Aetna Better Health of Kentucky 9900 Corporate Campus Drive Suite 100 Louisville, KY 40223	Date	June 6, 2023
	To	All Network Providers
	From	Provider Experience
	Subject	Home Health PA Guidance
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PRIOR AUTHORIZATION REQUIREMENT REMINDER
HOME HEALTH SERVICES

Aetna Better Health of KY is sending out this friendly reminder on the prior authorization requirements for home health services. We have not made any changes in the overall review process, however, there have been recent updates to the Home Care Services criteria in InterQual and as a result you may see a difference in the number of visits that are recommended.

The list below has helpful information to help guide you when submitting your prior authorization request:

- Initial requests should typically be a 30-day timeframe, this allows time for the plan of care (MAP 130) to be signed by the physician
- Subsequent requests can be made for additional visits for the remaining certification period and should be submitted with the signed plan of care.
    - The plan of care (MAP 130) must be complete and a dated physician's signature must be obtained within twenty-one (21) days of the establishment of the plan of care. The plan of care is not to exceed 60 days.
    - Plan of care includes the following: homebound status, current diagnoses, prior medical history, prior level of function, current living situation and if there is a caregiver available, services needed with frequency
- CON (certificate of need) is required
- We follow the DMS service limitations for therapies, with the ability to exceed that limitation based on medical necessity.
    - Benefit limit applies to members Over age 21: annual benefit limit of 20 visits for each service (PT/OT/ST)
    - <21 years old, there is no benefit limit
- Therapy services will need recertification notes.
    - **Please provide how many visits have been used on the prior authorization form when submitting a request as this will help process them quicker and more efficiently.
- If the Member is Medicare primary and are asking for Medicaid to cover the requests - we will need a MAP 34 (signed and dated within a year)
- Overlapping dates of service (DOS):
    - Please avoid submitting requests with overlapping dates of service
    - If all visits have been used prior to the end date of your original authorization, provide the last approved visit date and that all visits have been used on approved auth on your Prior authorization form.
        - We will adjust the dates of service on the prior approved auth when this occurs
    - Exception to overlapping DOS:
        - PRN visits

- When requesting PRN visits please indicate on the Prior Authorization form. The date of service end date for a PRN visit should not exceed the current authorization end date.
- PRN visits require documentation as to why the visit is needed. MD order is needed if its not embedded in the plan of care or exceeds amount of PRN visits that is embedded in the plan of care.

Questions?

Simply contact your Network Relations Manager. Our most current listing is attached, the listing can also be found on our website.

<<<insert Network Listing >>>