlier episode which have no bearing on this plan of care. These diagnoses can be changed to reflect changes in the patient's condition. In listing the diagnoses, place them in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided. If there are more than four pertinent diagnoses, use the addendum (HCFA-487/addendum to the plan of care) to list them. Enter N/A if there are no pertinent secondary diagnoses. The date reflects either the date of onset, if it is a new diagnosis, or the date of the most recent exacerbation of a previous diagnosis. Note the date of onset or exacerbation for each pertinent diagnosis as close to the actual dates as possible.
14	DME and Supplies	Enter all non-routine durable medical equipment & supplies that are being used by the client. For example, dressing changes may require use of 4x4's, telfa pads, kling and non-allergic tape. The client may use a shower chair and a bedside commode. Catheter changes may require catheter kit and irrigation kit as well as irrigating solutions. Enter N/A if the client is not using any supplies.
15	Safety Measures	Enter the physician's instructions for safety measures such fall risk precautions, pathways clear, etc.
16	Nutritional Requirements	Enter the physician's order for the diet. This includes specific therapeutic diets and/or any specific dietary requirements or restrictions. Record fluid needs or restrictions. Total Parental Nutrition (TPN) or g-tube feedings can be listed. If more room is needed for TPN or formulas, agencies may place additional information under medications. If more space is necessary, use the HCFA-487/addendum to the plan of care.
17	Allergies	Enter all medications to which the patient is allergic and other allergies the patient experiences (e.g., foods, adhesive tape, iodine). "No known allergies" may be an appropriate response.

Field	Field Title	Information That Must Be Present
18A	Functional Limitations	Check all items that describe the patient's current limitations as assessed by the physician and agency. If "Other" is checked under "Functional Limitations" category, provide a narrative explanation in Item 17 of the HCFA-486/home health update.
18B	Activities Permitted	Check the activity(ies) which the physician allows and/or for which physician orders are present. If "Other" is checked under the "Activities Permitted" category, provide a narrative explanation in Item 17 of the HCFA-486/home health update.
19	Mental Status	Check the block(s) most appropriate to describe the patient's mental status. If "Other" is checked, specify the conditions.
20	Prognosis	Check the box that specifies the most appropriate prognosis for the patient.
21	Orders for Discipline and Treatments (Specify Scope/ Amount/Frequency/Duration for all disciplines involved in the client's care)	Specify the frequency and expected duration of the visits for each discipline ordered. State the duties/treatments/tasks to be performed by each discipline during each visit. A discipline may be one or more of the following: skilled nursing (SN), physical therapy (PT), speech therapy (ST), occupational therapy (OT),speech therapist (SLP) or home health (AIDE). Orders must include all disciplines and treatments, even if they are not billable to Medicaid. The orders must be specific and include any extenuating factors such as the client requires 2 aides to safely complete tasks of daily living. If PRN or as needed visits may be required, the orders must include situations and circumstances that would trigger the use of the PRN visit. If a client is receiving telehealth home health services, this field must also include the telehealth orders to include the frequency of monitoring, the client specific parameters that will be monitored and that warrant agency intervention as well as interventions that will be utilized by the agency in their efforts to maintain the client at home. When care is required outside of the home for extraordinary home health pediatric clients, the orders shall include a reason that the client needs to have services performed outside of the home. Orders should be written to encompass the tasks that will be performed during the visit and shall not include a block of time or "shift" during which tasks will be completed. If same services provided on one day take longer on other days, the orders must include a rationale for the additional time being needed. The orders section shall also include a summary that: • Provides a description of the clients past and current condition; • Provides any additional justification for the services the agency will be providing; • Has a statement regarding the availability of family/caregivers and what care they provide if they are available. • Includes a brief description of the client's living situation • Includes the specific information on the homebound status of the client
22	Goals/Rehabilitation Potential/ Discharge Plans	Enter information that reflects the physician's, therapists and/or nurse's description of the achievable goals and the patient's ability to meet them and should include plans for care after discharge. Rehabilitation potential addresses the patient's ability to attain the goals and an estimate of the time needed to achieve them. This information is pertinent to the nature of the patient's condition and ability to respond to treatment. The words "Fair" or "Poor" alone are not acceptable. Add descriptors.

