USER MANUAL

Home Health

Prior Authorizations
Fee for Service

Ohio Department of Medicaid

Table of Contents

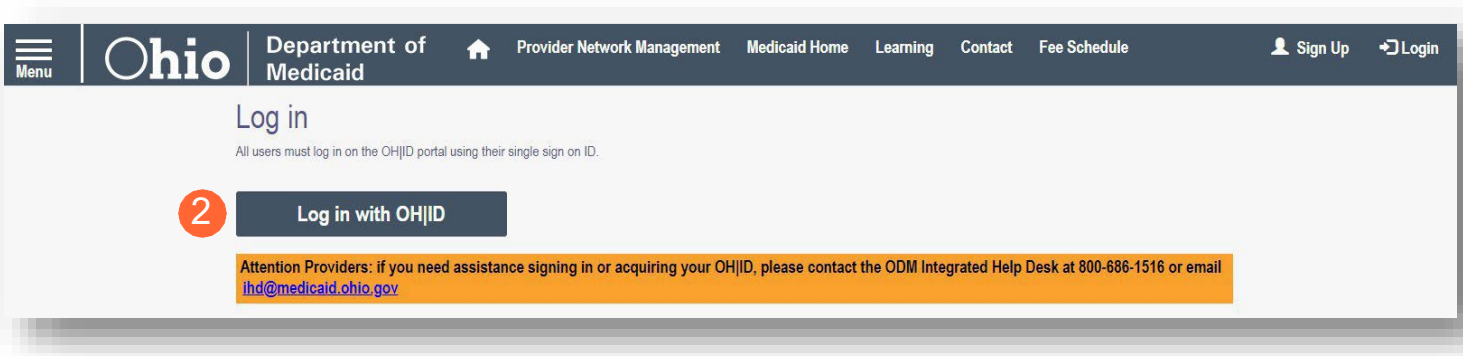
Provider User Initial Login 3
Provider Home Page 4
Accessing the Provider Self Service Panel 5
Submit a New Prior Authorization 7
Recipient Information 10
Requester Contact Information 10
Service Information 11
Non-Institutional 11
Service Provider Information 12
Ordering Provider Information 12
Diagnosis Information 14
Service Details 15
Professional 15
Limited Home Health Services (No PA Required) 18
Provider Notes (Optional) 18
How to Access Reviewer Notes 19
Outcome of Review 19
Attachments (Mandatory) 20
Recommended Attachments for Home Health 21
Submit Prior Authorization 22
Resources 23

Provider User Initial Login

In this section of the user guide we will review the initial steps of logging into PNM. All users will log into the PNM system by using IOP (Innovate Ohio Platform).

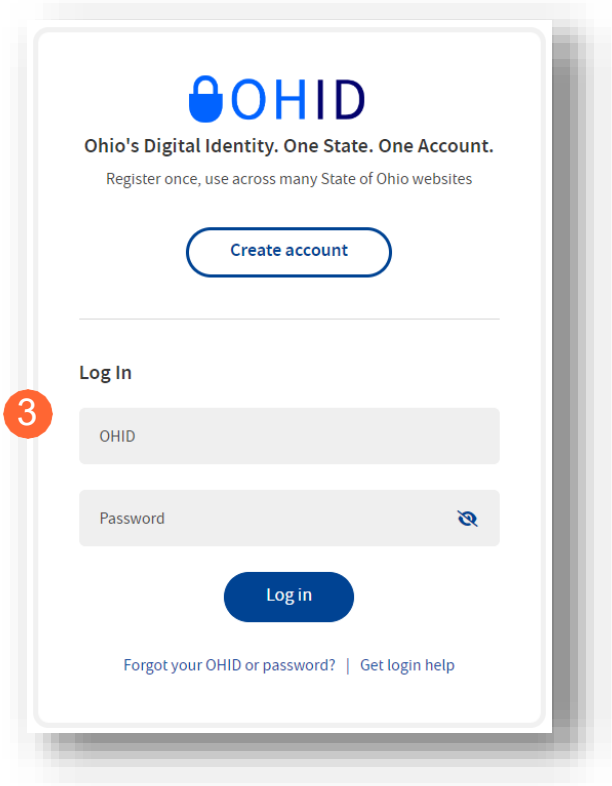
Step 1: Visit the PNM web address: https://ohpnm.omes.maximus.com/OH_PNM_PROD/Account/Login.aspx.

Step 2: Click **Log in with OH|ID**.

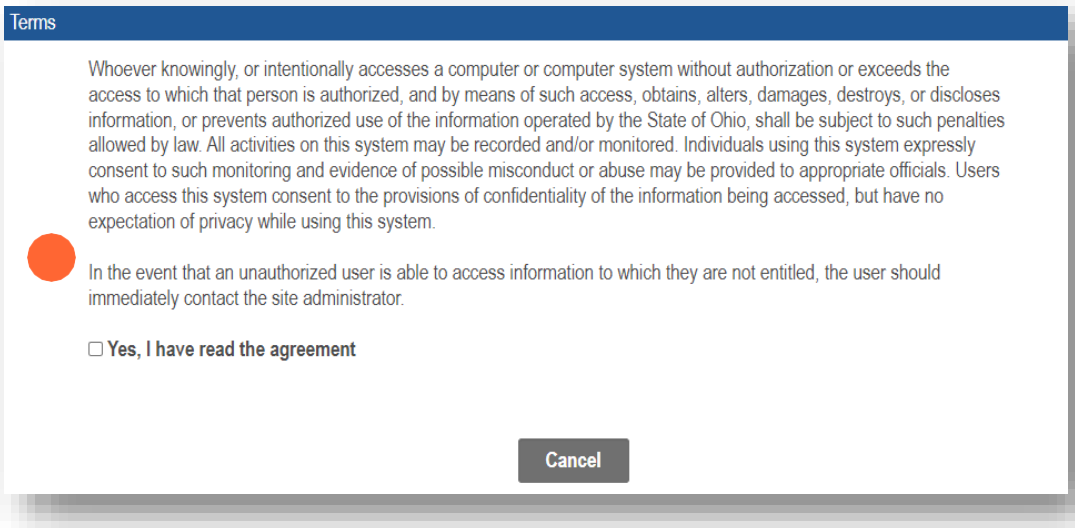


Step 3: The system will prompt you to enter your username and password on the IOP login screen. Once entered, click **Log in**.

- If you have not created an IOP account previously, you can click **Create Account** and follow the steps to create a new account.



Step 4: You will be redirected to the PNM system. Read the Terms of Use and click "Yes, I have read the agreement" to proceed into PNM.



Provider Home Page

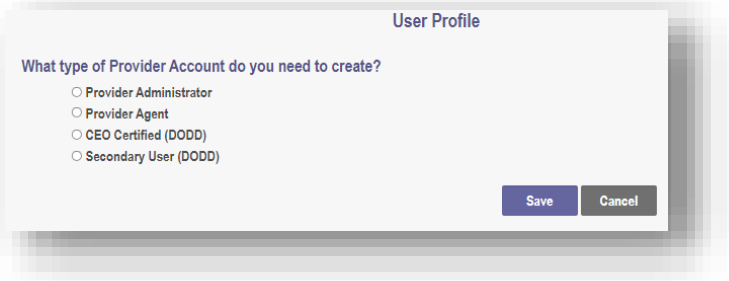
There are two provider roles in PNM:

- **Provider Administrator:** *(Also known as CEO Certified for DODD)* A role assigned to a user in PNM that allows that user to create new enrollment applications, update provider records, and complete revalidations among other tasks. The Administrator role will also be able to grant accesses/actions to other users in PNM, known as Agents.

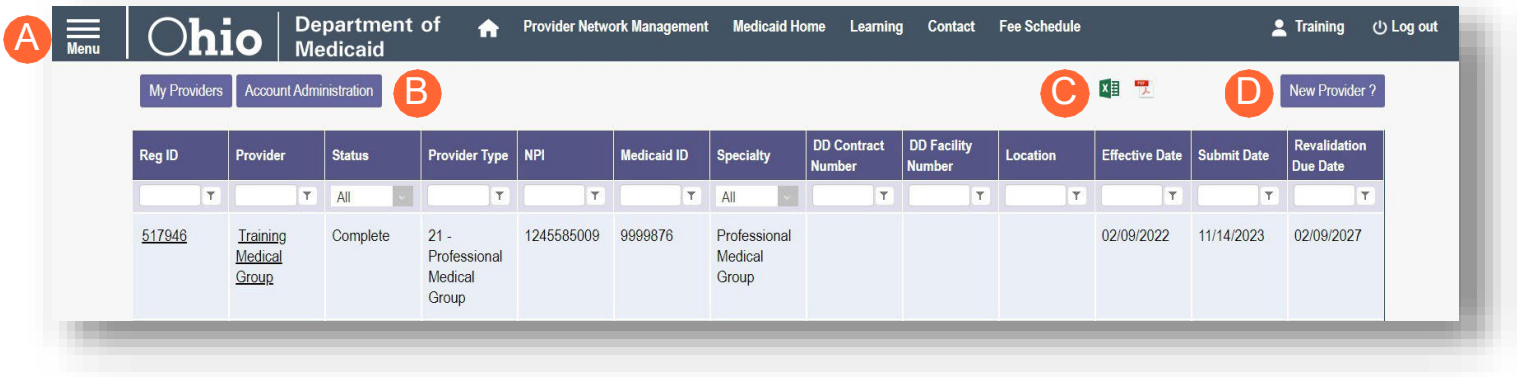
    - There is one Administrator role per NPI/Medicaid ID. However, a single user with the Administrator role can administer to multiple providers (NPIs/Medicaid IDs).

