Utilization Management Program for Home Health
Texas Medicare Advantage

Frequently Asked Questions
Listed below are Frequently Asked Questions (FAQs) regarding the clinical policies and procedures for providers providing home health services to Amerigroup MA members.

Why is Amerigroup implementing this Utilization Management (UM) program?
Amerigroup is implementing the program to more closely manage Medicare Advantage member care in the Home Health setting. myNEXUS will manage the care and utilization between Amerigroup, providers, and members.

What is the effective date for the program?
The effective date of this program is January 1, 2017 for Home Health services in IN, KY, OH, and TX. myNEXUS will begin to accept requests for prior authorization beginning December 19, 2016 for dates of service January 1, 2017 and after.

What impact, if any, will this have on providers?
This program does not eliminate any current providers from the Amerigroup provider network. The program is designed to provide a uniform, outcome-based set of criteria for the provision of home health services. Providers will be required to contact myNEXUS for Home Health precertification.

Have physicians been educated on myNEXUS and its role?
Yes, myNEXUS will be leading informational sessions designed to orient you and your staff with our services. There will be several dates and times available to you and your staff for a web orientation session with the myNEXUS implementation team. Provider orientation information is available at https://www.mynexuscare.com/Anthem

What services does this include?
The following services are included for Individual Medicare Advantage members:

- Skilled Nursing
- High Tech Nursing
- Home Health Aide
- Therapies (PT, OT, ST)
- Wound Care
- Behavioral Health
- Medical Social Worker

What services are not included?
This management program does NOT include inpatient rehabilitation, Durable Medical Equipment (DME) requests (e.g., oxygen) or home infusion services.

What is myNEXUS’ role in the authorization process?
Amerigroup has delegated utilization management responsibilities for home health services to myNEXUS for delegated membership. myNEXUS’ scope of responsibility includes the management of the prior authorization process for these home health services in accordance with Amerigroup’s medical polices and clinical utilization management guidelines.

Does this change impact member benefit limits for home health?
No, this does not affect any current benefits. Amerigroup member benefit information for home health services is available either by calling the number on the member’s card or through the Availity provider portal.

How is the servicing provider selected?
If the requesting provider is not a home health care agency, myNEXUS will contact the member and inquire if the member has previously received Home Health. If so, with which provider, and inquire if the member has a
preference for a specific provider. The provider which best meets the member's needs, contractual and regulatory requirements, is identified and contacted.

How will providers submit their claims for home health services?
Providers should continue to bill Amerigroup for services as they do today. There is no change to the claims submission process. Claims for these services will be paid according to their existing Amerigroup agreement.

How do I obtain an authorization from myNEXUS?
Providers will receive information from the plan explaining the authorization process. Additional information is available either online at [https://www.mynexuscare.com/Anthem](https://www.mynexuscare.com/Anthem), via the Provider Portal at myNEXUS [https://portal.mynexuscare.com](https://portal.mynexuscare.com), or by calling myNEXUS at 1-844-411-9622

Please note: An authorization is not a guarantee of payment and it is contingent upon the member's benefits, contract limitations and eligibility at the time of service.

What documentation is required for submission on an initial authorization?
For an initial authorization, at a minimum, a signed MD order, clinical documentation, patient demographics and any additional notes.

What documentation is required for continuation of Home Health services?
For continued authorization of home health visits, please submit a completed OASIS assessment, the J-Haven, and the most recent clinical notes including clinical data that address both the member’s response to treatment and the progress made towards outlined goals. It is also important to submit baseline scoring and subsequent results of any functional testing performed during the treatment period. All requests should be submitted with the myNEXUS Authorization request form.

How do I submit a request for prior authorization for home health services?

1. **Complete a self-service online authorization request at the myNEXUS portal at** https://portal.mynexuscare.com
   For faster authorizations, providers are encouraged to use the self-service myNEXUS portal at https://portal.mynexuscare.com

2. **Complete the myNEXUS Fax Request Form.**
   - In the Provider Information section provide either the facility name or following physician name with their corresponding provider identification number (tax ID and/or NPI). Also, to identify offices with multiple locations, please complete the address, city, state, zip code fields and the fax number of the location where the member is to be treated and where return authorization notification is to be sent.
   - In the Member Information section, fill in the member's name, date of birth and the member’s Amerigroup identification number. Please fill in the fields from left to right. In the Request Information section, darken the appropriate request type circle and complete the request type, service type, whether the visits will be used for post-operative therapy, date of initial evaluation and diagnosis.