Field	Field Title	Information That Must Be Present
22 (continued)	Goals/Rehabilitation Potential/ Discharge Plans	EXAMPLE: Rehabilitation potential good for partial return to previous level of care, but patient will probably not be able to perform ADL independently. Where daily care has been ordered, be specific as to the goals and when the need for daily care is expected to end. EXAMPLE: Granulation of wound with daily wound care is expected to be achieved in four weeks. Skilled nursing visits are decreased to 3x/week at that time. Discharge plans to include a statement of where, or how, the patient will be cared for once home health services are not provided. For long term home health clients, a discharge plan may not be realistic; in this case, the 485 must reflect the plans to avoid preventable ER or inpatient interventions.
23	Verbal Start of Care Nurse's Signature and Date	This verifies that a nurse spoke to the attending physician and has received verbal authorization to visit the patient. This item is signed by the nurse receiving the verbal orders, by the nurse responsible for the completion of the form by the therapist (for therapy only cases) or other clinical staff permitted to sign the 485 per the agency, CMS and CDPHE regulations. This field must be signed and dated at the time the Colorado Medical Assistance Program HH PAR is requested. If this field is not signed, the PAR request may be denied for technical reasons. Rubber signature stamps are not acceptable. Electronic signatures may be used, but the agency must maintain a logbook with the physical signature of the clinician that signed this field. Note: The date may precede the SOC date in Item 2, and may precede the "From" date in Item 3.
24	Physician's Name and Address	Enter the attending physician's name and address. The attending physician is the physician who establishes the plan of care and who certifies and recertifies the medical necessity of the visits and/or services. Mention supplemental physicians involved in a patient's care only on the HCFA-486/home health update.
27	Attending Physician's Signature and Date Signed	Prior to submitting the final claim for a certification period, the agency must have this field completed. The attending physician signs and dates the plan of care/certification Rubber signature stamps are not acceptable. Electronic signatures may be accepted, but the agency must maintain a logbook with the physical signature of the provider. The form may be signed by another physician who is authorized by the attending physician to care for the patient in the attending physician's absence. Do not predate the orders for the physician, nor write the date in this field.

Any changes to the current plan of care must be documented on an agency's interim order form. The orders may be received verbally by any agency clinician that the agency permits to take verbal orders. Verbal orders must be signed by the ordering physician or another physician who is authorized by the attending physician to care for the patient in the attending physician's absence. Rubber signature stamps are not acceptable. Orders may also be taken electronically from a provider. Electronic signatures may be accepted, but the agency must maintain a logbook with the physician's physical signature. See Attachment B of this bulletin for a current copy.

An interim order is required when:

- There has been an increase or decrease in frequency or duration of visits; or
- There is a medication change (all medication changes should be included on the client's recertification plan of care); or
- A new discipline has been added to the plan of care since the certification or recertification (for example, therapies added after the start of the plan of care).

Using ICD-9 V-Codes on the Plan of Care

When completing a home health plan of care, home health providers must accurately capture the primary condition or diagnosis that illustrates the primary diagnosis or main reason that home health is ordered for a client. The agency must also identify secondary diagnoses, which should include only conditions actively addressed in the patient's plan of care and any comorbidities that might affect the client's responsiveness to treatment or the outcomes of the plan of care. The agency must prioritize the secondary diagnoses in the order that reflects the diagnoses requiring the most intensive to least intensive home health services. Agencies should avoid listing diagnoses that do not affect the patient's progress or outcome.

If the client has an acute condition relevant to the plan of care, list the code for the acute condition. ICD-9 V-codes should be used whenever possible, because they provide descriptive information on why the client needs home health services. V-codes may be used as the primary or secondary diagnoses, but V-codes are typically used in the home health setting when a person with a current or resolving disease or injury encounters the health care system for specific aftercare of that disease or injury. If there is a complication of medical or surgical care, such as infection or wound dehiscence, select a code specific to either condition rather than a V-code. Some V-Codes are only to be used as primary diagnosis codes; do not use these as secondary diagnosis codes.