- **Provider Agent:** *(Also known as Secondary User for DODD)* A role assigned to a user in PNM that allows that user to complete specific actions such as updating a provider record, revalidation, claims submission, prior authorization, the viewing of reports, etc. These actions are assigned to each Agent by the Administrator for the Medicaid ID.

A user must select a role the first time they log into PNM.



When first logging in to the PNM system there are a variety of buttons to help with administering providers. Some of the buttons, as indicated below, are only accessible to certain user roles.



Menu: The menu can be accessed by clicking on the three bars in the top left corner of the screen. The Menu provides a variety of key topics to choose from such as the Provider Directory, Learning Resources, and Contact Us (A).

Account Administration: This button allows a Provider Administrator to set up Agent users, assign them actions/roles, or transfer the Provider to another Provider Administrator user *(button only displays for users holding the Provider Administrator or CEO Certified role)* (B).

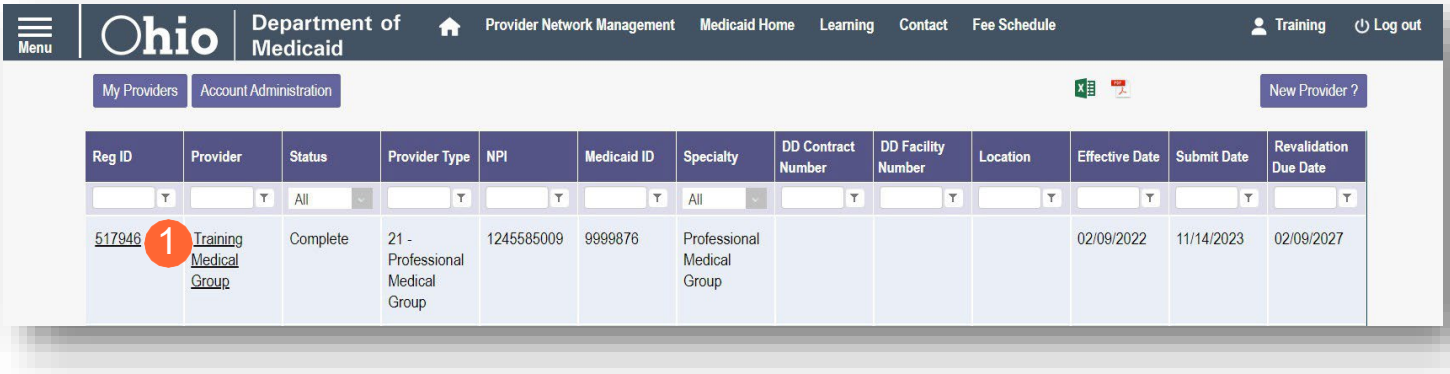
Excel and PDF Icons: These buttons allow you to export the list of providers appearing on your dashboard. Click the 'green' icon to export the list in an Excel format or the 'red' icon to export the list in a PDF format (C).

New Provider?: This button is used to start a New Enrollment Application (first time enrolling with ODM, ODA, or DODD) for any new Ohio Medicaid provider that you will be responsible for administering *(button only displays for users holding the Provider Administrator or CEO Certified role)* (D).

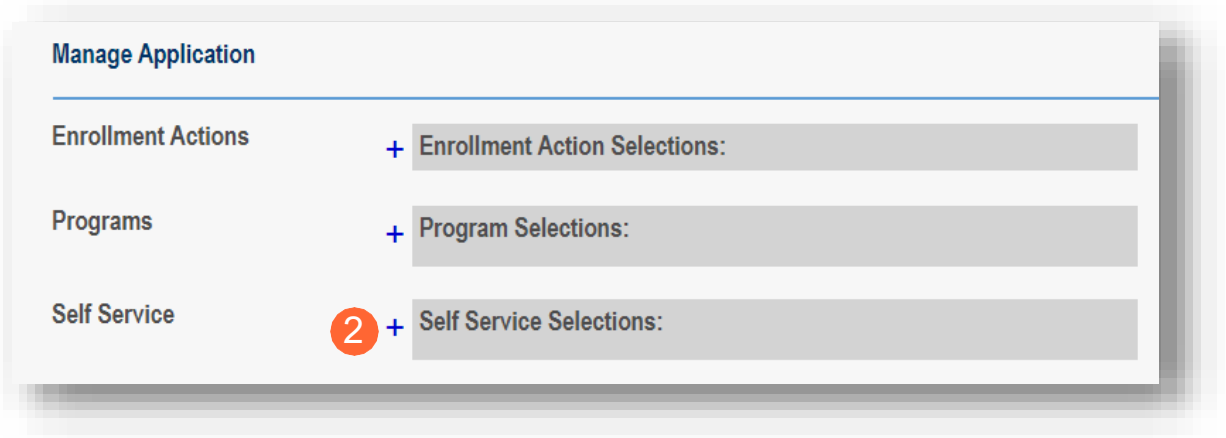
Accessing the Provider Self Service Panel

This section displays the necessary steps for accessing the Self Service functionalities for a provider file.

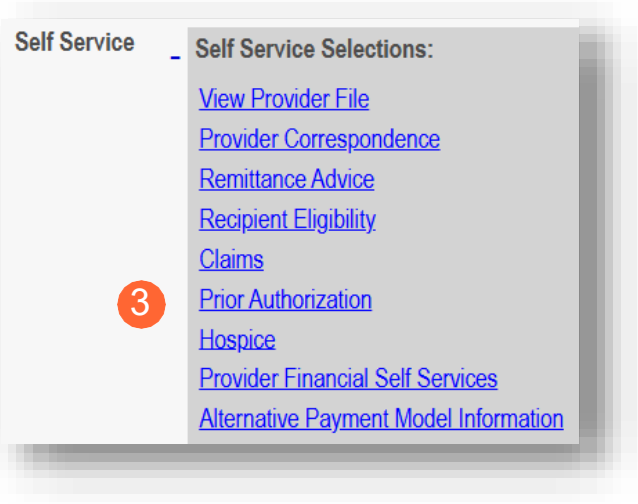
Step 1: From the Provider Homepage/Dashboard, click the hyperlink under Reg ID or Provider to manage the file of the Provider you wish to access.



Step 2: Under the Manage Application section, click the '+' icon to expand the Self Service Selections.



Step 3: Click the hyperlink for "Prior Authorization."



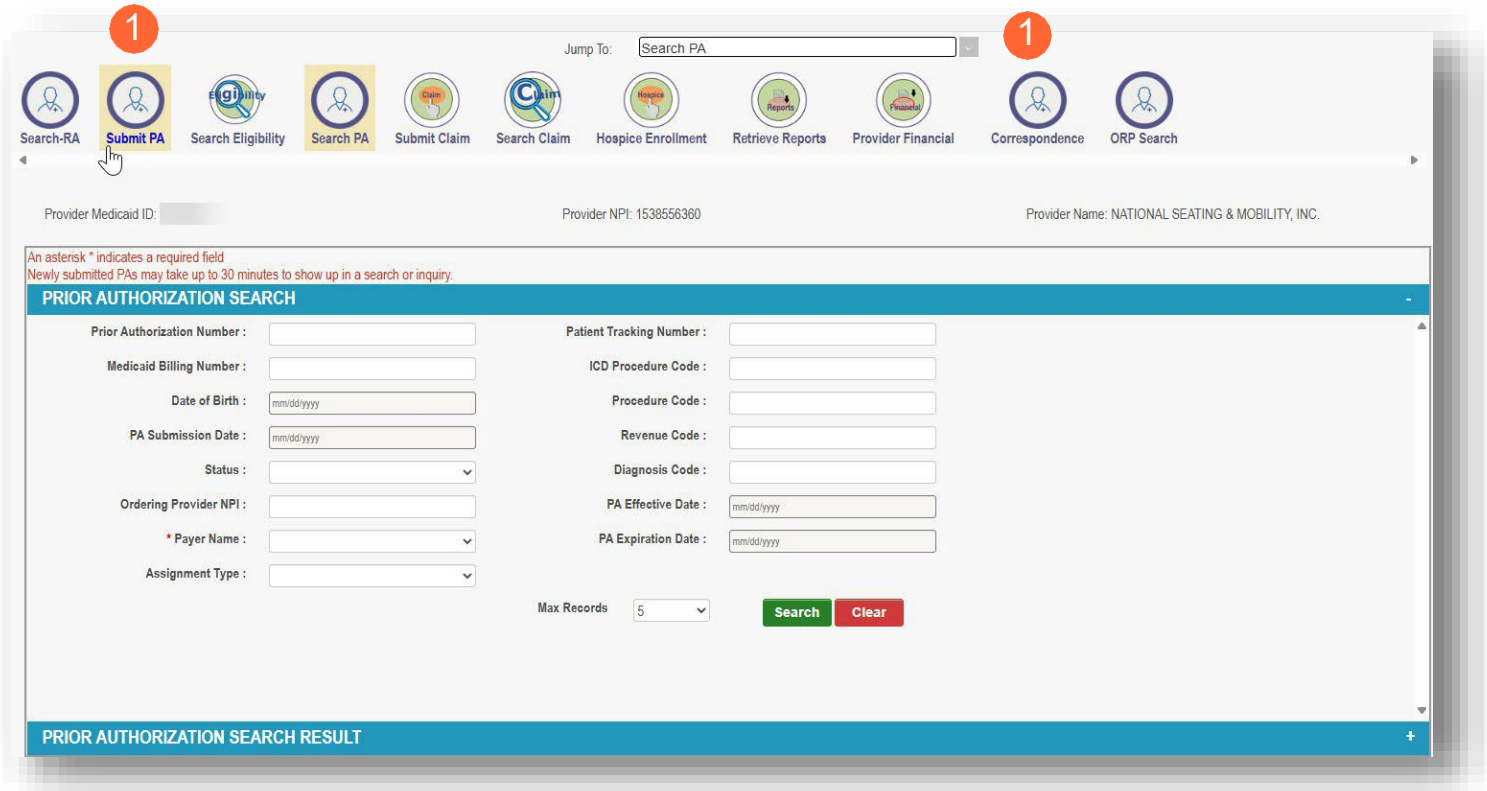
Submit a New Prior Authorization

Visit the Ohio Department of Medicaid (ODM) website and view the 'Prior Authorization Requirements' page to confirm services that require a prior authorization: https://medicaid.ohio.gov/resources-for-providers/billing/prior-authorization-requirements/prior-authorization-requirements

