Nevada Medicaid and Nevada Check Up

# Instructions for Completing Form FA-16A

***(Authorization Request for Home Health (HH) Agency-Intermittent Services)***

To stay current with policy and documentation updates, providers are encouraged to visit www.medicaid.nv.gov weekly and be sure to read any messages included on your Remittance Advice.

## Finding the Form and Instructions Online

Form FA-16A and these instructions are online at www.medicaid.nv.gov (select "Forms" from the "Providers" menu and scroll down until you see form FA-16A and FA-16A Instructions).

## General Form Instructions

All form fields must be completed. Write "N/A" in a field if the item does not apply.

Please print or type information on this form. If information is illegible, processing may be delayed. You can enter information directly into the form on your computer by clicking in any field and typing. You can check and uncheck the checkboxes by clicking them.

When you are finished completing the form, submit the request online using the Provider Web Portal with the attached medical documentation to support the request.

If the FA-16A is incomplete, including the physician signature, it will be denied. If the authorization request is pended for additional clinical information, you will need to upload a corrected FA-16A to the same authorization. DO NOT create a new authorization. The received date is the date a completed correct request is received. The date of receipt of incorrect or incomplete requests is not valid. To avoid uncovered dates of service, please complete the FA-16A in its entirety the first time it is submitted. Only a completed FA-16A will be processed. If the information is not received within five (5) calendar days, the request will be denied, and a notice of decision will be sent.

**For initial Home Health (HH) authorizations:** New requests for HH services must be submitted within 15 business days after the initial evaluation and start of care. Providers are required to provide any recent hospital discharge summaries, and any other documentation to support the number of hours requested.

**For ongoing HH authorizations:** Requests for continuing HH services must be submitted **within 15 business days after the expiration date of the existing authorization**. Providers are required to submit any supporting documentation to support the number of hours requested. Examples include, but are not limited to: nursing notes, discharge summaries from any recent hospital admissions, and recent physician office notes.

## Completing the Form

This section describes the information to enter in each form field.

### NOTES

Providers may use this section to communicate any special requests or additional information the Nevada Medicaid reviewers may find helpful.

**DATE OF REQUEST:** Enter the date you submit the form to Nevada Medicaid.

### REQUEST TYPE

Check one of these boxes to indicate the type of prior authorization you are requesting.

- Initial – Check this box to request a recipient's initial prior authorization request.
- Continued Services – Check this box to request continued Home Health.
- Retrospective – Check this box for a retrospective authorization request. For retrospective requests, enter the date the recipient was determined Medicaid eligible.
- Unscheduled Revision – Check this box if you are requesting an unscheduled revision to the recipient's previous prior authorization due to a change in recipient's condition.

**REQUESTED SERVICE DATES**

- Anticipated Start & End date – Indicate the anticipated start and end date of Home Health services.

## RECIPIENT INFORMATION

- Recipient Name – Enter the recipient's name as it appears on their Medicaid card.
- Recipient Medicaid ID – Enter 11-digit number shown on the front of the recipient's Medicaid card.
- Date of Birth – Enter the recipient's Date of Birth (DOB).
- Which program(s) is the recipient eligible for – Check all applicable boxes to indicate which program(s) the recipient is eligible for.
- Medicare Eligibility – Check this box to indicate the recipient's Medicare insurance eligibility, if none check the "N/A" box.
- Other Insurance – Enter other Insurance name and insurance ID # if applicable.
- Recipient's Social Situation – Check all boxes which most accurately describe the recipient's current social situation.
- **Note:** Verify the address and phone number are current, whether or not they match the information on file with Nevada Medicaid. If the recipient has moved, remind him/her to update address and phone number with the Division of Social Services (DSS).

## LEGALLY RESPONSIBLE INDIVIDUAL (LRI) INFORMATION

The definition of an LRI is: An individual who is legally responsible to provide medical support, including spouses of recipients, legal guardians [not power of attorney], and parents of minor recipients, including stepparents, foster parents and adoptive parents. Complete this section whether or not the recipient has an LRI.

You must include the contact information of a recipient's legally responsible individual when submitting a Home Health prior authorization request for a recipient who is unable to speak on his or her own behalf or who is less than 18 years of age.

Does recipient have an LRI? If the definition of the LRI is met, complete the LRI Information section.

## GUARDIAN CONTACT INFORMATION

Complete this section to provide a guardian contact information, if other than the recipient.

