

HP Connect Provider Portal Home Health Authorizations Hospice Utilization Webinar

January 28, 2020 12:30-1:30

Presented by HPP Utilization Management

HP Connect Utilization Webinar

- How to Register for HP Connect
- HP Connect overview
- Demonstration of Outpatient Request (DME/Home Care)
- Demonstration of Transportation Request
- Hospice utilization review
- Provider resources
- Conclusion/Questions

HP Connect Registration/Support

- To obtain access to the Authorization functions, you must register HP Connect, our provider portal (if you don't have credentials):
- <https://www.healthpartnersplans.com/providers/provider-portals/register>
- You will be directed to fill out a form with your information:

PROVIDERS

- Provider Portals**
- Tools and Resources
- Training and Education
- Provider News
- Eligibility and Claims
- Clinical Info
- Plan Info
- Join Our Provider Network

Register

Health Partners Plans' enhanced Provider Portal gives you easy access to member eligibility and claims status information, and more! The first step is to request setup of an administrator who can add/remove/update users for your practice/organization. Please complete and submit this form to designate your administrator.

* required field

Provider Type:*

Office Type:*

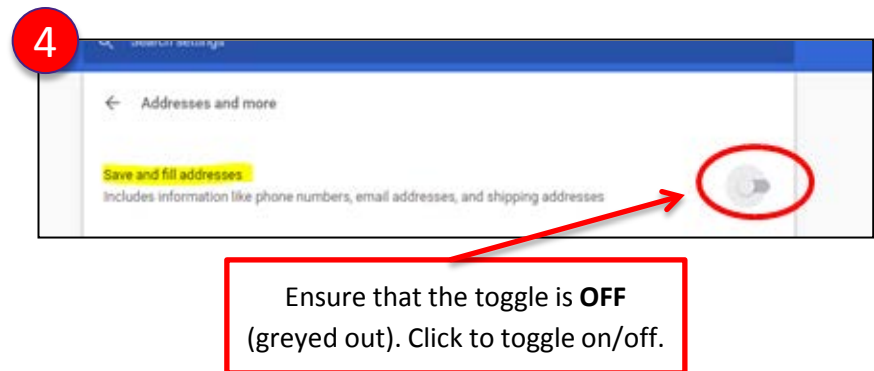
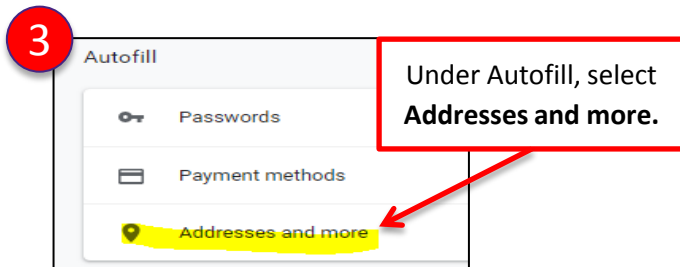
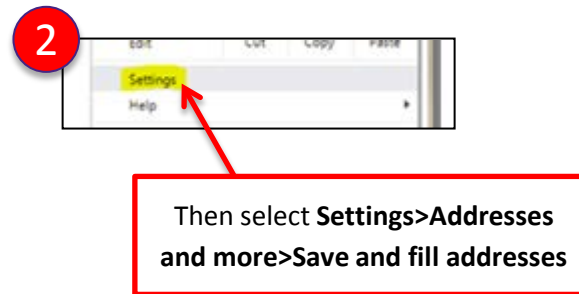
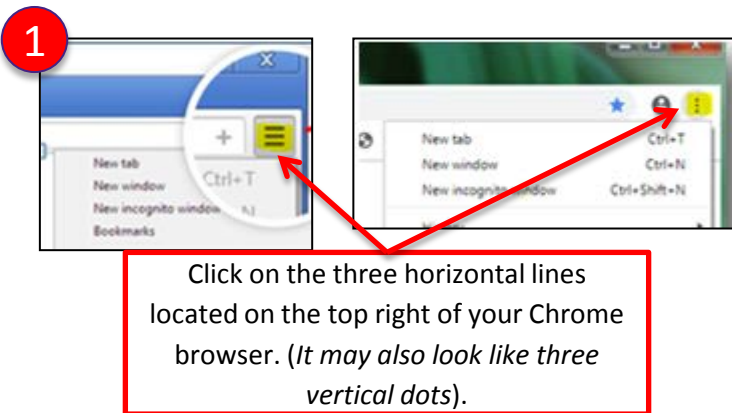
User First Name:*

User Last Name:*

If further assistance is required, please contact our Provider Services Helpline at 1-888-991-9023 (M-F, 9 a.m. – 5:30 p.m.).