Important Home Health PA Notes

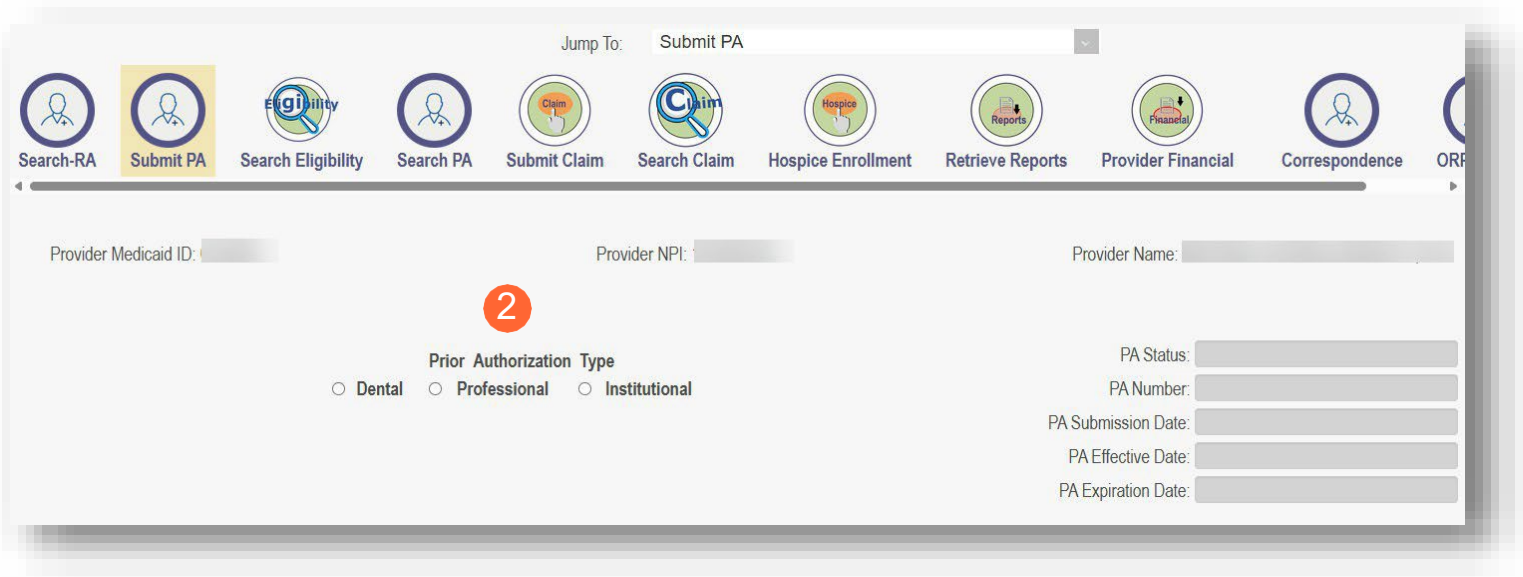
- Initial RN Assessment (T1001) does *not* require prior authorization.
- For individuals receiving ongoing maintenance care, submit authorization spans as appropriate, up to 365 days.
- Prior authorization for service/payment is separate from practitioner orders and may extend beyond the prescription period, but signed orders are required to continue billing.
- The clinical stability and ongoing need for services should determine the length of the requested authorization up to a maximum of 365 days.

Step 1: To submit a prior authorization, click the 'Submit PA' icon at the top of the page or select "Submit PA" from the drop-down menu.



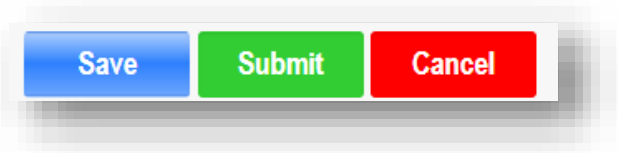
Step 2: Select the Prior Authorization Type you are submitting by choosing the appropriate radio button:

- Professional



Note: If you select the incorrect prior authorization type, click **Cancel** at the bottom of the page. This will reset the prior authorization submission page and allow for the correct type to be selected

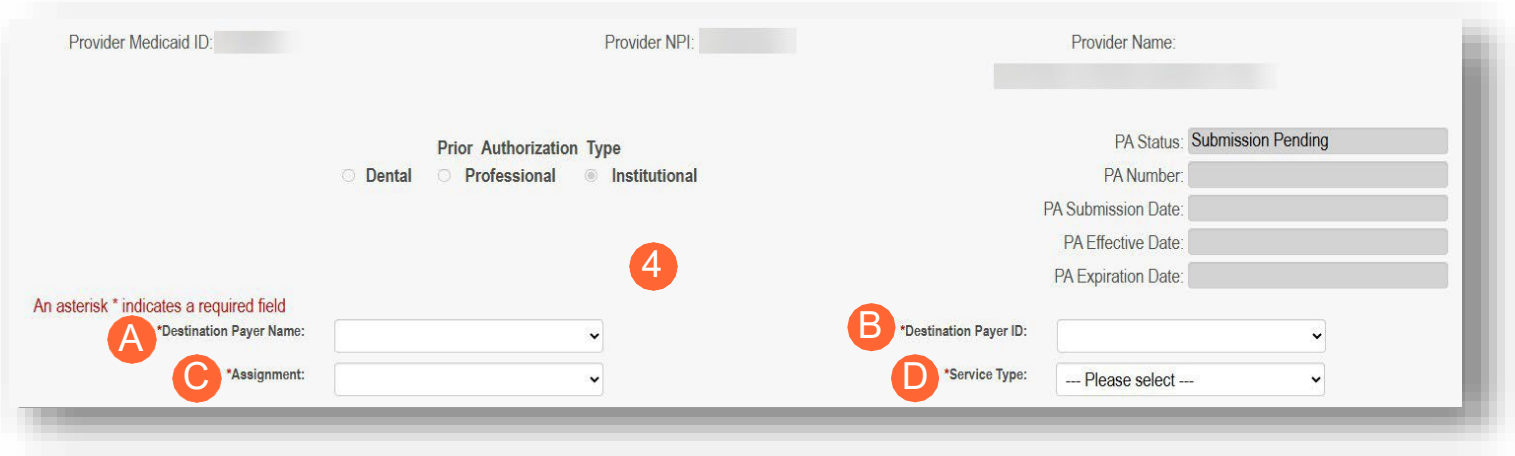
Note: The Save, Submit, and Cancel buttons below appear at the bottom of the prior authorization submission page.



- **Save**: Saves the prior authorization form and data entered
  - Prior authorizations that are in 'Saved' status have not been submitted to the payer and are able to be saved in the PNM system for up to 72 hours for future retrieval.
- **Submit**: Sends the prior authorization for review.
- **Cancel**: Cancels the prior authorization and erases data entered.

Step 3: After selecting a Prior Authorization Type, additional options will appear below.

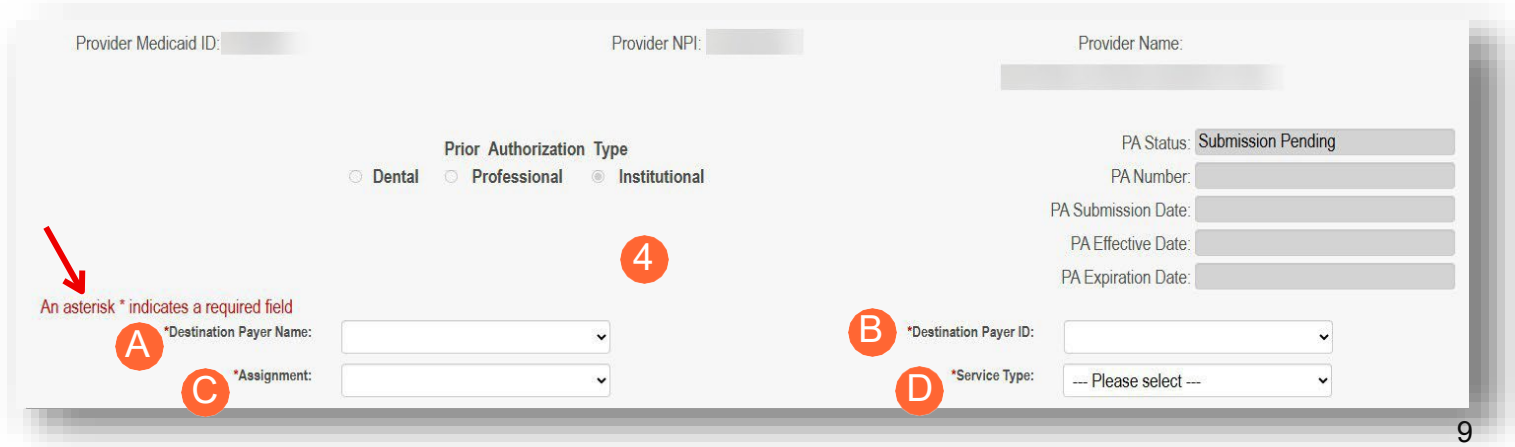
Note: The same Destination Payer options will appear regardless of what type of Prior Authorization Type is selected.