3. **Submit the Fax Request Form.**
   Please fax the completed form along with a copy the MD order, member demographic information and any available clinical documentation to myNEXUS’ Fax at 1-844-834-2908. Please submit only Fax Request Forms and any associated documents to this number. If you do not have any Fax Request Forms they may be obtained by accessing the myNEXUS website at https://portal.mynexuscare.com or by calling myNEXUS at 1-844-411-9622.

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4. **Receive the authorization number.**
   It is myNEXUS’ goal to review the request and supporting clinical data, verify eligibility/benefits, render a determination and assign an authorization number, if approved, within 72 hours for urgent requests and 14 days for routine pre-service requests following the receipt of all necessary information. Providers will be notified via fax of the approval status and the number of visits approved. **For faster authorizations, providers are encouraged to use the self-service myNEXUS portal at https://portal.mynexuscare.com**

If an urgent decision is needed regarding Home Health admission, what is the process for urgent review?
   For those members that require immediate care, you may request that authorization through the myNEXUS portal, or fax the authorization request form in marking the box at the top of the form as “urgent.”

Important to note: **Urgent requests should only be submitted if** waiting for a decision under the standard time frame could place the enrollee’s **life, health, or ability to regain maximum function** in serious jeopardy. If member’s condition does not meet this description and the authorization is submitted as an Urgent Request, delays in processing may occur. If an urgent request is submitted that doesn’t meet this definition, your request may be delayed for additional review.

**Who will be reviewing my request?**
   Requests requiring medical necessity review will be reviewed by board-certified physicians and professionals with experience in home health services.

**How do I check the status of an authorization?**
   Providers can check the status of an authorization via the myNEXUS Provider Portal at https://portal.mynexuscare.com or phone at 844-411-9622.

**How will I find out about the decision?**
   **myNEXUS Provider Portal:** If a request was submitted via the portal, providers may access decisions online. Please note: the provider will receive a fax of the determination regardless if the request was submitted through the portal or not.

   **Fax:** myNEXUS will fax all decision notifications to the fax number on each provider’s file after a decision has been made. For this reason, it is especially important for providers that have more than one location to specify the location where the member will be treated on the Fax Request Form and to complete the fax number section of the form. In addition, myNEXUS will require a contact name and number for questions regarding the request.

**How many visits are typically authorized on an initial Home Health admission?**
   myNEXUS will authorize the appropriate number of visits up to 14 days to conduct the initial clinical assessment in the home and to provide the start of skilled care for those services requiring immediate care. Please submit your OASIS assessment within 48 hours of completion to avoid delay of ongoing visit authorization. Upon receipt of the completed OASIS, myNEXUS will authorize visits up to an additional 30-day timeframe, based on individual member clinical needs.

**How is the final decision determined if there is a variance between myNEXUS and the Home Health Agency (HHA) regarding a member’s plan of care?**
   Medical decisions are based on collaboration between myNEXUS and the HHA on a case-by-case basis. myNEXUS will send any cases where agreement cannot be reached to a myNEXUS physician reviewer for final determination. Peer to peer discussion is available upon request.

**What criteria does myNEXUS use to make Home Health Services decisions?**
The Utilization Management Program uses the following national and state approved coverage determinations, as well as objective evidence based clinical guidelines as clinical decision support tools in making coverage determinations and medical necessity determinations:

A. Medicare National Coverage Determination (NCD), Medicare Local Coverage Determination (LCD), Medicare Benefit Policy Manual, Medicare Managed Care Manual Chapter 4 and Home Health Services Chapter 7, and other coverage guidelines and instructions issued by CMS. The CMS guidelines and national and local coverage determinations are consulted when making UM decisions for Medicare members.