Google Chrome Autofill Settings

- To utilize the **Authorization** functions in HP Connect, please ensure you have the Google Chrome Autofill browser settings turned **OFF**.



Prior Authorization Requests

- Effective Jan. 6, 2020, home health agencies and non-emergent transportation providers must use HP Connect to submit all prior authorization requests.
- Increase efficiency to provide faster determination to providers.
- Future Portal initiatives: Providers will be able to receive determinations quickly via HP Connect and will be able to attach additional supporting documentation to an existing request.

Utilization Management Process Updates

- Effective Jan. 6, 2020, date of service extensions of home care authorizations will no longer be processed by HPP.
- UM will provide extended date range for all approved home care approvals disciplines. If visits not completed within the extended timeframe, the Agency may submit a new request with updated clinical documentation for the medical necessity review of more visits. If more visits are needed before the end date of authorization, the Agency may submit a new request with updated clinical documentation for the medical necessity review of more visits. At this time, an HPP Case Manager will adjust the end date of the previous Home Health authorization to prevent overlap of dates of services.
- HPP is working to allow Home Care providers to adjust the end date of their current Home Care authorization before submitting a new request for additional Home Care visits.

Home Care Requests

- Home care agencies should continue to submit requests for disciplines and number of visits as supported by physician orders and the clinical documentation provided for review of medical necessity.
- HPP requests home care agencies provide oversight from their Intake / Authorization teams to ensure that the clinical documentation they submit is specific to their current request.
 - Files cannot exceed 5 MB
 - Attachment names cannot exceed 30 characters or contain special characters
 - Maximum of 9 attachments

Medical Outpatient Authorizations

[Home](#)

Medical Outpatient

Please note that fields marked with an asterisk (*) are required.
Please be advised your request has been pending for clinical review. Please provide all clinical documentation applicable to this request within 24 hours. Please refer to Health Partners Plans Provider Manual for review timelines for each line of business.

Member Eligibility

Enter either a Member No or a Last Name, First Name and DOB.

Member DOB /

Member No /

Member Last Name /

Member First Name /

Gender /

HPP Ordering Physician

If Ordering Physician is not located in search, please enter Physician information manually under Alternate Referring Physician. If Physician entering this authorization is not in the HPP network, please enter Provider Number as AA02 and include information about actual Ordering Physician in the box below. Referring Physician information must be accurate to ensure letter notifications are submitted to the correct Physician.

Last Name /

First Name /

Provider No. /

Provider Specialty /

Out Of Network Ordering Physician

If the Ordering Physician is not found in the search above or not in the HPP network enter information here.

Last Name / First Name /

Provider Specialty / Promise ID if Medicaid /

Provider Street Address /

City / State / Zip /

Phone No. / FAX No. /

DEA# / NPI# / TIN# /

DEA or TIN #

- Member eligibility points
- Ordering physician information required (no longer defaults to PCP)
- Out of network request (HPP file of providers)

Medical Outpatient Authorizations

Diagnosis Information

Enter or search for up to 2 valid diagnosis codes.

Code Set* / ICD10 ?

Diagnosis Code* /

Admitting/Delivering/Service Provider Info.

If Servicing Provider is not located in search, please enter Provider information manually under Out of Network Servicing Provider. If Physician entering this authorization is not in the HPP network, please enter Provider Number as AA02 and include information about actual Servicing Provider in the box below. Out of Network Servicing Provider information must be accurate to ensure letter notifications are submitted to the correct Provider. Attach W-9 document if Provider is not in HPP file.

Last Name / First Name / ? Provider No. /
Line Of Business / ? Par Code /
Provider Type / Specialty / Select a Provider Type to Populate List

Out Of Network Servicing Provider

If Servicing Provider is not located in the search, please enter Provider information manually under Out of Network Servicing Provider. If Physician entering this authorization is not in the HPP network, please enter Provider Number as AA02 and include information about actual Servicing Provider in the box below. Out of Network Servicing Provider information must be accurate to ensure letter notifications are submitted to the correct Provider. Attach W-9 document if Provider is not in HPP file.

Last Name / First Name / Provider Specialty /
Promise ID if Medicaid / Provider Street Address /
City / State / Zip / ?
Phone No. / FAX No. /
DEA# / NPI# / TIN# /






Out of Network, speaking point.

Medical Outpatient Authorizations

Service Information

If Servicing Provider is not located in search, please enter Provider information manually under Out of Network Servicing Provider. If Physician entering this authorization is not in the HPP network, please enter Provider Number as AA02 and include information about actual Servicing Provider in the box below. Out of Network Servicing Provider information must be accurate to ensure letter notifications are submitted to the correct Provider. Attach W-9 document if Provider is not in HPP file.