Appropriate Utilization and Billing of Acute and Long-Term Home Health Services

Per 10 CCR 2505-10 Section 8.520, home health providers must adhere to the following guidelines when deciding whether to provide acute or long-term home health services to Medicaid clients:

- If the service is medically necessary and appropriate for the treatment the client requires, acute and long-term home health services are available to any client eligible for Colorado Medicaid or Old Age Pension.
- Acute home health services are provided for clients who experience an acute incident such as infection, pneumonia, heart attack or discharge from an inpatient facility. Acute home health services are also provided for clients with a new diagnosis of a life-altering disease, such as diabetes or Chronic Obstructive Pulmonary Disease (COPD). Individuals who experience an acute incident related to a chronic disease, such as diabetes or COPD, may also be treated under the acute home health benefit. Acute home health services are allowed for up to 60 days or until the acute condition is resolved, whichever comes first. The services do not require a prior authorization request (PAR) and must not exceed 60 days in duration.
- A client may only receive an additional period of acute home health services if at least 10 days have elapsed since the last acute episode, *and* the acute episode is for a new acute issue. The new period of acute home health may not be used for continuation of treatment from a prior acute home health episode.
- Long-term home health is for clients who have long-term chronic needs that require ongoing home health services, and allow them to remain at home instead of nursing facilities. All long-term home health services require a PAR. If a client requires home health services for chronic needs, the provider may not begin with acute home health services and transition to long-term home health later. Instead, the provider must submit a PAR for long-term home health so the client may begin long-term home health services.
- Long-term home health may be used for a client who has been receiving acute home health services but requires additional time and services to allow the client to be safely discharged from home health services, once the acute episode has ended. Long-term home health services require a PAR.

A client who is receiving either long-term home health services for chronic conditions or Home and Community Based Services (HCBS) waiver services may receive acute home health services only if the client experiences an acute incident that makes acute home health services necessary.

Home Health Advanced Beneficiary Notice (HHABN)

Effective February 3, 2012, the Centers for Medicare & Medicaid Services (CMS) requires that home health providers use a revised HHABN to inform fee-for-service Medicare beneficiaries about possible non-covered charges when limitation of liability applies.
Per chapter 30, section 60, of the Medicare *Claims Processing Manual*, "The HHABN is issued to Original Medicare beneficiaries in advance of furnishing what HHAs believe to be noncovered care, and it also is issued before reducing or terminating most ongoing care provided by the HHA."

Agencies must complete and deliver HHABNs according to the Advance Beneficiary Notice Standards. The revised HHABN now includes three option boxes:

1. Financial Liability Notice — to be issued prior to the HHA providing an item or service that Medicare usually covers, but may not pay for in this instance because of one of the following reasons:
    - the item or service is not medically reasonable and necessary;
    - the beneficiary is not confined to his or her home;
    - the beneficiary does not need skilled nursing care on an intermittent basis; or
    - the beneficiary is receiving custodial care only.
2. Change of Care Notice (due to agency reasons) — to be issued prior to the HHA reducing or discontinuing care listed in the beneficiary's plan of care for reasons specific to the HHA on that occasion.
3. Change of Care Notice (due to physician's orders) — to be issued prior to the HHA reducing or discontinuing Medicare covered care listed in the plan of care because of a physician-ordered change in the plan of care or a lack of orders to continue the care.

The HHABN may be optional for Financial Liability Notice, but is required for Change of Care Notice for any reason. Notices must be delivered to the patient either prior to delivery of services, or immediately upon determination of reduced or discontinued care.

For complete instructions on the revised HHABN, see CMS Transmittal 2362, Change Request 7323. An additional summary of the changes may be found in MLN Matters® MM7323.

Transferring a Client's Home Health PAR

When a client moves their home health services from one Home Health Agency to another, the receiving Home Health Agency is responsible for coordinating with the previous Home Health Agency to transition the plan of care and the PAR.

