

HP Connect Provider Portal Home Health Authorizations Hospice Utilization and Home Infusion Webinar

April 20, 2021 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:*

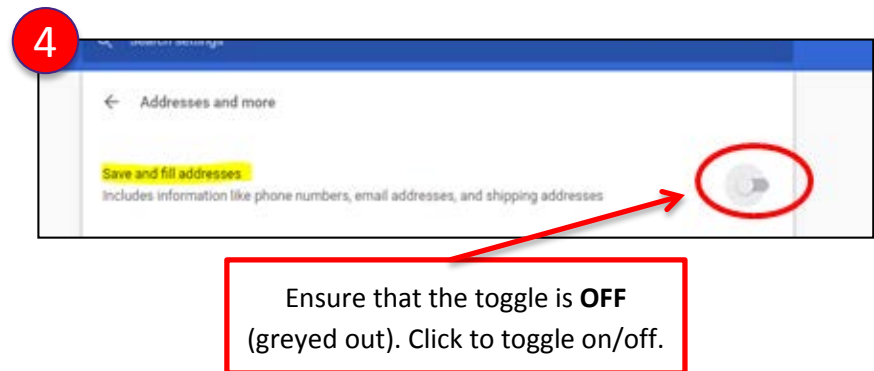
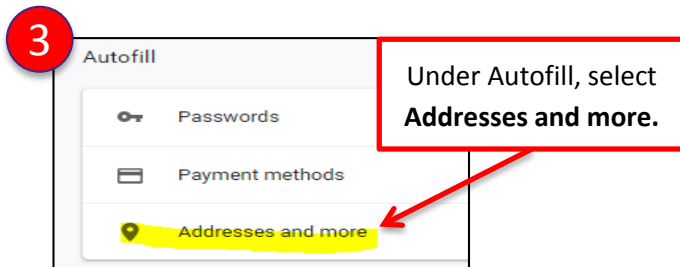
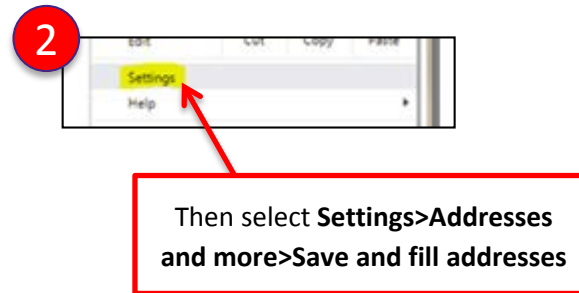
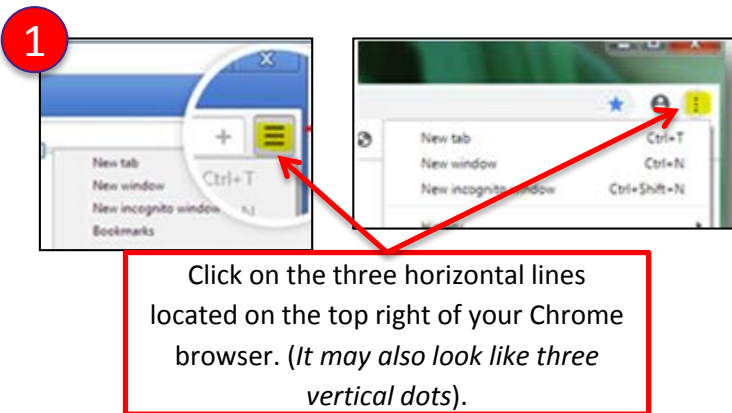
User First Name:*

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**.



Technical Direction

- Internet Explorer (IE) is an unsupported browser for the Aldera Provider Portal.
- Must use Google Chrome as the recommended browser for Aldera Provider Portal.
- If you do not have Google Chrome, Mozilla Firefox or Microsoft Edge may be used as well.

Prior Authorization Requests

- Home health agencies, DME Providers and Non-emergent Transportation Providers re encouraged to use HP Connect to submit all prior authorization requests.
- Increased efficiency to provide faster determination to providers.
- Future Portal initiatives: Providers will be able to receive determinations quickly via HP Connect
Home Care providers will be able to adjust the end date of their current Home Care authorization before submitting a new request for additional Home Care visits. Thus preventing overlap and potential claims issues.