B. State Published Guidelines and legislative changes in benefits; Medicaid Coverage and Limitations Handbook, based on Medicaid documents, lists items and service for which Medicare has established a formal coverage policy. The manual covers home care, Medicaid exclusions among other services, treatments and equipment.

A synopsis of the criteria is available to providers and members on request and free of charge by calling myNEXUS at 844-411-9622.

When a member with a Home Health Agency has a change of condition or there is a hospital readmission during the home care episode, who should be contacted?
Please contact myNEXUS to notify us of the hospitalization or clinical complications. myNEXUS will complete an authorization review based on the up-to-date clinical documentation.

Why do I have to use myNEXUS’ Home Health Authorization Request Form?
For faster and more efficient association of clinical information to member file, it is imperative that all fax submissions be accompanied by a myNEXUS Fax Request Form. This enables myNEXUS to identify, route, track and review all submissions in a prompt and efficient manner. The form also contains the information required to process your authorization request. Submissions without the form or incomplete forms may be delayed or not be processed.

To avoid any extra submission of fax forms, providers are encouraged to use the self-service myNEXUS portal at https://portal.mynexuscare.com

Do I have to use myNEXUS’ clinical documentation templates?
No, information may be supplied on myNEXUS’ authorization forms, or by using your own forms or clinical notes that would supply the same information. It is important that all objective information be provided in order for the request to be processed in a timely manner.

For faster clinical review, providers are encouraged to use the myNEXUS provided forms available at https://portal.mynexuscare.com

Can I treat prior to authorization?
If you treat a member prior to myNEXUS’ authorization determination, please be advised that your authorization request may not be approved and your claim may not be paid. Providers may request an authorization myNEXUS online at https://portal.mynexuscare.com.

Will the myNEXUS clinical reviewer be available to have conversations with members and/ or their families?
myNEXUS staff will be in contact with the member throughout the course of home health care treatment when there are questions regarding their homebound status, coordination with their assigned home health care agency or general questions regarding their health status.
Once the member is discharged, what documentation needs to be sent to myNEXUS? Please fax or submit through the portal the discharge OASIS, any other discharge summaries, and a copy of the completed NOMNC (Notice of Medicare Non-Coverage).

What is myNEXUS’ role in discharge planning? When a member is being discharged from a hospital or SNF, the facility discharge planner will contact myNEXUS as soon as the need for home health care is identified. myNEXUS will coordinate the transition between the facility discharge and the assigned home health care provider. myNEXUS provides all needed information to the agency to facilitate their initial assessment and start of home health care services.

myNEXUS works with the agency throughout the duration of a home health care episode. myNEXUS communicates the length of stay through the authorization of services and provides guidance on the anticipated discharge. myNEXUS confirms discharge by the receipt of the completed NOMNC.

Where do Providers send claim appeals? There is no change to the claims appeal process. Providers should continue to submit claim appeals to Amerigroup in the usual manner. Questions regarding claims and appeals should be directed to Amerigroup.

What are the policies and procedures for a servicing provider when a member or physician complaint is received? All complaints and grievances are handled by Amerigroup. Please call the number on the back of the member’s ID card.

What are considered Ancillary Medical Supplies? Ancillary Medical Supplies are routine wound care supplies that are customarily used in small quantities during the course of home health visit and not designated for a specific member.

What about members currently undergoing a course of treatment? Any member, whose course of treatment will continue after 1/1/2017 will need services authorized as of 1/1/2017.

What if an authorization was already submitted to Amerigroup for an admission to a Home Health Agency to begin on or after January 1, 2017? Will a new authorization need to be submitted from myNEXUS? For any service after January 1, 2017 for a per diem provider will require authorization, even if the member was on service prior to January 1, 2017. For an episodic provider, if the member was on service prior to January 1, 2017, authorization will not be required until a new episode begins. myNEXUS will begin to accept requests for prior authorization beginning December 19, 2016 for all dates of service January 1, 2017 and thereafter.

What if I have a question that is not answered above? If you should have additional questions regarding this program, please visit the myNEXUS website at www.mynexuscare.com or contact myNEXUS at 1-844-411-9622 for further assistance.