The receiving Home Health Agency should call ACS Provider Services (1-800-237-0044) to find out whether there is a current Colorado Medical Assistance Program HH PAR in the system. If there is, ACS Provider Services will provide the name and phone number of the Home Health Agency who currently has the approved PAR, but will not able to provide any of the details for the PAR. The new agency must contact the previous agency and notify them that the client is transferring agencies and the effective date of the change. Effective May 1, 2012, providers are required to fill out the Change of Provider Form located under Update Forms in the Provider Services Forms section for proper PAR and claims processing.

Revised HH PAR Form

The Department has revised the Colorado Medical Assistance Program HH PAR form. The revised form will be the only form accepted for Home Health, Extraordinary Home Health and PDN requested services effective May 1, 2012. The form can be found under Prior Authorization Request Forms in the Provider Services Forms section of the Department's Web site. The form has a revision date of April 2012. The form includes more detailed instruction with a flow chart noting where to send PARs for proper processing. The form may also be completed electronically and then printed for submission. The previously used PAR form will be accepted until April 30, 2012. Extraordinary HH PARs may be submitted electronically directly to ColoradoPAR. See www.coloradopar.comor call 1-888-454-7686 for more information.

Reminder: Primary Agency and the Plan of Care

Only one Home Health Agency may be reimbursed for providing home health services during a specific plan of care period to the same client, unless the second agency is providing a home health service that is not available from the first agency. The first agency must take responsibility for the coordination of all home health services. HCBS, including personal care, are not home health services. When more than one agency is caring for a client, the agency who employs the certified nursing assistant is responsible for providing supervisory visits.

Additional Reminder

Provider Training has been revamped with new components. Please refer to the Provider Services Trainings section of the Department's Web site for the most recent information and future Home Health training.

For questions please contact Guinevere Blodgett at Guinevere.Blodgett@state.co.us or 303-866-5927.

Attachment A

Program/Services and Authorizing Agencies

The following list is a reference for identifying the agent authorized to perform prior authorization or peer review functions for the Colorado Medical Assistance Program. Specific questions regarding prior authorization or peer review should be directed to the Authorizing Agency.

Program/Services	Authorizing Agencies
Audiology services	
Cochlear implant repairs and supplies	The ColoradoPAR Program
Hearing aids	The ColoradoPAR Program
Hearing aid batteries and supplies	The ColoradoPAR Program
Contact lenses, under age 20 and under	The ColoradoPAR Program
Dental services	
Age 20 and younger	Fiscal Agent
Inpatient/surgery hospital care, all ages	Fiscal Agent
Non-routine, age 21 and older	Fiscal Agent
Oral maxillofacial surgery, age 21 and older	Fiscal Agent
Orthodontia	Fiscal Agent
Durable Medical Equipment	
Orthotics	The ColoradoPAR Program
Prosthetics	The ColoradoPAR Program
Power wheelchairs	The ColoradoPAR Program
Power scooters	The ColoradoPAR Program
Repairs/Modifications	The ColoradoPAR Program
All Others	The ColoradoPAR Program
EBI bone stimulator	Fiscal Agent
Home and Community Based Services	
Children With Autism (CWA)	Developmental Disability Services-Community Centered Board (CCB)
Brain Injury (HCBS-BI)	Single Entry Point (SEP)/ Case Management Agency (CMA)
Developmentally Disabled (HCBS-DD)	Developmental Disabilities Services – Community Centered Board
Supported Living Services (HCBS-SLS)	Developmental Disabilities Services- Community Centered Board
Children's Extensive Support (CES)	Developmental Disabilities Services-Community Centered Board
Day Habilitation Services and Support (DHSS)	Developmental Disabilities Services-Community Centered Board
Children's Habilitation Residential Program (CHRP)	County Department of Human Social Services
Consumer Directed Care for the Elderly	Single Entry Point/ Case Management Agency
Elderly, Blind, and Disabled (HCBS-EBD)	Single Entry Point/ Case Management Agency
Mental Illness (HCBS-MI)	Single Entry Point/ Case Management Agency
Persons Living With AIDS (HCBS-PLWA)	Single Entry Point/ Case Management Agency