New Service

Service Date*  Service Date End*  Admission Source* Standard 
Service Type Code*  Facility Type Code* 

Procedure Information

Enter or search for a Procedure Code and update the Quantity, if needed.

Procedure Code*  Procedure Quantity

[Add Another Service](#)

Service type code required – DME or Home care

File Attachments

Click Add File and select a Report Type. Click Browse to navigate to the file to upload. For Outpatient Authorizations, please attach Plan of Care, Goals of Care and Barriers to Care documentation here or you will be asked to enter them manually on the form below. Attachment names cannot exceed 30 characters and may not contain special characters. Attachment size cannot exceed 5MB. A maximum of nine attachments are allowed.

[Add File](#)

Must attach clinical documentation

Medical Outpatient Authorizations

Auth Service Survey Info

Ordering Physician Order Date* / [] [v]

Ordering Provider's Last Face-to-face Visit with Patient* / [] [v]

Home Care Contact Person* / [] [v]

Home Care Contact Phone* / [] [v]

Home Care Contact Fax* / [] [v]

Comments / [] [v]

Home Care Clinical Details* / [] [v]

Provide clinical details to support HOMEBOUND status per Medicare guidelines:

Clinical details to support request: Summarize the CURRENT Skilled Need(s) and Plan of Treatment including initial nursing evaluation visit note, education of member and family - include wound measurements, medication changes, ambulatory status, diagnostic data and family support.

Plan of Care -- enter information or indicate that Plan was attached* / [] [v]

Check if Plan of Care has been attached to Authorization* / [] [v]

Goals of Care -- enter information or indicate that Plan was attached* / [] [v]

Check if Goals of Care has been attached to Authorization* / [] [v]

Complete all fields

- Contact Person
- Phone Number of agent entering
- Fax number for determination
- Home care clinical details: clinical, notes supporting medical necessity
- Items indicated with red star must be completed
- Sections outlined in red are mandatory for Home Care and optional for all other authorizations.

Non-Emergent Transportation

- Ambulance Providers must use HP Connect to submit authorization requests for all non-emergent transportation.
- **For Medicaid members**, please attach the signed Physician Certificate Statement (PCS) for all levels of transport other than Van.
- **For Medicare members**, please complete the Medicare criteria listed on HP Connect.
- **For all lines of business**, Ambulance Provider Professional to sign the attestation certifying the medical necessity of the level of transportation requested.
- Same HP Connect rules apply:
 - Attachments cannot exceed 5 MB
 - Attachment names cannot exceed 30 characters or contain special characters
 - Maximum of 9 attachments

Non-Emergent Transportation

[Home](#)

Transportation

Please note that fields marked with an asterisk (*) are required.

Please be advised your request has been pending for clinical review. Please provide all clinical documentation applicable to this request within 24 hours. Please refer to Health Partners Plans Provider Manual for review timelines for each line of business.

Member Eligibility

Enter either a Member No or a Last Name, First Name and DOB.

Member DOB

Member No

Member Last Name

Member First Name

Gender

HPP Ordering Physician

If Ordering Physician is not located in the search, please enter Physician information manually under Out of Network Ordering Physician. If Physician entering this authorization is not in the HPP network, please enter Provider Number as AA02 and include information about actual Ordering Physician in the box below. Ordering Physician information must be accurate to ensure letter notifications are submitted to the correct Physician.

Last Name First Name

Provider No. Provider Specialty

Out Of Network Ordering Physician

If the Ordering Physician is not found in the search above or not in the HPP network enter information here.

Last Name First Name

Provider Specialty Promise ID if Medicaid

Provider Street Address

City State Zip

Phone No. FAX No.

DEA# NPI# TIN#

Non-Emergent Transportation

Diagnosis Information

Enter or search for up to 2 valid diagnosis codes.

Code Set* ICD10 ?

Diagnosis Code*

Admitting/Delivering/Service Provider Info.

If Servicing Provider is not located in search, please enter Provider information manually under Out of Network Servicing Provider. If Physician entering this authorization is not in the HPP network, please enter Provider Number as AA02 and include information about actual Servicing Provider in the box below. Out of Network Servicing Provider information must be accurate to ensure letter notifications are submitted to the correct Provider. Attach W-9 document if Provider is not in HPP file.