Home Care and DME Requests

- Home care and DME Providers should continue to submit requests for disciplines / Items and volume as supported by physician orders and the clinical documentation provided for review of medical necessity.
- HPP requests Providers maintain oversight of their Intake / Authorization teams to ensure that the clinical documentation they submit to HPP is specific to the current request.
- Valid Physician orders must be provided that match the 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 /

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

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 #

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*

Service type code required – DME or Home care

Procedure Information

Enter or search for a Procedure Code and update 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.

[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* / []

Home Care Contact Phone* / []

Home Care Contact Fax* / []

Comments / []

Home Care Clinical Details* / []

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* / []

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

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

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

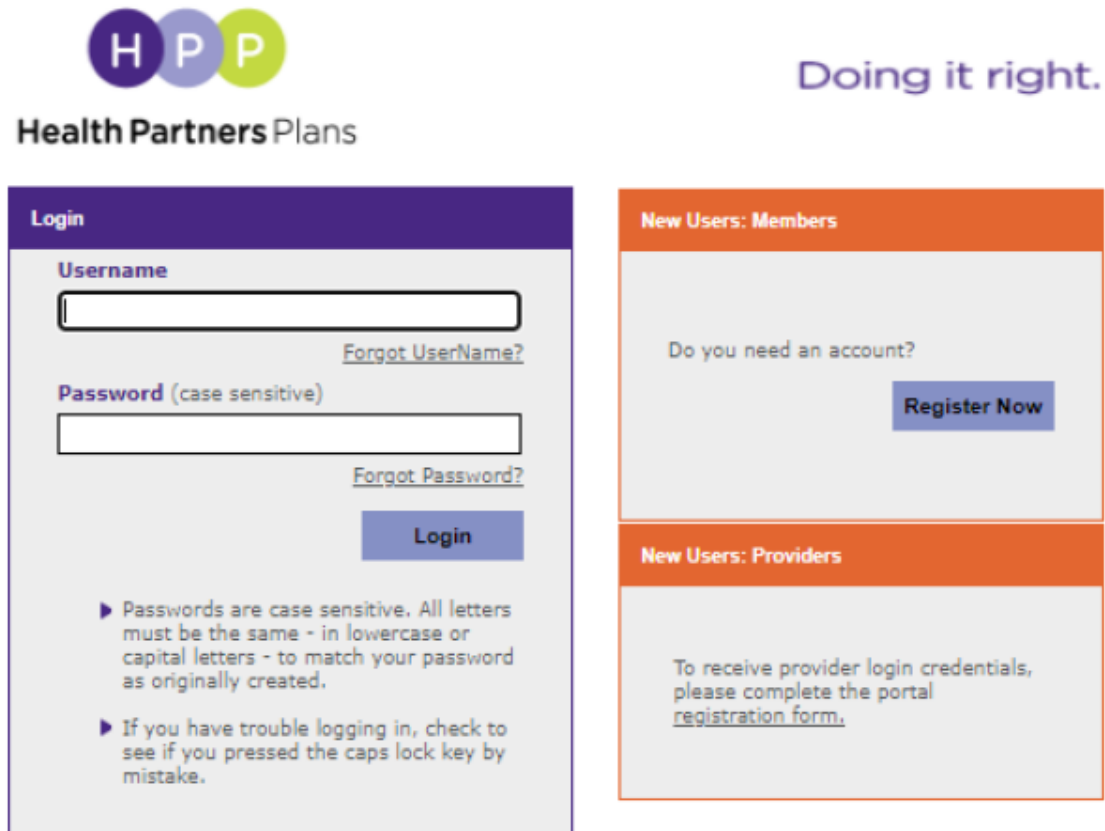
Complete all fields

- 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.

Portal Enhancement !!

- Providers now have the capability to attach additional clinical documentation to an authorization that has already been submitted. This new functionality eliminates the need for Providers to manually fax in the additional clinical documents after an authorization and initial documentation have been submitted in the Portal.
- Following slides contain details on how to submit additional attachments to an existing authorization.