Step 4: Select the following from the provided drop-down menus:

- Destination Payer Name **(A)**
  - Ohio Department of Medicaid
- Destination Payer ID **(B)** *(options dependent on what is selected for Destination Payer Name)*
  - *When selecting Ohio Department of Medicaid*
    - MMISODJFS - Ohio Department of Medicaid
- Assignment **(C)**
  - The Assignment options that appear are dependent upon the Prior Authorization Type selected. Professional (P)
    - **38 – State Plan Home Health**
- Service Type **(D)**
  - Select the type of service being requested.
  - Selections populated from the EDI 278 Service Type Code List

Note: A red asterisk (*) anywhere on the page (in a section header/title or next to a field) indicates that field or panel is required to be completed. If required fields are not completed, PNM will display error messages in red text.

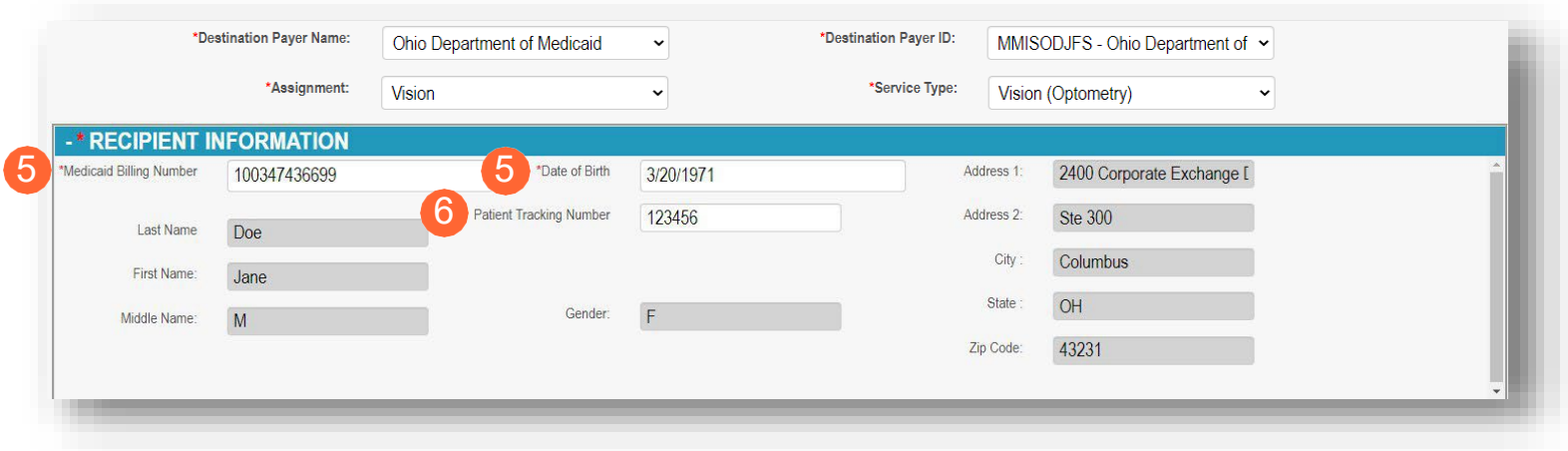


Recipient Information

Step 5: Enter the Medicaid Billing Number and Date of Birth for the recipient.

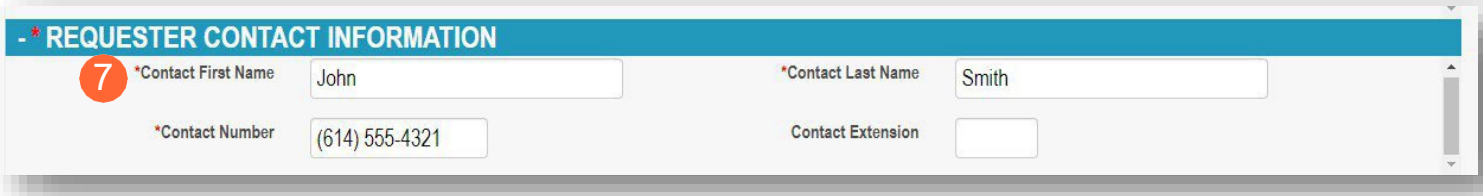
Step 6: Create a unique patient tracking number for the recipient to use when reconciling the prior authorization (this is not a required field and is used for any internal tracking number you have for the recipient).

Note: The information appearing in gray boxes populates after a Medicaid Billing Number and Date of Birth have been entered for the recipient. This information is read-only data and cannot be changed.



Requester Contact Information

Step 7: Enter contact information for the requester. This is the person the Destination Payer will contact if there are any questions regarding the prior authorization. First Name, Last Name, and Contact [Phone] Number are required.



Service Information

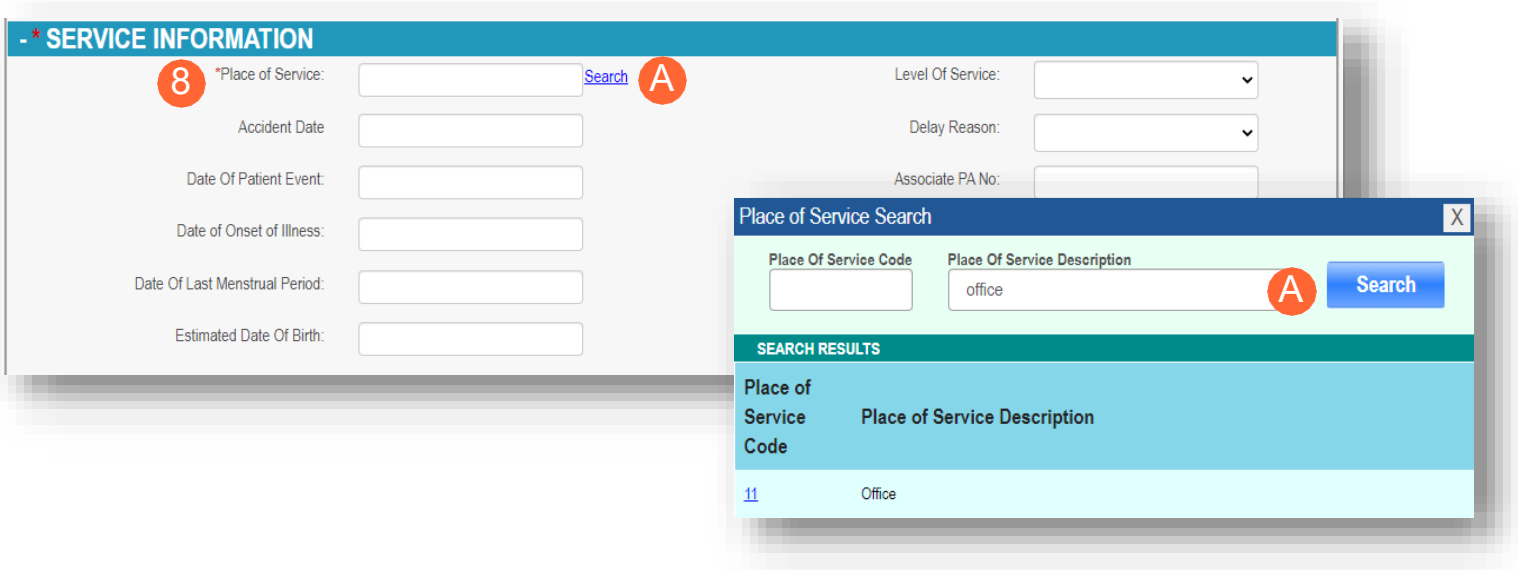
The Service Information section for Home Health is titled 'Non-Institutional'.

Non-Institutional

Visit the Ohio Department of Medicaid (ODM) website and view the 'Prior Authorization Requirements' page to confirm services that require a prior authorization: https://medicaid.ohio.gov/resources-for-providers/billing/prior-authorization-requirements/prior-authorization-requirements

Step 8: Enter information related to the service.

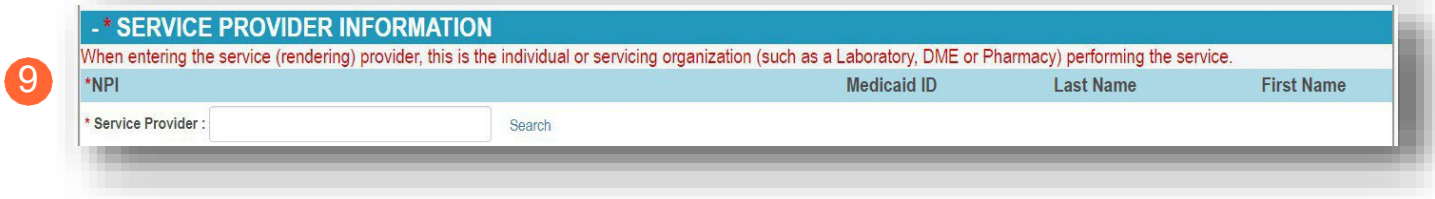
- Place of Service is the only required field in this section.
  - If you don't know the place of service, click the 'Search' hyperlink to bring up a search panel to locate the Service Code. Enter a Place of Service Description and click **Search** (A). Once the Place of Service code is located, click the code hyperlink.
- Accident Date
  - If entered, date must be in MM/DD/YYYY format and future date is not allowed.
- Date of Patient Event
  - If entered, date must be in MM/DD/YYYY format and future date is not allowed.
- Date of Onset of Illness
  - If entered, date must be in MM/DD/YYYY format and future date is not allowed.
- Date of Last Menstrual Period
  - If entered, date must be in MM/DD/YYYY format and future date is not allowed.
- Estimated Date of Birth
  - If entered, date must be in MM/DD/YYYY format.
- Level of Service
  - E – Elective
  - U – Urgent
- Delay Reason
  - 1 – Proof of Eligibility Unknown or Unavailable
  - 2 – Litigation
  - 3 – Authorization Delays
  - 4 – Delay in Certifying Provider
  - 7 – Third Party Processing Delay
  - 8 – Delay in Eligibility Determination
  - 10 – Administration Delay in the Prior Approval Process
  - 11 – Other
  - 15 – Natural Disaster
  - 16 – Lack of Information
  - 17 – No Response to Initial Request
- Associate PA Number
  - A prior authorization number assigned by the payer that is related to this request.
  - This field can be used during a Continued Stay Review to indicate the associated PA.



