Prior authorization

How to request prior authorization

Prior authorization requests may be made by phone or by submitting a completed Medical Prior Authorization Request Form to the Utilization Management (UM) department. The form is available online at **www.amerihealthdc.com > Provider > Forms**.

- The UM department hours of operation are 8:00 a.m. to 5:30 p.m., Monday through Friday.
- Requests can be made by phone: **202-408-4823** or **1-800-408-7510**.
- Requests can be made by fax: **1-855-355-0700**.

What requires prior authorization?

The most up-to-date list of services requiring prior authorization is maintained online in the provider area of **www.amerihealthcaritasdc.com**, unless the service is not covered by the member's benefit plan. When submitting a prior authorization request, there may be minor exceptions in timing — for example, in the number of referral visits allowed before a prior authorization request must be made.

The following services require prior authorization in accordance with the member's benefit plan:

- Skilled nursing facility admissions.
- Rehabilitation facility admissions.
- All home health care services related to pregnancy and postpartum.
- Home infusions and injections ($250 and over) provided in an outpatient setting.
- Home health aide and personal care services (not covered for Alliance members).
- Home health care (nursing, physical therapy, occupational therapy, speech therapy and home infusion therapy):
  - Skilled nursing after the first six home visits.
  - Therapy (speech therapy, occupational therapy and physical therapy) after the first 12 home visits for each modality.
  - Hospice.
- Enteral feedings (including related durable medical equipment).

The prior authorization request process follows these steps:

1. The hospital or facility writes the referral for home health services.
2. Within 24 hours of receiving a referral, the home health agency is expected to complete a comprehensive assessment (environmental, physical and behavioral) by a licensed registered nurse acting within the scope of their practice and based on a physician's orders as part of a treatment plan.
3. As part of the request for authorization, the assessment, treatment plan and original physician orders (if available) must be faxed to the UM department at **1-855-355-0700**.
4. The home health agency is also encouraged to call the UM department to verify receipt and to avoid duplication, in case more than one agency received the orders.
5. AmeriHealth District of Columbia's UM department will review the request based on the treatment plan and will respond to the request via phone by close of business if supporting clinical documentation supports medical necessity of the requested service.
6. Within one week of the initial assessment and the initiation of services, the home health agency is also expected to provide the UM department with a clinical update based on the treatment plan.

What clinical information must be included with the prior authorization request form?

Weekly clinical summaries must be submitted by fax to the AmeriHealth District of Columbia UM department at **1-855-355-0700 or 202-408-1031**.

If the number of visits required is greater than the number of direct access visits (the initial visits, not requiring an authorization), the home health agency is expected to fax the physician orders, a completed authorization form and supporting clinical documentation to the UM department.

Documentation requirements

Documentation to keep in the client's medical record:

- Visit notes for every billed visit.
- Supervisory visits for home health aide services as described in Coverage/Limits.
- All medications administered and treatments provided.
- All physician orders, new orders and change orders, with notation that the order was received before treatment.
- Signed physician new orders and change orders.
- Home health aide services as indicated by a registered nurse or licensed therapist in a home health aide care plan.
- Interdisciplinary and multidisciplinary team communications.
- Medical tests and results.
- Pertinent medical history.

Written documentation or progress notes should include:

- Skilled interventions per the plan of correction (POC).
- Member response to the POC.
- Any clinical change in the client status.
- Follow-up interventions specific to a change in status with significant clinical findings.
- Any communications with the attending physician.

In addition, when appropriate:

- Any teachings, assessment, management, evaluation, member compliance and member response.
- Weekly documentation of wound care, size (dimensions), drainage, color, odor, and identification of potential complications and interventions provided.
- If a member's wound is not healing, the client's physician has been notified, the member's wound management program has been appropriately altered and, if possible, the client has been referred to a wound care specialist.

The home health agency should validate and obtain orders from the prescribing physician.

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