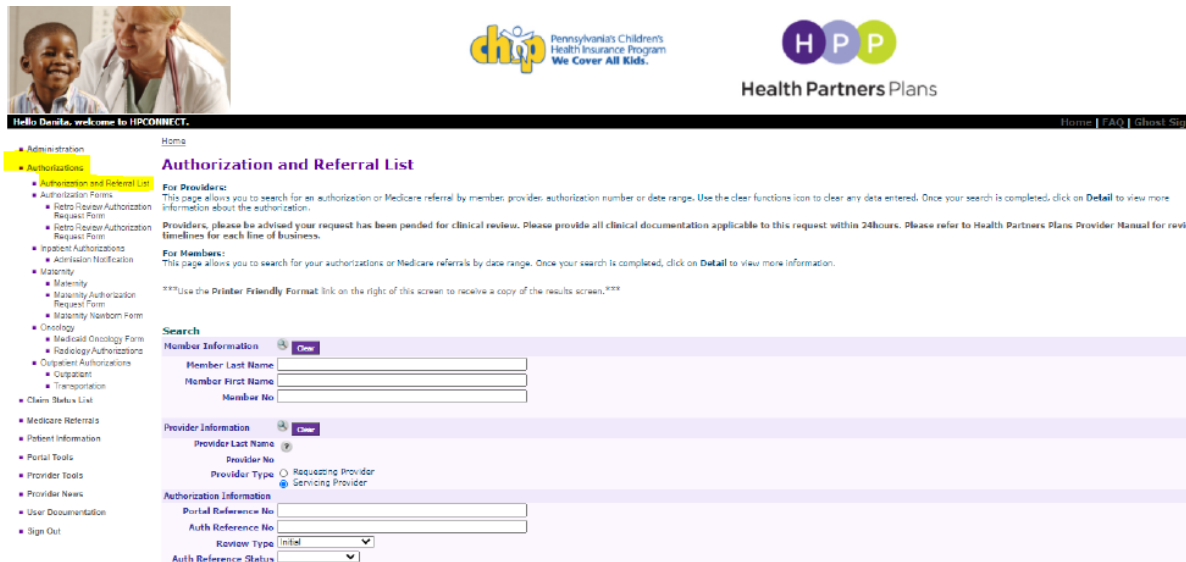
1. Log into Aldera HP Connect Portal <https://hpconnect.alderaplatform.com/>



The screenshot shows the Health Partners Plans website. At the top left is the logo consisting of three overlapping circles: a purple one with 'H', a light blue one with 'P', and a green one with 'P'. To the right of the logo is the text 'Health Partners Plans' and the slogan 'Doing it right.' Below the logo is a 'Login' section with a purple header. It contains two input fields: 'Username' and 'Password (case sensitive)'. Below the 'Username' field is a link for 'Forgot UserName?'. Below the 'Password' field is a link for 'Forgot Password?'. A blue 'Login' button is positioned below the password field. At the bottom of the login section are two bullet points: '► Passwords are case sensitive. All letters must be the same - in lowercase or capital letters - to match your password as originally created.' and '► If you have trouble logging in, check to see if you pressed the caps lock key by mistake.' To the right of the login section is a 'New Users: Members' section with an orange header. It contains the text 'Do you need an account?' and a blue 'Register Now' button. Below that is a 'New Users: Providers' section with an orange header. It contains the text 'To receive provider login credentials, please complete the portal [registration form.](#)'

Authorization and Referral list

- In the menu located to the right of the screen, navigate to “*Authorizations>Authorization and Referral List*”



CHIP Pennsylvania's Children's Health Insurance Program
We Cover All Kids.

HP
Health Partners Plans

Hello Dante, welcome to HPCONNECT. Home | FAQ | Guest Sign

- Administration
- Authorizations and Referral List**
- Authorization Forms
 - Retro Reversal Authorization Request Form
 - Retro Reversal Authorization Request Form
- Special Authorizations
 - Admission Notification
 - Maternity
 - Maternity
 - Maternity Authorization Request Form
 - Maternity Newborn Form
- Oncology
 - Medical Oncology Form
 - Radiology Authorizations
- Outpatient
 - Outpatient
 - Transportation
- Claim Status List
- Medicare Referrals
- Patient Information
- Portal Tools
- Provider Tools
- Provider News
- User Documentation
- Sign Out

Authorization and Referral List

For Providers:
This page allows you to search for an authorization or Medicare referral by member provider, authorization number or date range. Use the clear functions icon to clear any data entered. Once your search is completed, click on **Detail** to view more information about the authorization.

Providers, 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.

For Members:
This page allows you to search for your authorizations or Medicare referrals by date range. Once your search is completed, click on **Detail** to view more information.

Use the **Printer Friendly Format** link on the right of this screen to receive a copy of the results screen.