Last Name First Name ? Provider No.
Line Of Business ? Par Code
Provider Type ? Specialty Select a Provider Type to Populate List

Out Of Network Servicing Provider

If Servicing Provider is not located in the search, please enter Provider information manually under Out of Network Servicing Provider. If Physician entering this authorization is not in the HPP network, please enter Provider Number as AA02 and include information about actual Servicing Provider in the box below. Out of Network Servicing Provider information must be accurate to ensure letter notifications are submitted to the correct Provider. Attach W-9 document if Provider is not in HPP file.

Last Name First Name Provider Specialty
Promise ID if Medicaid Provider Street Address
City State Zip ?
Phone No. FAX No.
DEA# NPI# TIN#

Note: Behavioral Health Non-Emergent Transportation does not require prior authorization.

Non-Emergent Transportation

Request of Service Information

Enter the Request for Information as needed.

Is this an Ongoing treatment? Ongoing Treatment Code Other Ongoing Treatment Code

Transportation Source

Transportation Destination

Service Information

Enter the service and procedure information. To add another service, select the Add Another Service button. To edit or delete an entered service, select the Edit or Delete link next to the service.

New Service

Service Date* Service Date End* Ambulance Transport Code*

Service Type Code*

Facility Type Code*

Ambulance Trans Rsn Code*

Complete all fields

Procedure Information

Select a procedure code and follow the instructions for the selection. Change the quantity, if needed.

Procedure Code* Procedure Quantity

[Add Another Service](#)

File Attachments

Click Add File and select a Report Type. Click Browse to navigate to the file to upload. For Outpatient Authorizations, please attach Plan of Care, Goals of Care and Barriers to Care documentation here or you will be asked to enter them manually on the form below. Attachment names cannot exceed 30 characters and may not contain special characters. Attachment size cannot exceed 5MB. A maximum of nine attachments are allowed.

Attach clinical PCS, trip notes

[Add File](#)

Non-Emergent Transportation

Procedure Information

Select a procedure code and follow the instructions for the selection. Change the quantity, if needed.

Procedure Code*

Procedure Quantity

Check which of the following conditions that apply to this patient (more than one condition may be selected)

- Patient can be safely transported by Wheelchair
- Can ambulate with or without assistance
- Can safely transfer from a wheelchair to a vehicle with or without assistance
- Member is unable to use the Medical Assistance Transportation Program (cannot make it to the curb for transport)

[Add Another Service](#)

Note: Medicaid members only

Non-Emergent Transportation

Procedure Information

Select a procedure code and follow the instructions for the selection. Change the quantity, if needed.

Procedure Code*

Procedure Quantity

Check which of the following conditions that apply to this patient (more than one condition may be selected)

- Requires care/monitoring by trained personnel during transport
- Requires Oxygen
- Requires isolation precautions (VRE, MRSA)
- Requires immobilization due to a fracture or possible fracture
- Patient is unable to get up from bed without assistance
- Patient is unable to ambulate
- Patient is unable to sit in a chair or wheelchair
- Cannot be safely transported by any other means
- Acute to acute transfers

[Add Another Service](#)

Non-Emergent Transportation

Specialty Care Ambulance

Procedure Information

Select a procedure code and follow the instructions for the selection. Change the quantity, if needed.

Procedure Code*

Procedure Quantity

Check which of the following conditions that apply to this patient (more than one condition may be selected)

- Ongoing MI
- Hemodynamic instability
- Multi trauma patient that is medically unstable
- Multisystem failure requiring ongoing interventions

[Add Another Service](#)

ALS Ambulance

Procedure Information

Select a procedure code and follow the instructions for the selection. Change the quantity, if needed.

Procedure Code*

Procedure Quantity


Check which of the following conditions that apply to this patient (more than one condition may be selected)


- Requires cardiac Monitoring
- Requires vent
- IV

[Add Another Service](#)

Non-Emergent Transportation

Auth Service Survey Info

Provider Order Date* 

Last Face-to-face Visit with Patient* 

Transport Contact Person* ?

Contact Phone*

Contact Fax*

Comments

Complete fields with red stars

Patient must meet one of the following two criteria per Chapter 10 Medicare Manual / NOVITAS LCD for Ambulance (Ground) Services (L35162)

Please indicate all that apply:

1. The patient being transported has, at the time of ground transport, a condition such that all other methods of ground transportation are contraindicated*

2. The patient is bed-confined before, during and after the transportation. All three must be met:*

Unable to get up from bed without assistance*

Unable to ambulate*

Unable to sit in a chair, including wheelchair*

Must provide Clinical Documentation in support of criteria selected in box below.
Indicate that Physician Certification Statement is attached by checking here.

Clinical Documentation:

- Medicare F2F/Provider Order not mandatory.
- Include transport contact information (name, phone and fax) to provide determination.
- Complete Medicare guideline (LCD/Medicare Manual, Chapter 10) and clinical documentation to support request.
- Attestation required.

