Home Health
Quick Reference Guide

This Quick Reference Guide is designed to assist providers in navigating the Delaware First Health (DFH) Home Health authorization process. It outlines key procedures, codes, and contact information to ensure timely and accurate service delivery for DSHP and DSHP Plus members such as:

SUBMITTING AN AUTHORIZATION REQUEST

PAR Provider Requests

- Providers should verify authorization requirements utilizing the Pre-Auth Check tool found on the website: Medicaid Pre Auth Check Tool

NONPAR Provider Requests

- Non-participating providers must submit Prior Authorization requests for all services.
- Requests must include whether the servicing provider has a Delaware Medicaid ID and is willing to accept Medicaid rates OR if a Single Case Agreement (SCA) is requested.
- Join our Network

Standard Authorization Requests should be submitted at least 5 calendar days prior to the scheduled service start date. Requests submitted within 5 calendar days of service start date will need extenuating circumstances noted on the request to avoid administrative denial for untimely request.

Urgent Authorization Requests should be submitted when the standard service authorization decision time could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function.

Prior Authorizations can be requested in the following ways:

- ✓ DFH Secure Provider Portal
- ✓ Availity Essentials Provider Portal
- ✓ Phone: 1-877-236-1341
- ✓ Fax: Submit via fax if you encounter issues with portal submission. Include the Outpatient Prior Authorization Request Form
  - Medical Fax: 1-833-967-0502
  - Behavioral (Outpatient) Fax: 1-833-967-0498
  - Prior Authorization Forms are located on our website under Provider Resources/Manuals, Forms, and Resources

Please ensure submissions include ALL clinical information.

VERIFYING ELIGIBILITY

Delaware First Health providers should verify member eligibility before services are rendered using one of the following methods:

1. You can check member eligibility online using our provider portals by searching with either the member's name and date of birth or their Medicaid ID and date of birth, along with the date of service. Both portals provide access to access eligibility verification and other provider resources.
   - Register and log in to our DFH Secure Provider Web Portal
   - Register and log in to Availity Essentials

   You may contact your assigned Provider Engagement Account Manager (PEAM) for assistance with registration or training resources.

VERIFYING ELIGIBILITY - *continued*

2. Call our automated member eligibility IVR system. Call our toll-free Provider Services number at 1-877-236-1341 from any touch-tone phone and follow the appropriate menu options to reach our automated member eligibility verification system 24 hours a day. The automated system will prompt you to enter the Medicaid ID and the month of service to check eligibility.

3. If you cannot confirm a member's eligibility using the methods above, call our toll-free number at 1-877-236-1341 to speak to a live representative. Follow the menu prompts to speak to a Provider Services Representative to verify eligibility prior to rendering services. Provider Services will need the member's name, Medicaid ID, and member date of birth to check eligibility. Possession of a Delaware First Health member ID card is not a guarantee of eligibility.

Methods above can also be used to verify member eligibility on the date of service.

COORDINATION OF BENEFITS (COB)

- No prior authorization is required if the primary payer covers the service.
- If the requested service is not a covered benefit or if the benefit has been exhausted by the primary payor, prior authorization is required, and an Explanation of Benefit (EOB)/Advanced Beneficiary Notice (ABN) must accompany the claim submission.
    - The signed ABN or EOB should be submitted with the initial authorization request.

REQUESTS FOR DIAMOND STATE HEALTH PLAN (DSHP) AND DIAMOND STATE HEALTH PLUS (DSHP PLUS) MEMBERS

Home Health Visits:

Codes: G0299 (RN), G0300 (LPN), G0156 (Aide)

- Physician order is required to be submitted at the time of initial request.
- Units per 15 minutes.
- DFH will approve up to the first 6 visits (evaluation and 5 visits = 28 units). Must submit request with HH order within 5 days of start of care.
- Clinical information and recent Plan of Care are required for ongoing visits – See Provider Manual.

PT/OT/ST

Codes: G0151/G0157/G0159 (PT) G0152/G0158/G0160 (OT), G0153/G0161 (ST)

- Physician order is required to be submitted at the time of initial request.
- Units per 15 minutes.
- DFH will approve up to the first 6 visits (evaluation and 5 visits = 28 units). Must submit request with HH order within 5 days of start of care.
- Clinical information and recent Plan of Care are required for ongoing visits – See Provider Manual.

REQUESTS FOR DIAMOND STATE HEALTH PLAN (DSHP) AND DIAMOND STATE HEALTH PLUS (DSHP PLUS) MEMBERS - *continued*

Private Duty Nursing/Home Health Aide

Codes: S9123 (RN), S9124 (LPN), G0156 (Hourly Home Health Aide)

- Prior Auth is required.
- S9123 and S9124 hourly units, G0156 units per 15 minutes.
- Delaware First Health Certificate of Medical Necessity (CMN) or a Letter of Medical Necessity is required.
- If requesting via fax, include DFH Outpatient Prior Auth Request Form
- Initial Requests are reviewed for 60 days from the requested service start date.
- Continuation requests are reviewed for 180 days and require a signed plan of care within 60 days prior to the continuation request.
- Annual updates are needed for the Letter of Medical Necessity to be submitted with auth requests or updated and submitted as a change in condition occurs.