Home Health Services	
Extraordinary Home Health (clients age 17 years and younger)	The ColoradoPAR Program
Extraordinary Home Health w/o Waiver (clients age 18, 19, 20)	The ColoradoPAR Program
Long Term Home Health (clients age 18 years and older)	*Single Entry Point / Case Management Agency ▪ HCBS-EBD ▪ HCBS- MI ▪ HCBS- BI ▪ HCBS- PHW ▪ HCBS- PLWA **Community Centered Boards ▪ HCBS- SLS ▪ HCBS- (DD) ▪ HCBS- CES ▪ HCBS- CWA ▪ HCBS- DHSS
Long Term Home Health w/ DHS waiver (clients 21 and older)	**Community Centered Boards
Long Term Home Health (clients age17 years and younger)	The ColoradoPAR Program CHCBS- Children's Home and Community Based Services
Long Term Home Health w/ or w/o HCPF waiver (clients age 21 and older)	*Single Entry Point/ Case Management Agency
Long Term Care, Nursing facility Admissions	Single Entry Point Agency/ Case Management Agency
Long Term Care diversion to HCBS	Single Entry Point Agency/ Case Management Agency
Medical supplies	The ColoradoPAR Program
Medical/Surgical services	The ColoradoPAR Program
Mental Health Services including psychiatric hospitalization	Regional Behavioral Health Organizations (BHO)
Occupational/Physical Therapy (over 24 units of service)	The ColoradoPAR Program
Oral surgery, age 20 and younger	Fiscal Agent
Organ transplantation	The ColoradoPAR Program
Vision	The ColoradoPAR Program
Out-of-state Inpatient Non-emergency surgical services	The ColoradoPAR Program
Private duty nursing	Dual Diagnosis Management
Prescription drugs	Prescription Drug Card System (PDCS)
Reconstructive surgery	The ColoradoPAR Program
Residential Treatment Centers	County Department of Human Social Services
Second surgical opinion	The ColoradoPAR Program
Transportation Meals and Lodging	The ColoradoPAR Program

Attachment B

Medical Assistance Program Prior Authorization Request (PAR) Form

Is client age 18, 19, 20? ☐Y ☐N HCBS eligible: ☐Y ☐N Extraordinary HH? ☐Y ☐N CHCBS: ☐Y ☐N

Revision: ☐Y ☐N Effective Date of Revision: ____________ PAR Number being revised: ____________

Please provide supporting documentation with this form. ★ See instructions on the reverse side of form.

Client Name: ______________________________ Today's Date: ______________________________

Client Birth Date: ____________________ Colorado Medicaid Client ID#: ______________________________

PAR Start Date: ____________________ PAR End Date: ______________________________

☐ Home Health ☐ Extraordinary HH	Specify Order	Units Requested	Revenue Code	Unit Reimb Rate	Over Daily Max Amt (✓)	Units Authorized	Total Amount Authorized	Approved (A) Pended (P) Denied (D)
HH RN LPN			551					
Brief Nursing Visit-1			590					
Brief Nursing Visit- 2+			599					
CNA Basic			571					
CNA Extended			579					
PT – Benefit for clients 20 and under			421					
OT – Benefit for clients 20 and under			431					
ST – Benefit for clients 20 and under			441					