Non-Emergent Transportation

Attestation

Enter your name and check the box to confirm the attestation.

Name and Credentials of clinical professional certifying the medical necessity for this level of transport*

I, as the individual logged on to Health Partners of Philadelphia, Inc.'s provider portal, certify that the name and credentials of the clinical professional, along with the requested medical necessity information entered above, is correct to the best of my information and belief according to the order form received and signed by that professional. I understand that Health Partners requires this information be kept on file and will be available to Health Partners upon request. [?](#)

Accept (by accepting you are attesting that all the above is true).*

HP Connect Best Practices

- If you need to provide more information, do not submit a portal request twice. This will create a duplicate request and will cause a delay.
- Call HPP if you submitted a portal request incorrectly or incompletely and direction will be provided.
- Provider Services Helpline at 1-888-991-9023 (M-F, 9 a.m. – 5:30 p.m.).

Hospice Auditing

- Bureau of Program Integrity (BPI) under DHS
- BPI randomly audits hospice providers to ensure all regulations are being met.
- BPI will notify hospice providers of membership files to be submitted for BPI review.
- BPI requests claims documentation from HPP and then compares with documentation submitted by the hospice provider.
- Violations are registered against the hospice provider and may result in recovery of Hospice payments.
- All providers, including, but not limited to ordering physicians, rendering providers, and hospice providers, must be in compliance with all state and federal regulations related to the provision of hospice care when servicing Medicaid and CHIP members.

Hospice Covered Services

- Coverage of all supporting hospice services (e.g., durable medical equipment, pharmacy services, non-emergent transportation, etc.) related to member's terminal diagnosis is the responsibility of the hospice provider, not HPP.
- HPP is only responsible for reimbursement for the following procedure codes related to services provided for hospice care:
 - **T2042** - HOSPICE ROUTINE HOME CARE
 - **T2045** - HOSPICE GENERAL CARE
 - **T2044** - HOSPICE RESPITE CARE
 - **T2043** - HOSPICE CONTINUOUS HOME CARE

Hospice Covered Services continued

- Without physician-signed orders, services being rendered will not be considered authorized.
- For inpatient hospice, appropriate clinical documentation must be provided to HPP to support the level of inpatient hospice care being requested.
- Home Hospice through a participating provider does not currently require authorization. Providers are expected to meet regulatory requirements obtaining hospice certifications and documentation of required hospice services and visits.
- Claims for hospice services are subject to retrospective review.

Inpatient Hospice

- Inpatient Hospice is a benefit for all Medicaid members.
 - A member qualifies for inpatient hospice if they are actively dying or require treatment that can't be managed in the home.
- Required documents for a pre-certification of a hospice admission:
 - Signed Hospice Election Form
 - Signed Certificate of Terminal Illness
 - Plan of care
 - Current assessment of the members condition/symptoms
 - What are the current exacerbating symptoms and interventions?
 - When did they start occurring?
 - Why is member unable to be managed at home?
 - Who is the members support network?

Inpatient Hospice Review Process

- Every inpatient hospice case will be reviewed for medical necessity by HPP's medical directors.
- If approved for inpatient level of care (LOC), 5 days will be approved.
- If the initial request or continued stay request is deemed not medically necessary, the request will be downgraded and be paid at a home hospice level of care.
- Appeal and P2P options will be available.

Respite Care

- Respite care is a covered Medicaid benefit while a member is in a hospice program.
- It is a short stay intended to give temporary relief-up to five days in a row to the person who regularly assists with home care.
- Members are entitled to 5 days covered every 60 certified days.
- Prior authorization is required.

BPI Examples of Hospice Violations

- Claims paid to hospice provider for General Inpatient Services (GIP) when recipient's medical record lacked documentation supporting GIP level of care. Per BPI, payment should have been made at a Routine Home Hospice rate.
- Hospice related services were billed by other providers while recipient was enrolled under hospice coverage (DME, pharmacy, non-emergent Transportation, etc.)
- Claims paid for hospice services when recipient's medical record was missing valid physician signed Certification or Re-certification of Terminal Illness, Hospice Consent, Patient's Rights & Responsibilities and/or clinical documentation of care, visits (all Hospice disciplines).

Questions?

Contact information:

- Provider Services Helpline 1-888-991-9023 (M-F, 9 a.m. to 5:30 p.m.)
- Member Relations
 - Medicaid: 1-800-553-0784
 - Medicare: 1-866-901-8000
 - CHIP: 1-888-888-1211
 - TTY: 1-877-454-8477