- Guardian Contact Name – Enter the name of the alternate contact person.
- Guardian Address – Enter the address of the guardian, include city, state and zip code.
- Phone – Enter the guardian's phone number.

- Relationship to Recipient – Enter the contact person's relationship to the recipient.

## ORDERING PROVIDER INFORMATION

Complete this section to provide ordering provider information, or the physician ordering home health agency services.

- Ordering Physician Name – Enter the name of physician ordering Home Health services.
- NPI – Enter the NPI of the ordering physician.
- Phone – Enter the ordering physician's phone number.
- Fax – Enter the ordering physician's fax number.

## SERVICING PROVIDER INFORMATION

Complete this section to provide servicing provider information, or the home health agency to provide services.

- Servicing Physician Name – Enter the name of physician providing Home Health services.
- NPI – Enter the NPI of the servicing physician.
- Phone – Enter the Home Health Agency's phone number.
- Fax – Enter the Home Health Agency's fax number.
- Contact Name – Enter the contact name at the Home Health Agency.
- Miles from the Home Health Agency to recipient's home – Enter the number of miles from the Home Health Agency to the recipient's home.
- Where does this provider render services – Indicate if the Home Health Agency renders services "In Nevada (including catchment areas)" or services are provided "Outside Nevada".

## CLINICAL INFORMATION

- Date of Registered Nurse (RN) Evaluation – Enter the date the RN evaluation was completed.
- Date of Last Physician Visit – Enter the date of the last physician visit.
- Primary Diagnosis – Enter the recipient's primary diagnosis, include ICD-10 code(s).
- Additional Diagnosis – Enter the recipient's additional diagnosis(es), include ICD-10 code(s).

## SUMMARY OF RECIPIENT NEEDS

Complete this section to provide a brief summary of the recipient needs.

## DESCRIPTION OF RECIPIENT'S FUNCTIONAL DEFICIT(S)

Complete this section to provide the description of the recipient's functional deficits.

## INTERVENTIONS TO BE PROVIDED AND MEASURABLE SHORT-TERM AND LONG-TERM GOALS

Complete this section to indicate the interventions to be provided. Indicate all measurable short-term and long-term goals for the recipient.

## SKILLED NEEDS

Complete this section to indicate the recipient's skilled needs (check all that apply). If "OTHER" specify skilled need.

## WOUND CARE

Complete this section only if requesting wound care services.

- Goal of Care – Indicate the goal of wound care.
- History of Wound – Enter the history of the wound (e.g., onset, longevity, current management).
    - If more than one wound, document the number of wounds (e.g., "recipient has 3 wounds-wound 1, 2, 3 etc. and write "see attached clinical documentation for wounds 2-3)
- Wound Type/Etiology – Indicate the type of wound if known by checking the appropriate box.
- Wound Location – Mark the location of the recipient's wound(s).
- Wound Measurements – Indicate the length, width, depth and thickness of the wound.
    - If pressure ulcer, indicate stage, tissue appearance and sinus tracks/tunneling.
    - Check the box to indicate wound edges.
    - Surrounding skin - indicate the condition of the skin surrounding wound by checking the appropriate box(es).
    - Exudate Amount - indicate the exudate amount by checking the appropriate box.
    - Exudate type - indicate the exudate type by checking the appropriate box.
- Wound Treatment plan as prescribed by Physician – complete this section to include intervention, frequency and duration prescribed by the physician for wound(s).

## REQUESTED SERVICES

Complete the table to indicate the Home Health services requested. Indicate the procedure code and requested units per day. Indicate the day of the week each of the procedure codes will be provided. Total the number of units per week and indicate the duration of weeks the services will provide. In the last column, indicate the total units being requested for each procedure code.

Provide the signature, NPI, and printed name of the physician who is ordering Home Health Services.

## HOME HEALTH FACE-TO-FACE DOCUMENTATION

Complete this section only for initial orders for home health services and for all episodes initiated with the completion of a start-of-care OASIS assessment. Provide the printed name, signature, and date the face-to-face documentation was completed.

### How to Submit the Form

After completing the form, submit request online including all supporting medical documentation using the Provider Web Portal.

### Questions

If you have any questions about Home Health program requirements or completing this form, contact the Gainwell Technologies Prior Authorization Department at (800) 525-2395.

### Additional Resources

The Billing Guidelines for Provider Type 29 provides information regarding proper billing procedures. These guidelines are online at www.medicaid.nv.gov (select "Billing Information" from the "Providers" menu).