Service Provider Information

Step 9: Enter the National Provider Identifier (NPI) for the Service Provider. This is the individual or servicing organization (such as a Laboratory, DME or Pharmacy) performing the service. If you don't know it, you can click 'Search' to search for the Provider by Medicaid ID, Business Name, or First and Last Name. Once the provider is located, click the NPI hyperlink.

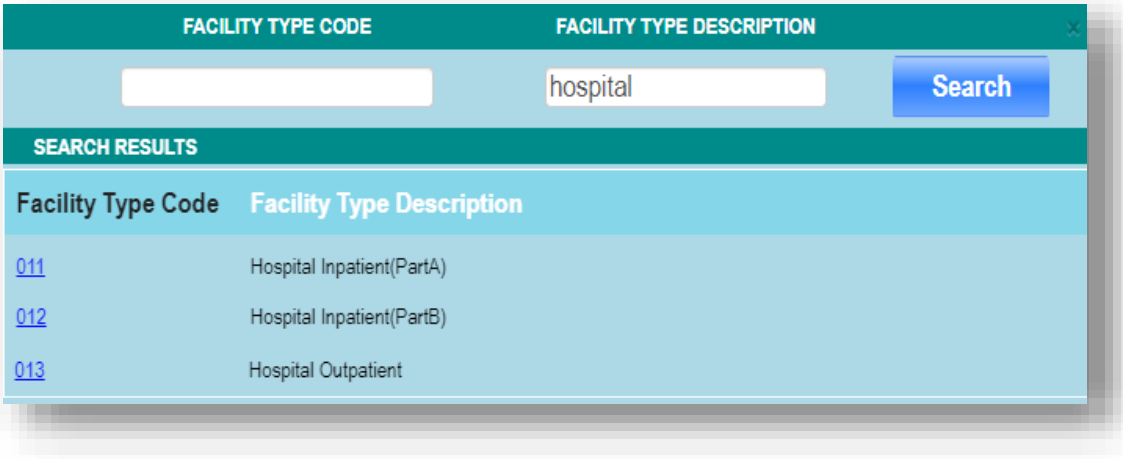
Note: Medicaid ID field will be populated only if NPI is not available.



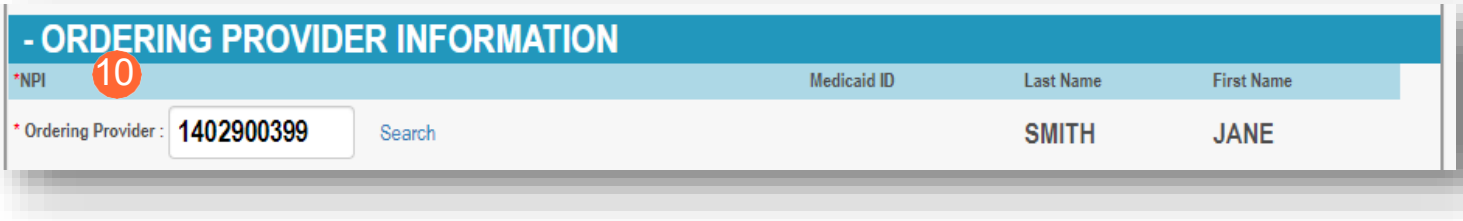
Ordering Provider Information

Note: This may not be a required section.

'Dressings, Surgical', 'Enteral Nutrition and Supplies', 'Hearing Aids', 'Hospital Beds', 'Incontinence Supplies', 'Miscellaneous Equipment', 'Orthotics (MTA)', 'Orthotics/Prosthetics (Nurses)', 'Repairs', 'Respiratory (MTA)', 'Respiratory (Nurses)', 'Speech Generating Devices', 'Supplies (Miscellaneous)', 'Therapies', 'Wheelchairs', 'PDN', 'Medicaid School Program' or 'Applied Behavioral Analysis.'

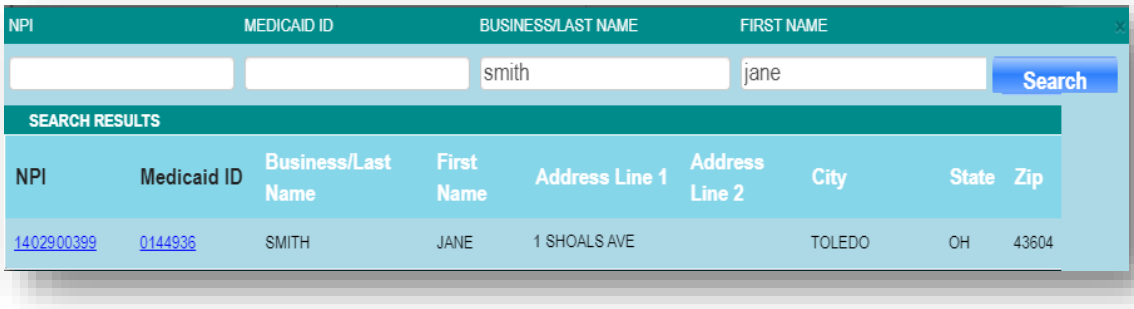


Step 10: Enter the NPI for the Ordering Provider if it is different than the provider who is completing the prior authorization information. If the provider completing the information is the same as the ordering provider, the section does not need to be completed.



Enter the National Provider Identifier (NPI) for the Service Provider. If you don't know it, you can click 'Search' to search for the Provider by Medicaid ID, Business Name, or First and Last Name. Once the provider is located, click the NPI hyperlink.

Note: Medicaid ID field will be populated only if NPI is not available.

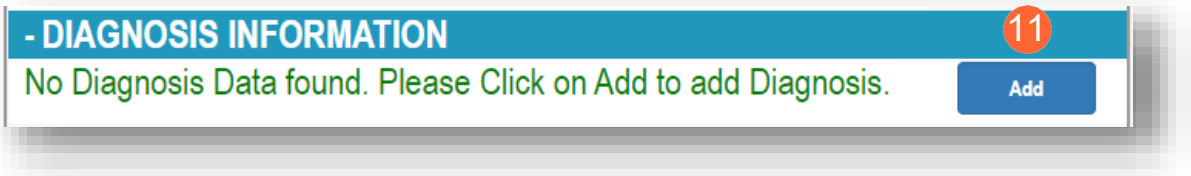


Diagnosis Information

Decimals are not allowed on PA submissions. Be sure to enter the diagnosis code without decimals.

Note: This may not be a required section for the prior authorization being submitted. Diagnosis panel is required when the Assignment *(Step 4 above)* selected is not 'Dental', 'Vision', or 'Orthodontics.'

Step 11: Click **Add** to enter diagnosis information.



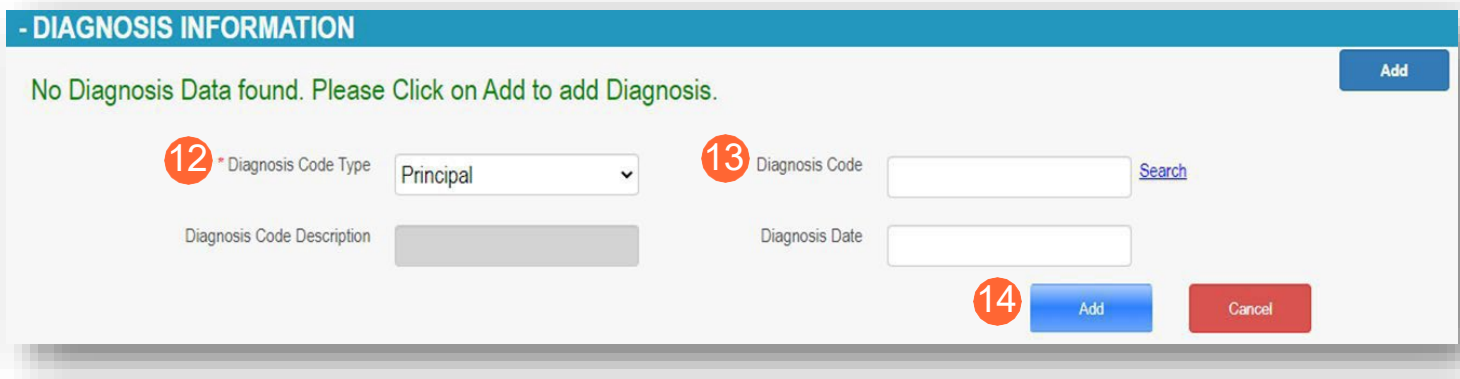
Step 12: Select a Diagnosis Code Type *(first line being added defaults to 'Principal').*

- Principal
- Admitting
- Patient Reason for Visit
- Other

Step 13: Enter a Diagnosis Code. If you do not know the code, click 'Search' to open a code lookup window.