Pediatric Respite: For Members < 21 years old

Code: S5150 (unskilled), S5150 U2 (unskilled SDAC), T1005 (PASA or agency)

- Prior Auth is required.
- Pediatric Respite Prior Authorization Request Form to be submitted with request
- Units per 15 minutes.
- Respite benefit limit per calendar year 285 hours/1140 units.
- S5150 with U2 modifier when self-directed option selected by member.
- Delaware First Health Certificate of Medical Necessity (CMN) or a Letter of Medical Necessity is required.
- Annual updates are needed for the Letter of Medical Necessity to be submitted with auth requests or updated and submitted as a change in condition occurs.

Pediatric Self-Directed Care (SDAC)

Code: S5130

- Covered for members < 21 years old with hourly home health aide services that are determined to be medically necessary, and the member's legal guardian is requesting self-direction as the mode of service delivery.
- Legally responsible family members are limited to providing 40 hours of service per week.
- Delaware First Health Certificate of Medical Necessity (CMN) or a Letter of Medical Necessity is required.
- Annual updates are needed for the Delaware First Health Certificate of Medical Necessity or Letter of Medical Necessity to be submitted with auth requests, or updated and submitted as a change in condition occurs.
- If requesting via fax, include DFH Outpatient Prior Auth Request Form
- S5130 with U2 modifier required for self-directed care.

REQUESTS FOR DIAMOND STATE HEALTH PLUS (DSHP PLUS) LTSS MEMBERS WITH HOME AND COMMUNITY-BASED SERVICES (HCBS)

Respite:

Code: S5150 (unskilled attendant care), T1005 (agency attendant care)

- Auth required.
- Auth request submitted by the member through the LTSS Case Manager based on member's Person-Centered Service Plan. Member preference given to provider selection.
  Respite benefit limit per calendar year 14 days or 285 hours/1140 units.
- U2 modifier when self-directed option selected by member.

Attendant Care and Self-Directed Attendant Care (SDAC):

Code: S5130

- Auth required.
- Request submitted by the member through the LTSS Case Manager based on member's Person-Centered Service Plan. Member preference given to provider selection.
- SDAC- covered for LTSS members requesting self-direction as the mode of attendant care service delivery.
- U2 modifier when self-directed option selected by member.

TIMEFRAMES FOR PRIOR AUTHORIZATION

REQUEST TYPE	TIMEFRAME
Standard	7 calendar days
Urgent	72 hours
Post-Service	30 calendar days
LTSS HCBS	14 calendar days

REIMBURSEMENT

DFH will reimburse participating providers per their Delaware First Health contract. The provider will be paid according to the fee schedule (based on the methodology below) for the equivalent HCPCS, and modifiers noted below.

The total allowable benefit amount will be based on the total authorized units for the member and agency. Critical Note: The Authorization will only contain the noted HCPCS code. The modifier will not be included in the authorization. The authorization does not determine the pricing, but only authorizes the service being performed.

Agencies billing for multiple patients in the same home, should bill each member on a separate and distinct claim with the appropriate modifier for HCPCS Codes S5130, S5150, S9123, S9124, and G0156. The chart below defines which modifier and the payment methodology to use.

NUMBER OF PATIENTS SEEN IN THE SAME HOME AT THE SAME TIME	MODIFIER	PAYMENT METHODOLOGY
One Individual	U2	100% of the established baseline rate
Two Individuals	U3	71.50% of the established baseline rate
Three Individuals	U4	70.62% of the established baseline rate

IMPORTANT CONTACT INFORMATION

To obtain assistance submitting a prior authorization request or to receive clarification on our prior authorization requirements, please contact us:

MEMBER ASSISTANCE	PROVIDER ASSISTANCE

• Member Handbook
• Member Services- (877) 236-1341
• LTSS HCBS - Contact assigned LTSS Case Manager or email: DFHLTSS@DelawareFirstHealth.com
• Care Coordination - Contact assigned Care Coordinator or email: decarecoordination@DelawareFirstHealth.com
	• Provider Manual
	• Billing Manual
	• Provider Services: (877) 236-1341
	• Utilization Management
	  • Phone: (877) 236-1341
	  • Fax: (833) 967-0502
	• LTSS HCBS Assistance - Email: DFHLTSS@DelawareFirstHealth.com

Call Center hours of operation: Monday - Friday 8:00 a.m. - 5:00 p.m. EST