Search

Member Information

Member Last Name

Member First Name

Member No

Provider Information

Provider Last Name

Provider No

Provider Type Requesting Provider Servicing Provider

Authorization Information

Portal Reference No

Auth Reference No

Review Type

Auth Reference Status

Finding an Existing Authorization

- To find an existing authorization that needs additional clinical documentation uploaded, enter applicable search criteria – this can be done by searching via the Portal Reference Number, PI/PO Authorization Number, or by Member ID, First and Last name, or any other combination of information. (You do not need to fill out all the fields on the screen to perform the search). Filtered results are displayed depending upon the fields that are filled out on this search screen.

Finding an Existing Authorization cont.

- Retro Review Authorization Request Form
- Inpatient Authorizations
 - Admission Notification
- Maternity
 - Maternity Authorization Request Form
 - Maternity Newborn Form
- Oncology
 - Medicaid Oncology Form
 - Radiology Authorizations
- Outpatient Authorizations
 - Outpatient
 - Transportation
- Claim Status List
- Medicare Referrals
- Patient Information
- Portal Tools
- Provider Tools
- Provider News
- User Documentation
- Sign Out

Providers, please be advised your request has been pended 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.

For Members:
This page allows you to search for your authorizations or Medicare referrals by date range. Once your search is completed, click on **Detail** to view more information.

Use the **Printer Friendly Format** link on the right of this screen to receive a copy of the results screen.

Search

Member Information [Clear](#)

Member Last Name

Member First Name

Member No

Provider Information [Clear](#)

Provider Last Name

Provider No

Provider Type Requesting Provider Servicing Provider

Authorization Information

Portal Reference No

Auth Reference No

Review Type

Auth Reference Status

Auth Type

Date Information

Search Date Type Submission Date Service Date

Time Frame

Single Date (mm/dd/yyyy)

Date Range (mm/dd/yyyy)

[Search](#)

Results

Export [Download PDF](#)

Portal Reference No	Auth Reference No	Auth Type	Auth Reference Status	Submission Date	Service Dates	Member No	Member Name	Provider or Facility Name	Admitting/ Referred To Provider Name
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Opening the Authorization

- Once you see the authorization you are looking for, click “*Detail*” to open the authorization

Once you see the authorization you are looking for, click “*Detail*” to open the authorization

Results

Portal Reference No.	Auth Reference No.	Auth Type	Auth Reference Status	Submission Date	Service Dates	Member No.	Member Name	Provider or Facility Name	Admitting/ Referred To Provider Name	Auth Status
Detail AUTH121620200000000009		Medical Outpatient	Pended	12/16/2020	12/01/2020 - 12/30/2020	41030				

Uploading Additional Documents

- Scroll down to the bottom of the screen. There is a new section below the existing File Attachments to upload additional documents called “*Upload File Attachments*”. Click on “*Add File*” to browse for the file or files to be uploaded/submitted. **The original limit of 9 files still stands. (Ex. If there are already 3 documents that were uploaded initially, there is a limit of 6 additional files that can be uploaded).**
- If you have more than 9 attachments, please fax and reference the portal request already submitted on your cover sheet. Should be rare that prior authorization request would require more than 9 attachments.
- Please also keep in mind naming convention, character limit of 30, and no special characters.

Uploading Additional Documents cont.

File Attachments

Report Type	File Name	Update Date
Discharge Summary	TEST 123.docx	12/17/2020 11:55:57 AM
Medical Record Attachment	AUTH121620200000000009.pdf	12/16/2020 04:15:29 PM
Durable Medical Equipment Prescription	Home care review process 2018.pdf	12/17/2020 11:55:27 AM
Medical Record Attachment	test.docx	01/12/2021 01:50:46 PM
Medical Record Attachment	Remarks Legend.docx	01/12/2021 01:50:47 PM
Continued Treatment	test - Copy (3).txt	01/13/2021 04:32:46 PM
Discharge Monitoring Report	test - Copy (10).txt	01/13/2021 04:36:48 PM
Discharge Summary	test - Copy (5).txt	01/13/2021 04:41:53 PM
Diagnostic Report	ACP-6669 Testing attachments.docx	01/14/2021 04:04:56 PM

Upload File Attachments

Confirmation of Authorization Update

- Once submitted, refresh the page or navigate to the homepage and go back to the authorization screen. A red exclamation point icon will display on the authorization that was updated -- located on the far right of the screen.