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AUTHORIZATION PROCESS QUESTIONS
Addendum dated 2/10/17

Can you provide additional insight around what is required for physician orders and the 485 plan of care?
The following information highlights myNEXUS requirements for initial authorizations and reauthorizations specific to the physician orders and 485 plan of care.

1) For initial visit requests where patient is coming from a hospital, SNF, or inpatient rehab:
   a) myNEXUS will accept a written statement stating that there is a verbal order from Dr. “x” (we must have a doctor’s name)

2) For initial visit requests from a physician office:
   a) myNEXUS will accept a verbal order from the patient’s physician

3) On 485 Plan of Care:
   a) myNEXUS will consider a 485 Plan of Care valid if it has the signature or a typed verbal order in Box 23 from the following:
      • RN
      • PT
      • Speech therapist
   b) The following will NOT be considered a valid 485 Plan of Care/MD Order:
      • There is no handwritten or electronic signature or verbal order in Box 23
      • The signature or verbal order in Box 23 is by an LPN, PTA, OT, OTA, Social Worker, or Home Health Aide

Can you clarify if any “face-to-face” documentation is required for myNEXUS authorizations?
There have been some questions about what (if any) face to face documentation is required for this new authorization process. myNEXUS would ask for the following information:

1) If a patient is coming from a hospital stay, Emergency Room visit, SNF, or inpatient rehab:
   a) myNEXUS requests clinical documentation from that stay (e.g. one or more of the following: H&P, discharge summary, progress notes, therapy evaluations, etc.)

2) If a patient is currently at home and the referral for home health is coming from a doctor’s office:
   a) myNEXUS requests a recent physician’s office visit note (preferably within past 30 days, but no more than 90 days)

3) Formal face-to-face documentation is NOT required by myNEXUS

Can you highlight how you authorize services at the HCPC code level?
Currently, myNEXUS authorizes home health services at a per visit per discipline level. For example, a provider could receive an authorization for “five skilled nursing visits.” Within the authorization for “skilled nursing visits,” providers should furnish these five visits as they believe appropriate. With this authorization, a provider could furnish two RN home health visits and three LPN home health visits, for a total of five visits.
What is the process for Resumption of Care (ROC)?
What follows below are the guidelines for providers around ROCs:

1) myNEXUS is updating the Provider Portal to ensure consistency in authorization business rules for the ROCs.

2) Unless a patient has been discharged (NOMNC issued) prior to a hospitalization, the home health agency will continue to utilize the current active authorization. If there are approved visits on the active authorization that were not used prior to the hospitalization, the agency may use those visits prior to requesting additional visits.

3) If a new discipline is ordered during an active authorization, the home health care agency will need to send in MD orders (verbal or written) for the new ordered service.

4) A new authorization is required only when a patient has been discharged (NOMNC issued) for that episode of care.

For providers reimbursed on episodic basis, how will myNEXUS handle these authorizations?
For providers contracted based on Medicare Episodic methodology, home health agencies may start care prior to notification of authorization to myNEXUS. The request for authorization is REQUIRED within 14 days of the start of care.

Required documentation:

1. OASIS
2. Signed MD or verbal order indicated on the 485
3. Discipline evaluation(s)
4. Supplemental orders for therapies
5. HIPPS code
6. myNEXUS will authorize the requested frequencies for SN, HHA and MSW, and will evaluate the plan of care against the submitted HIPPS code for total therapy visits (PT, OT, ST combined), and authorize visits for the certification period.

Important to note:
This authorization will be for the entire certification period.

Provider Portal:
The Provider Portal will be enhanced to include this new process, information will be forthcoming.

Requests:
A Re-Authorization Request form and episodic cover sheet are required to request authorization until all enhancements are completed on the provider portal. This fax request can be found at https://www.mynexuscare.com/wp-content/uploads/2017/02/Reauth-form-with-Episodic-cover-letter.pdf.

Amerivantage is a DSNP plan with a Medicare contract and a contract with the State Medicaid program. In New Mexico: Amerivantage is an HMO with a Medicare contract. Enrollment in Amerivantage depends on contract renewal.