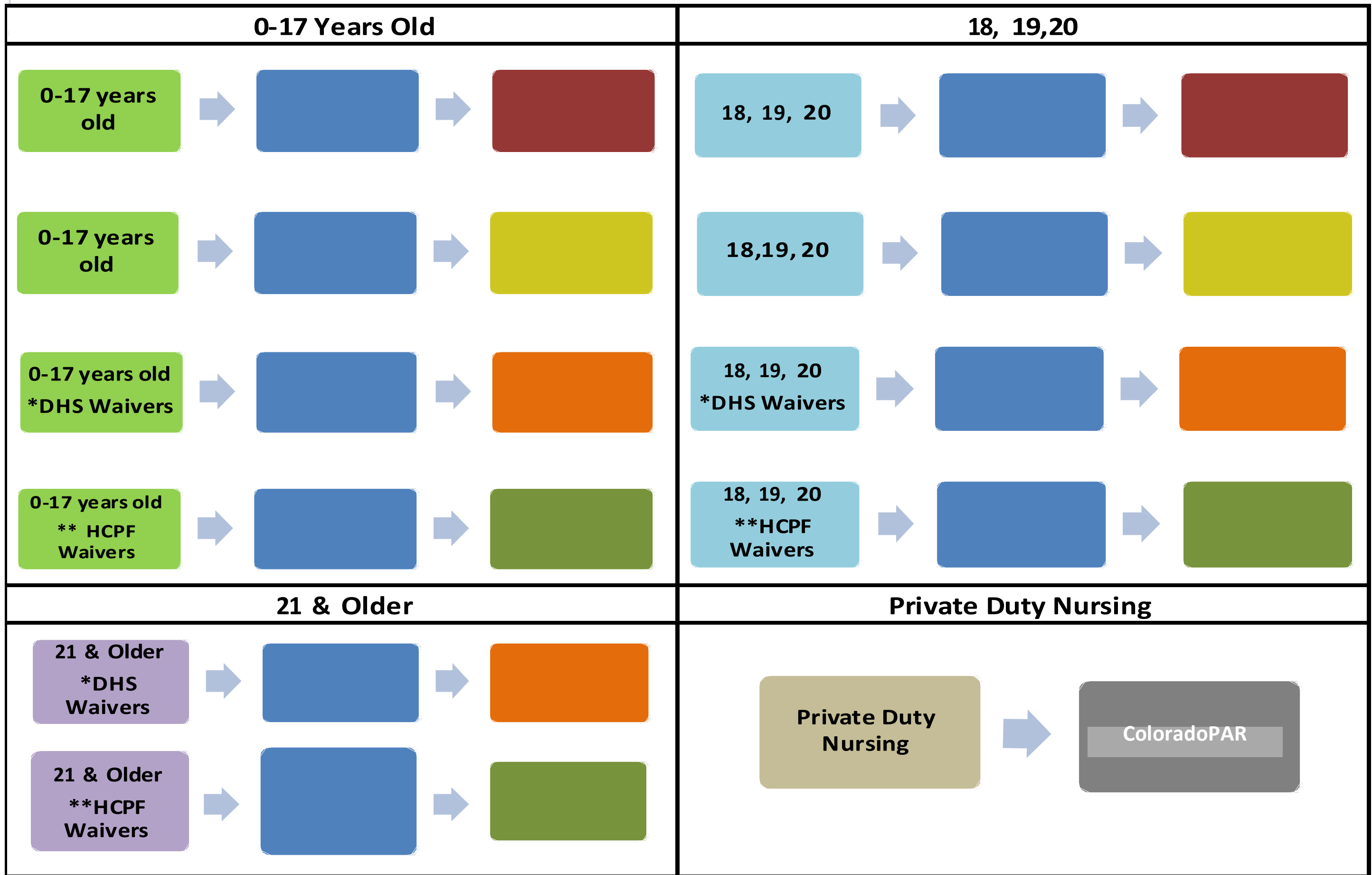
Private Duty Nursing	Specify Order	Units Requested	Revenue Code	Unit Reimb Rate	Units Authorized	Total Amount Authorized
PDN RN			552			
PDN LPN			559			
RN Group			580			
LPN Group			581			
RN/LPN Blended			582			

Reviewers Comments:

Requesting Agency:		**Provider ID #:**	
CMA, if appropriate:		**Provider Local Phone #:**	
Narrative Information:			
Denial Reason Codes:			
Signature of Authorizing Party:		**Date PAR processed:**	

Form Revised: 04/12

Home Health PAR Completion Instructions



Notes:

*colorado.gov/pacific/hcpf > Clients & Applicants>Long-Term Care>
Case Management Agency (CMA)
(http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1205189474
HCPF Waivers include: HCBS-EBD, MI, BI, PHW, PLWA

**colorado.gov/cdhs>Home> Developmental Disabilities> Service Providers> Community Centered Boards
(http://www.colorado.gov/cs/Satellite/CDHSVetDis/CBON/1251586997819)
DHS Waivers include: HCBS-SLS, DD, CES, CWA, DHSS
See Appendix C for prior authorization agency contact information.