Results Export Download PDF

Portal Reference No	Auth Reference No	Auth Type	Auth Reference Status	Submission Date	Service Dates	Member No	Member Name	Provider or Facility Name	Admitting/ Referred To Provider Name	Auth Status
Detail AUTH011420210000000001		Medical Outpatient	Pended	01/14/2021	01/05/2021 - 01/05/2021	2300				Pended 
Detail AUTH121620200000000009		Medical Outpatient	Pended	12/16/2020	12/01/2020 - 12/30/2020	4103				Pended 

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

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

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 / NOVITAG 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.
- Refer to the new enhancement process discussed earlier to add documentation to an existing authorization.
- 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

- HPP covers Hospice for Medicaid/ CHIP Members
- Bureau of Program Integrity (BPI); is a Program under DHS
- BPI randomly audits hospice providers to ensure all Hospice regulations are being met.
- 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.

Home Hospice Referral Initiative

- Health Partners Plans Portal team is developing an initiative to submit Home Hospice notifications via the Portal.
- This will provide a check list to ensure Hospice regulations are met.
- Will also ensure appropriate Claims reimbursement and minimize BPI violations. Including inappropriate payment to other Providers for services that should be covered under the Hospice compensation (e.g. Pharmacy, DME, Transport related to Hospice diagnosis)
- Notification will provide documentation for HPP Case Management that member is receiving Home Hospice services.
- Portal development will also include option to report when a member revokes Home Hospice or when they expire.

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 obtained within the regulatory timeline, Hospice services rendered will not be considered authorized.
- Portal referral will allow Hospice Provider to attach the Certificate of Terminal Illness, Member Consent for Hospice and Plan of Care – all signed per CMS regulatory requirements and timelines.
- For Inpatient hospice, appropriate clinical documentation must be provided to HPP to support the level of inpatient hospice care being requested. Authorization is still required for Inpatient Hospice.
- Home Hospice through a participating provider does not currently require authorization. Hospice Providers are expected to understand and meet regulatory requirements.
- Hospice Providers will be able to attest to the validity of their documents.
- Hospice Referrals will be randomly audited that all DHS regulatory requirements have been met.
- 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?
- **** You risk delaying the authorization from being processed if all required forms are not rec'd, completed, and signed as stated above****.

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).

Home Infusion Requests

- New Home Infusion Request form
- Provider Network will provide form and form will be available on the Provider website.
- Ensure that Ordering Physician information and dosing on prescription matches the request submission.
- Ensure Claims submissions are correct and minimize claims recovery relating to payment errors.
- If billable code for a drug, it must be used. HPP will not default to a miscellaneous code.
- Claims and reimbursement issues must be directed to the Provider Helpline or to your Provider Network Account Manager

Milrinone Authorizations and Dosing

- The Home Infusion form offers a specified section to standardize Milrinone reporting as mg/kg/day.
- Preferably provide the per day administration of a drug when applicable.
- Authorization will allow for a 10% dosing range to account for possible weight gain
- Any member's weight above the authorized administration of Milrinone and 10% range, will require a new authorization.

Home Infusion Billing Requirements

- **Important Billing Reminders for all Drug Therapy:**
- Ensure the drug is always billed with a therapy code
- Ensure the drug is billed per the authorized measurement type
- Calculate the actual drug usage and waste to support the therapy
- Report drugs according to the Dose Administered or NDC Units
- Report the JW modifier on Part B drug claims for discarded drugs and biologicals
- Document the amount of discarded drugs or biologicals in Medicare beneficiaries' medical records

Home Infusion Request Form

Home Infusion Provider Name:	Contact person:
NPI:	Phone #/extension:
Tax ID:	Fax #:
Provider ID:	
Member name:	Member DOB:
Member ID#:	Member weight:
Diagnosis code(s):	
Ordering Physician Name:	Office Contact:
NPI:	Phone#/extension:
Provider ID:	Fax #:
Date of orders:	
Dates of service:	
Place of service - Please circle HOME MD office Infusion center	
If being given in a SNF, is this member's home (custodial care):	
MILRINONE (If WEIGHT GAIN over 10% new request is required)	
Dose ordered:	Attach orders
Concentration: _____mg/ _____kg/ _____day	Waste: MUST be reported on claim with modifier JW
J code	99601/visits
S code/per diem	99602/hours
OTHER MEDICATION OR Hydration	
Dose ordered:	Attach orders
Concentration:	Waste: MUST be reported on claim with modifier JW
J code	99601/visits
S code/per diem	99602/hours
OTHER MEDICATION OR Hydration	
Dose ordered:	Attach orders
Concentration:	Waste: MUST be reported on claim with modifier JW
J code	99601/visits
S code/per diem	99602/hours

Please check here Attesting that all documentation is accurate

Questions?

Thank you for attending today's session.

- 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