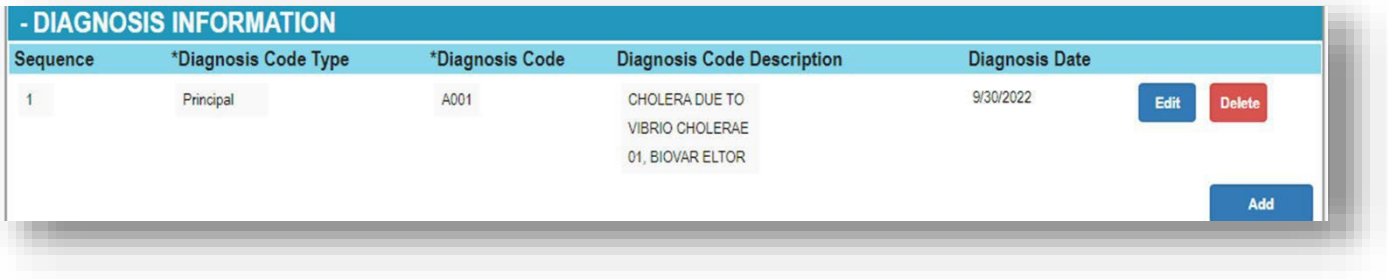
Note: Once the code is entered, the Diagnosis Code Description auto-fills.

Step 14: Click **Add** to add the diagnosis.



- The added diagnosis appears on a list. Repeat the process above to add an additional diagnosis.

- 12 Diagnosis Code lines are allowed (*Principal and Admitting Diagnosis Code Types are each allowed just once).*



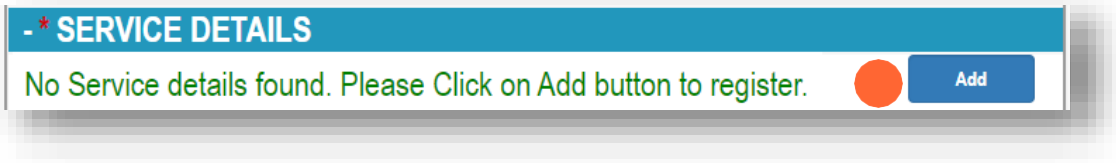
Service Details

Information shown in the gray boxes reflects data provided by the Fiscal Intermediary (FI) following the submission and processing of the prior authorization request.

Professional

Visit the Ohio Department of Medicaid (ODM) website and view the 'Prior Authorization Requirements' page to confirm services that require a prior authorization: https://medicaid.ohio.gov/resources-for-providers/billing/prior-authorization-requirements/prior-authorization-requirements

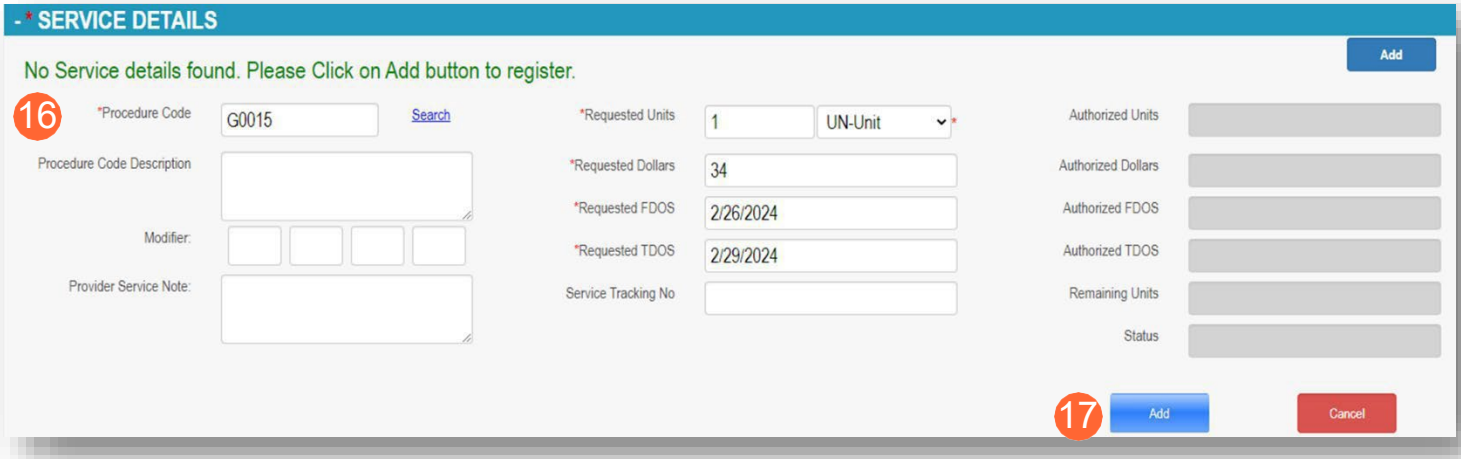
Step 15: Click **Add** to enter service details.



Step 16: The following information:

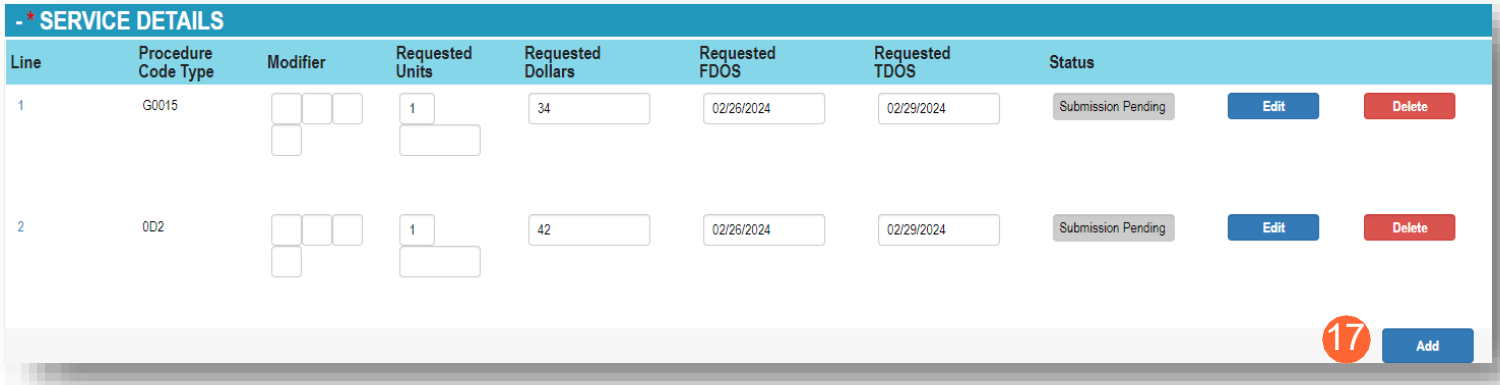
- Procedure Code *(required)*
  - If you do not know the code, click 'Search' to open a code lookup window.
- Procedure Code Description *(as needed)*
- Modifier *(as needed)*
  - Up to 4 values allowed on a prior authorization
- Requested Units (The number of which you are ordering)
- Provider Service Note *(as needed)*
- Requested Units – (1st field) *(required)*
  - The number of which you are ordering

- Requested Units – (2nd field) *(required)*
  - F2 – International Unit
  - DA – Days
  - UN – Unit
- Requested Dollars *(required)*
- Requested From Date of Service (FDOS) *(required)*
- Requested To Date of Service (TDOS) *(required)*
- Service Tracking No *(as needed)*
  - Allows entry of a service reference number that corresponds to provider's system to reconcile each service requested for the Prior Authorization.



Step 17: Click **Add** to add the service.

- The added service appears on a list. Repeat the process above to add additional services.
- A maximum of 999 service detail lines can be added.



Units

- **1 unit = 15 minutes**

Unit Rate applies when:
(a) The home health service is **greater than 60 minutes**, or
(b) The service is **34 minutes or fewer** for home health aide or nursing.

Base Rate applies to:
(a) First 35–60 minutes of home health aide
(b) First 35–60 minutes of home health nursing
(c) First 4 units of initial skilled therapy

Home Health Billing Codes

Codes:
G0151 – Physical Therapy
G0152 – Occupational Therapy
G0153 – Speech-Language Pathology
G0156 – Home Health Aide
G0299 – Registered Nurse (RN)
G0300 – Licensed Practical Nurse (LPN)

Modifiers in Home Health

- **U1:** Required with G0299 for home infusion therapy (Rule 5160-12-01).
- **U2, U3:** Identify second and third visits of the same service on the same date (per rule).
- **HQ:** Group visit, per Rule 5160-12-04.

Note: U5, U7, and additional modifiers will no longer be used with home health billing codes.

Home health services are intended to be part-time and intermittent:

1. Up to **4 hours per visit** for nursing, aides, and skilled therapies
2. Up to **8 hours per day** total for all home health services

Limited Home Health Services (No PA Required)

Available to any Medicaid-eligible individual based on medical necessity:

• **56 hours (224 units)** of combined services per calendar year, or
• **56 hours (224 units) up to 30 consecutive days** following an inpatient stay of **3+ days (post hospital benefit)**

Important:

- Claims submitted for the post-hospital benefit **must** include both the hospital admission date and the discharge date. Claims missing these dates will not be processed under this benefit.
- For claims that are not related to post-hospital care, **do not** enter hospital admission or discharge dates, as doing so will result in a denial.