Complete this form for Prior Authorization Requests for Private Duty Nursing, Long Term Home Health, and Extraordinary Home Health (EPSDT). Submit appropriate documentation to support your request including detailed demographics, diagnosis, physician's orders, treatment plans, medications, etc.
Acceptable documentation includes a complete CMS-485 form, MD orders, and Admission paperwork for PDN and EPSDT HH.
Complete the Revision section at the top of the form ***only*** if you are revising a current approved PAR.

Remember

For LTHH PAR revisions you must add the number of units being requested to the original number of units approved and include all services that were approved on the original PAR

At the top of the form - Answer all questions completely.

Top of form complete the following fields

Client Name - Required **Date -** Required
Client Birth Date- Required

Colorado Medicaid Client ID # – Required

PAR start date – Required **PAR end date -** Required

Specify Order- Enter visit frequency daily/weekly, etc.
Units Requested- Enter the number of units next to the services for which you are requesting reimbursement.
Do ***NOT*** enter anything to the right of the double vertical line. This is for the authorizing agency use only.

Bottom of form complete the following

Enter your agency name - Required
Sign your name - Required

Enter the Colorado Medical Assistance Provider ID number - Required
Enter the CMA Provider ID - *Only as appropriate for revisions*. The CMA will complete this portion for all others when appropriate.
Narrative information - Home Health Agencies may use this **field to explain the reasons for requested frequency, duration,** medical necessity, or by CMA to explain reasons for denial or approval of a reduced amount, as needed.

Do *NOT* write in the following sections:

Denial Reason Codes - Authorizing agent use only.
Signature of Authorizing Party - Authorizing agent use only.
Date PAR processed - Authorizing agent use only

Form Revised: 04/12

Attachment C

Plan of Care

DeP<ltment at Health and Human Services
Health Care Financing Administration

HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's Claim No. | 2. Start of Care Date | 3. Certification Period From To | 4. Medical Record | 5. Provider

6. Patient Name and Address

7. Provider's name, Address and Telephone Number

8. Date of Birth | 9. Sex M F

10. Medication: Dose/Frequency/Route (N)ew (C)hanged

11. ICD-9-CM Principal Diagnosis Date

12. ICD-9-CM	Surgical Procedure	Date
13. ICD-9-CM	Other Patient Diagnosis	Date

14. DME and Supplies

15. Safety Measures:

16. Nutritional Req.

17. Allergies

18. Functional Limitations

1. Amputation	5. Paralysis	9. Legally Blind
2. BoweVBiadder (incontinence)	6. Endurance	A. Dyspnea With Minimal Exertion
3. contracture	7. Ambulation	B. other (specify)
4. Hearing	8. Speech	

Activities Permitted

1. Complete Bedrest	6. Partial Weight Bearing	A. Wheelchair
2. Bedrest BRP	7. Independent At Home	B. WalKer
3. Up as Tolerated	8. Crutches	C. No Restrictions
4. Transfer Bed/Chair	9. cane	D. Other (specify)
5. Exercise		

19. Mental Status

1. Oriented	3. Forgetful	5. Disoriented	7. Agitated
2. comatose	4. Depressed	6. Letharaic	8. Other

20. Prognosis: 1. Poor 2. Guarded 3. Fair 4. Good 5. Excellent

21. Orders for Discipline and Treatments (Specify AmounVDuration)

22. Goals/Rehabilitation PotentiaVDischarge Plans

23. Nurse's Signature and Date of Verbal SOC where Applicable:

25. Date HHA Received Signed POT

24. Physican's Name and Address

26.

27. Attending Physician's Signature and Date Signed

28.

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Form HCFA-485 (C4) (02-04) Revisian 1 2005