Health Partners Plans

Home Health Care, Hospice and Transportation Authorization Requests – Webinar Frequently Asked Questions (FAQ)

Q: What time frame should we request: 2 weeks, 4 weeks or 30 days?

All requests are due prior to the start date. Requests are typically approved for 2-week periods as supported by current clinical documentation. HPP may extend this time frame. We will allow a 5-day grace period for the start of care.

Q: Do we still need signed doctor's orders attached to the portal request for home health care?

Yes, signed doctor's orders are required.

Q: Should we continue to fax our requests for additional visits on an existing auth?

All home care requests, initial and ongoing, should be submitted through the portal. Do not use RightFax for additional visit requests.

Q: Can you clarify where to enter the AA02 for the Out-of-Network Provider section? Do we attach it to the existing auth or start a new one?

Please enter the AA02 code in the "Provider No." field in the box in the HPP Ordering Physician section OR the Admitting/Delivering/Servicing Provider section. It is applicable to each section if there is an out-of-network provider. Once you enter the code, please select "Search" to populate the fields and then manually enter the PCP information in the Out-of-Network Provider section.

Q: Do we attach a request for additional visits to the existing auth or start a new one?

Currently, all portal submissions create a new home care authorization. Future portal enhancements may allow you to attach to the current authorization.

Q: For home health, do we use the outpatient authorization area?

Yes, use the outpatient authorizations area for home health.

Q: If we request a wheelchair van with CPT code A0130, does the system ask for a PCS? Or will it allow us to bypass that?

If you are requesting a wheelchair van, you will not be required to submit the PCS. If you have clinical support for the level of transport, you can attach it in the portal when you are submitting the authorization. In some cases you may have already transported the member due to the situation; in this case trip notes will be needed to support the transportation. If PRIOR auth was requested you will not have trip notes, so any documentation you can provide will work. All transport auths are subject to

random audit. Ambulance Providers must be able to provide the required certifications, documentation and orders to support medical necessity for the level of transport provided, for all lines of business.

Q: For barriers to care, does this mean why the member is home bound? What if there are no barriers and the patient is just home bound. I'm a little confused about what barriers to care means.

The barriers will support why goals are not met. Please identify member issues, as we already know the member is home bound. Barriers should explain and justify why continued home care is needed.

Q: If the request is for PRIOR authorization, how can we provide trip notes? They are completed during the actual transport.

If the transport will occur in the future, please provide the clinical data and PCS to support medical necessity. Trip notes are required only if the transportation event has already occurred.

Q: Will fax requests no longer be processed?

RightFax will be used as a backup to the portal and for clinical data for a pending authorization that was requested by HPP. If you are unable to submit through the portal, please reach out to HPP Provider Services.

Q: If a portal submission fails, what steps should we take to get resolution and submit our request timely?

If a portal submission fails, please reach out to the Provider Services Helpline at 1-888-991-9023. If the issue occurs after hours, please send an email to PortalTeam@hpplans.com.

Q: When submitting for home health, does the plan of care need to be signed by the MD prior to submitting?

You can submit a plan of care that is signed by the nurse as a verbal order from the physician. Then send the signed MD plan of care to HPP plans. Future portal enhancements may allow you to submit via the portal.

Q: If we need to submit an attachment that exceeds the allowable size (i.e., an OASIS), should this be faxed in separately?

The OASIS is not required as long as the clinical data supports the plan of care and the services requested. Avoid sending any document that exceeds the size limits. Instead, have staff submit a summary of the current, clinical documentation specific to supporting the Home Health disciplines and number of visits requested.

Q: Why do all HP Connect portal submissions show as pended after the fact—even the ones that have been approved?

All portal submissions are currently listed as "Pended" even if they are approved. This is a functionality we are working to enhance in the future so that each authorization is updated as it is approved.

Q: Would the notes for home care count as including barriers to care? For example, if we have a client who's been seen only for two weeks, it's not enough time. Could I state that it is a barrier?

Yes, notes (visit) for home care would count. You can type in the barriers or attach the visit notes. The documentation provided would need to explain why goals were not met in two weeks due to these barriers, and so more visits are required. For some home care, two weeks is sufficient.

Q: For transportation requests, under the "Auth Service Survey Info," if the servicing provider is the one requesting the auth, is the "provider order date" the same as the date of service? What do we put for "Last Face-to-face Visit with Patient"?

These dates may be the same. The provider order date is the date the service is requested (order date). The "Last Face-to-face" date is the last day the member was seen by the MD.

Q: For Medicare patients and Non-Emergent Transportation authorization requests, is a PCS required? Sometimes HPP has a PCS on file for the Medicare patients. How long is a PCS valid?

Medicare requests for Non-Emergent transportation do not require a PCS. If you have a PCS for a Medicare member you can still submit it with the request and we will attach it to the clinical data.

The PCS is valid for 60 days for Medicaid for multiple scheduled transports for the same diagnosis, e.g., dialysis, radiation therapy, chemotherapy, medical daycare, etc. In these cases, the physician certificate will be valid for 60 days from the date it is signed. A separate PCS is required when separate transport is needed that is not related to an ongoing need.

Q: Is the authorization time frame for home care still every two weeks?

Typically we review for 2-week increments. HPP will evaluate the request based on the clinical data and may provide a longer time frame based on medical necessity.

Q: Would the 5-day grace period start from the Start Of Care (SOC) date then?

The 5-day grace period is for the initial SOC and begins with the SOC date.

Q: Are we able to see a list of pending authorizations on this portal or do we have to search by individual?

You can pull up all authorizations by navigating to "Authorization and Referral List" in the left menu and selecting the Search button. You can also narrow down results by entering in member information, reference numbers, or date range.

Q: Are servicing providers still able to request transportation authorizations? (It seems that the request form has questions about the patient that only clinical professionals are able to answer, such as provider order date and last face-to-face visit with patient.)

Yes, servicing providers are able to submit transportation authorizations thru the portal. They should receive the clinical information to support medical necessity for non-emergent transportation from the Discharge Planner, Physician or Medical Practitioner requesting the service.

Q: Is authorization required for ambulance transport of Health Partners Medicare patients?

Yes, authorizations are required for non-emergent ambulance transport for Health Partner Medicare members.