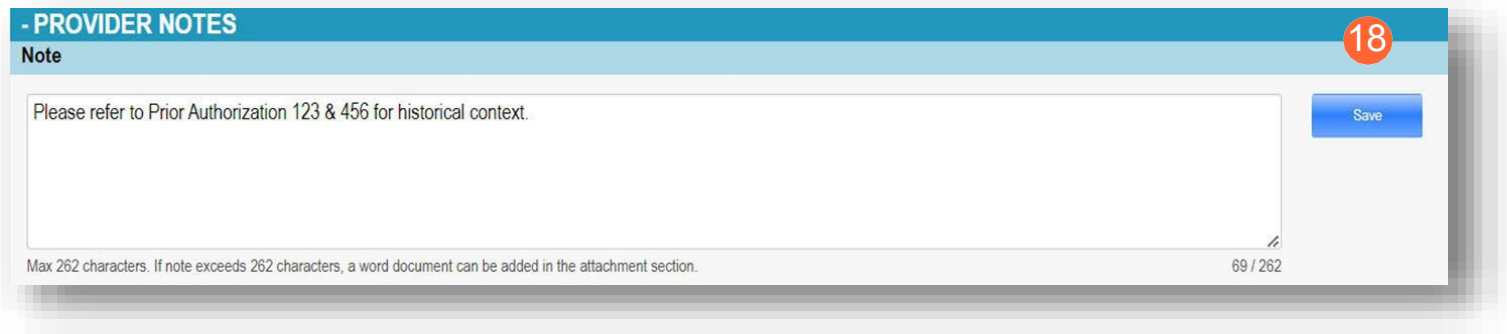
Ongoing Home Health Services

- Once the above thresholds are met, prior authorization is required to determine the individual medical necessity of the member.

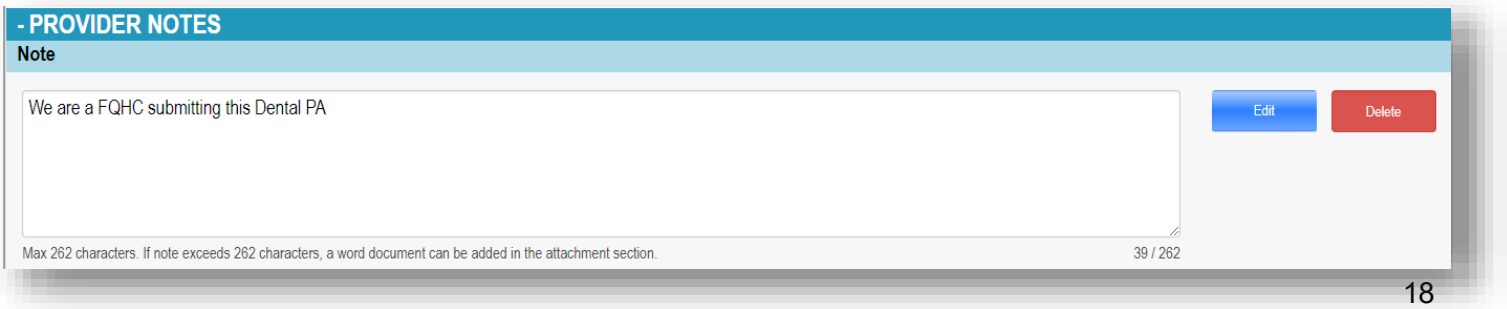
Provider Notes (Optional)

Step 1: Enter any notes related to the Prior Authorization request and click **Save**.

- Save button appears after text in entered in the box.
- A maximum of 262 characters can be entered for a provider note.
- If additional notes need to be provided beyond the 262 characters, these comments can be captured by including an attached document in the submission. *(See Attachment section)*



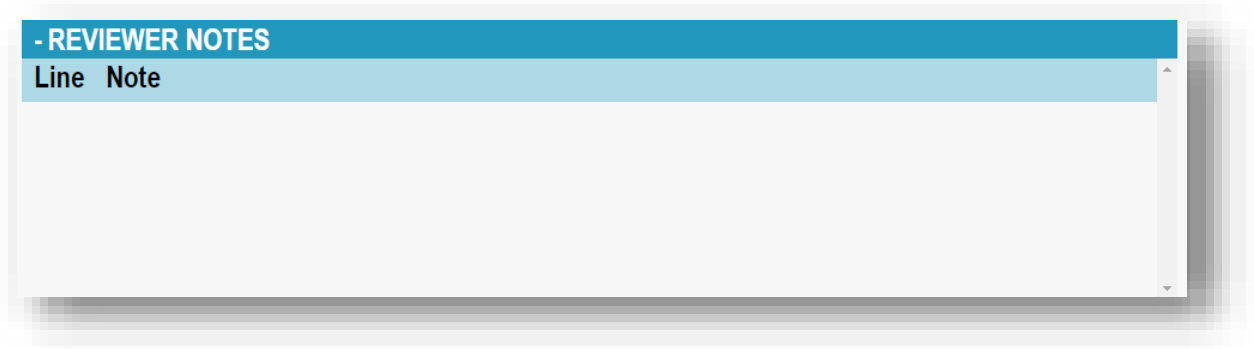
- Edit and Delete options appear after saving the note.



How to Access Reviewer Notes

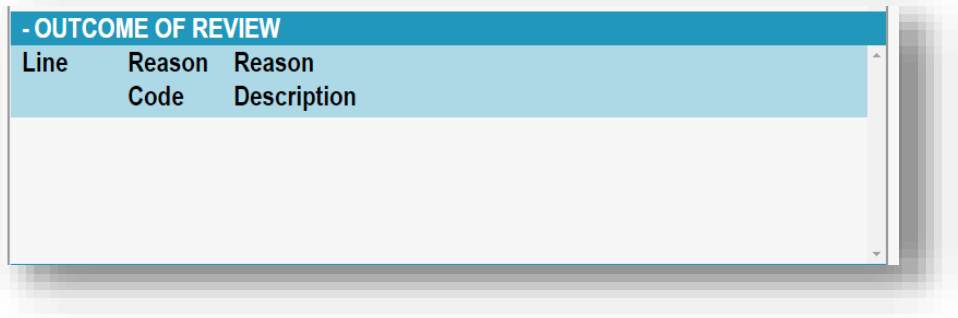
After the Prior Authorization request is reviewed, notes from the reviewer will display in this section.

If the reviewer leaves a note that is longer than 262 characters, a letter with this information will be listed under Provider Correspondence for the Medicaid ID in PNM. Follow the steps for Accessing Prior Authorization Letters.



Outcome of Review

After the Prior Authorization request is reviewed, an outcome for each service requested will display in this section.



Attachments (Mandatory for Home Health)

This section allows for the uploading of support documentation for the prior authorization.

***IMPORTANT:** A Medicaid Billing Number must be listed for the Recipient on the PA submission before a document is attached.*

Note: The maximum allowed documents to upload in a prior authorization submission is 10 documents. The maximum upload size for each document is 10 MB.

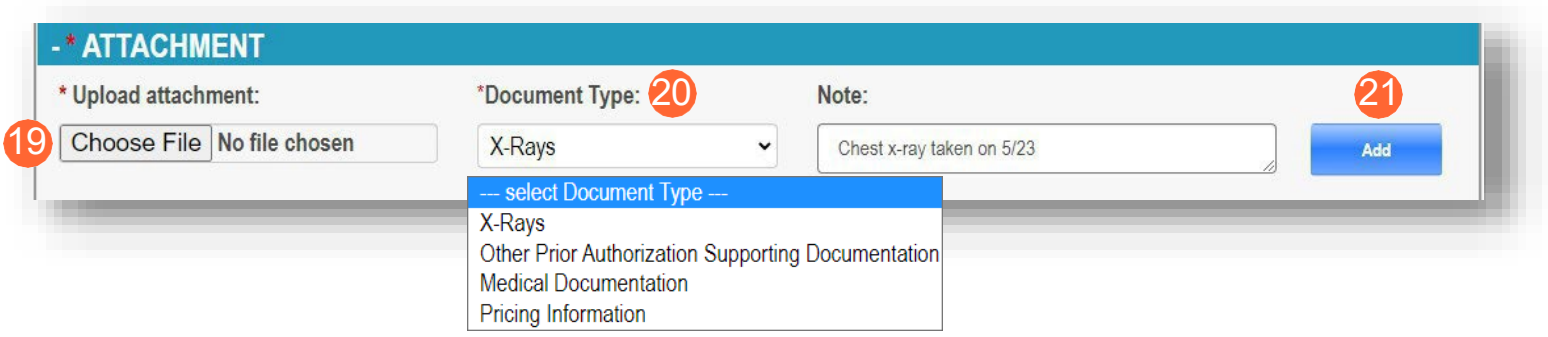
Step 1: Click **Choose File** and locate the file you wish to upload on your computer.

Step 2: Select a Document Type from the drop-down menu.

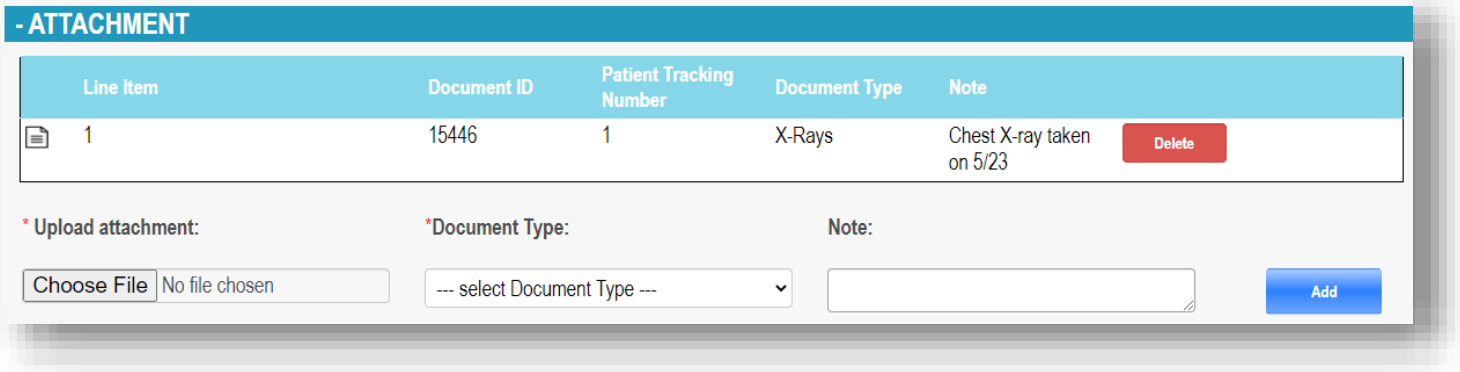
- X-Rays
- Other Prior Authorization Supporting Documentation
- Medical Documentation
- Pricing Information

- Enter any notes related to the uploaded document (maximum of 80 characters).

Step 3: Click **Add**.



- The added attachment appears on a list. Repeat the process above to add additional attachments.
- Up to 10 documents are allowed in a single prior authorization submission.



Accepted File Types:

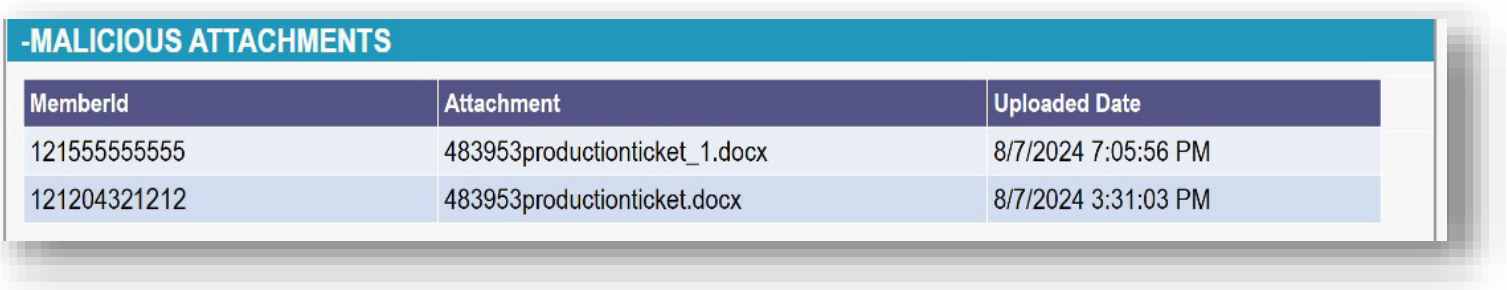
- Word: doc, docx
- Excel: xls, xlsx, xlsm, xlsx
- Image: mdi, jpe, jpeg, jpg, png, gif, bmp, tif, tiff
- PDF: pdf
- Other: pi, ec, zip, csv, acrbak, msg

Recommended Attachments for Home Health Authorizations

- **ODM 07137 or Plan of Care and Order**
    - Verbal orders may start care; practitioner signature required before billing.
    - Include OASIS (if completed). If not completed, submit within 30 days.
- **Post-hospital requests:** Include hospital notes related to the stay and need for home health.
- Ensure the **discipline, frequency, and duration** are listed in the signed order/plan of care.
- Do **not** include waiver hours within the same request.

If Malicious Attachments Are Uploaded

After the Prior Authorization request is reviewed, if an attached document is found to contain damaging macros, it will be flagged as a 'malicious attachment.' Malicious attachments for the prior authorization request will be listed in this section. To replace the malicious attachments, follow the steps for Malicious Attachments.

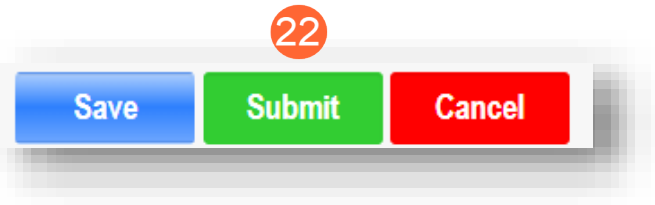


-MALICIOUS ATTACHMENTS

MemberId	Attachment	Uploaded Date
121555555555	483953productionticket_1.docx	8/7/2024 7:05:56 PM
121204321212	483953productionticket.docx	8/7/2024 3:31:03 PM

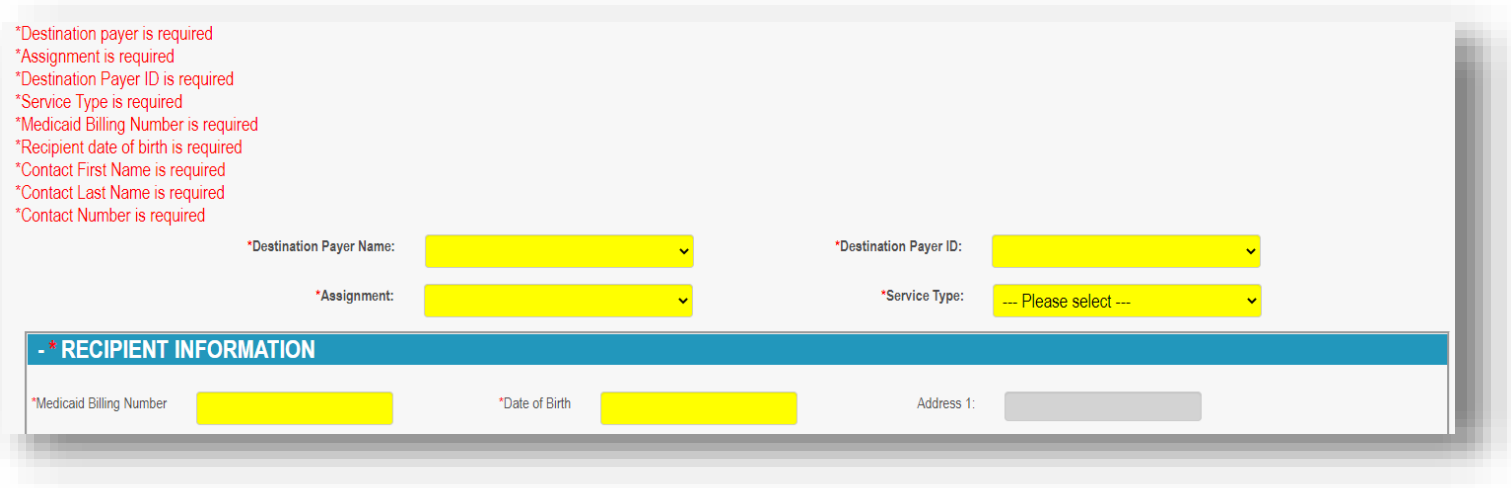
Submit Prior Authorization

Step 18: When all data has been entered, click **Submit** at the bottom of the page.



Note: If there are any entry errors in PNM preventing submission, error messages will display at the top of the page in red text.

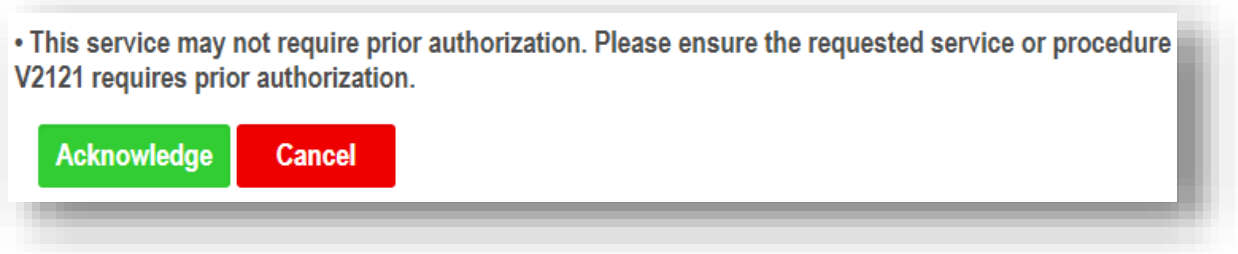
Click on the PNM error message text and PNM will direct you to the section that needs to be reviewed/corrected. The field that needs attention will be highlighted.



Note: Messages that appear in pop-up windows are from the Fiscal Intermediary (FI). Error messages or informational messages may be received from FI.

If error messages are received, please work to correct, or reach out to the contact information provided for assistance.

If informational messages are received, please review, and either click **Acknowledge** or **Cancel**.

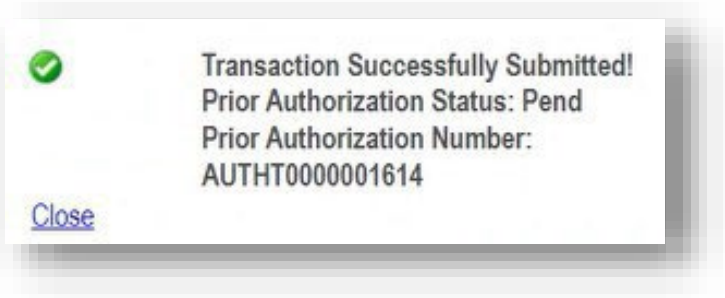


Note: If you wish to proceed with the submission, click **Submit** again.

Step 19: If no errors are present, or once they have been resolved, a confirmation message appears informing that the transaction was successfully submitted.

> Note: The submission confirmation message contains the Prior Authorization Number assigned to the submission. This number can be used to search for the prior authorization in PNM and will be **required when submitting the claim for billing**.

Click 'Close.'



This completes the submission of Prior Authorization

Resources

If you cannot find the information you are looking for on the fee schedule, then email the ODM Integrated Help Desk (IHD) at: ihd@medicaid.ohio.gov or call at 1-800-686-1516.

- For additional Prior Authorization resources, visit:

  The Learning Page

- Several Prior Authorizations user and billing guides can be found following these links:

  Prior Authorization - PNM User Guide

  Prior Authorizations - PNM Billing Guide

  Prior Authorization (PA) Reinstatement FAQs