Ohio Living Holdings
Referrals, Admissions and Initial Authorizations Process
July 23, 2021

Personnel:

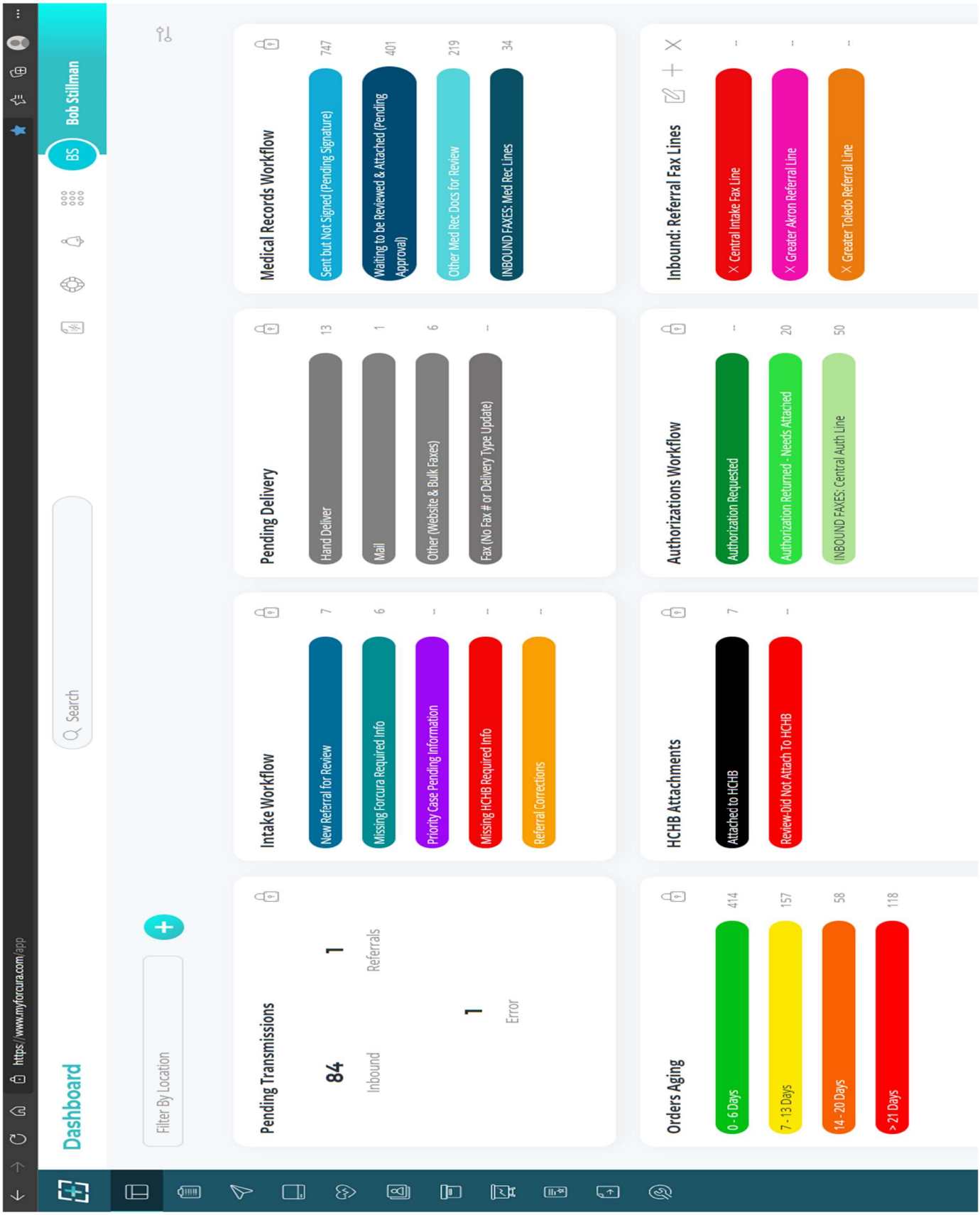
1. Marketer, Marketing Liaison, Transitional Care Liaison, Business Development Liaison, Director of Business Development – refer to this group below as "Business Development" (BD).
2. Health Information Coordinators (HIC) aka The Referral Management Team
3. Central Intake Coordinator (CIC)
4. Central Authorization Coordinator (CAC)
5. Clinical Supervisor or Clinical Team Leader (CTL)
6. Central Medical Records Coordinator (CMRC)
7. Site Medical Records Coordinator (SMRC)
8. Scheduler
9. Administrator (May be assigned coverage responsibilities under other roles)

Referrals-Admissions Process:

The following documentation is intended to identify key general steps in the process and related key personnel responsibilities. It does not identify absolutely all the functionality within Forcura or HomeCare HomeBase (HCHB) for which there are endless scenarios affecting the processing of a Referral.

1. Referral Information (RI) is sent to Forcura by:
    a. Facsimile directly from hospital, physician office, or another direct referral source to the primary Central Intake fax line, Toledo Intake fax line and Akron Intake fax line all ported to Forcura.
    b. Facsimile by BD utilizing the Xmedius software tool/application loaded to their phone/tablet.
        i. BD can create a Quick Referral Form/Face Sheet within Xmedius and use as the basis for referral notification.
        ii. Must use the Xmedius tool if sending information from a mobile device.
        iii. BD receives message from Xmedius as to a sent fax being affirmatively received or rejected.
    c. Referrals received by Allscripts/ECIN, Ensocare, email, or Back Office Fax (an Inbox in Outlook).
        i. HICs will monitor all sources, access/pull the referral information and send to Forcura via **Secure Document Delivery** or drag and drop into Forcura within **"My Drive"**. This process is intended to only be available for those working on a laptop or computer workstation, it is not available via mobile device.
        ii. If HICs do not have access to the Back Office Fax, someone at the site who monitors the Back Office Fax needs to determine whether it is a 'Referral' or 'Other Medical Records' and then they need to send it to the appropriate fax line number as identified below.
    d. Referrals are not going to be sent using:
        i. Referral Source Link (RSL). RSL will be used for other information gathering for ongoing case support.
        ii. Forcura mobile application.

Forcura Dashboard



1. **Forcura Dashboard – "Pending Transmissions"**
    a. "Inbound" Section: Includes all information received by a single fax transmission.
    b. "Referral" Section: Includes any documents received in the "Inbound" section that Forcura recognizes as "Referral Information".
    c. "Error" Section: Relates to attempts by OLH staff to send information by fax to a third party (e.g. physician office) and the fax number is not correct.
        i. This functionality has not been designated for use as of yet.

2. **Health Information Coordinators (HICs)** must monitor and access the "Referral" section as well as the "Inbound" section looking for any documents that are relating to a New Referral.

3. The HIC will select a document using the **"Eye"** Icon in Forcura. Forcura with then automatically generate a **"Case Panel"** (aka a **"Case"**) which will appear on the screen. This Panel is where the Basic Information is then entered. The HIC will determine if the document has all the required Basic Information to create a referral. Forcura requires data entry of the following minimum information (**Only the Blue Asterisks – which are highlighted in Yellow below**):

    a. Case Name: An Ohio Living standardized Case-Naming system will be in effect as follows:

        Last Name.First Name.Date this Particular Document was received in Forcura

        Example: **Smith.Joseph.05.11.2021**

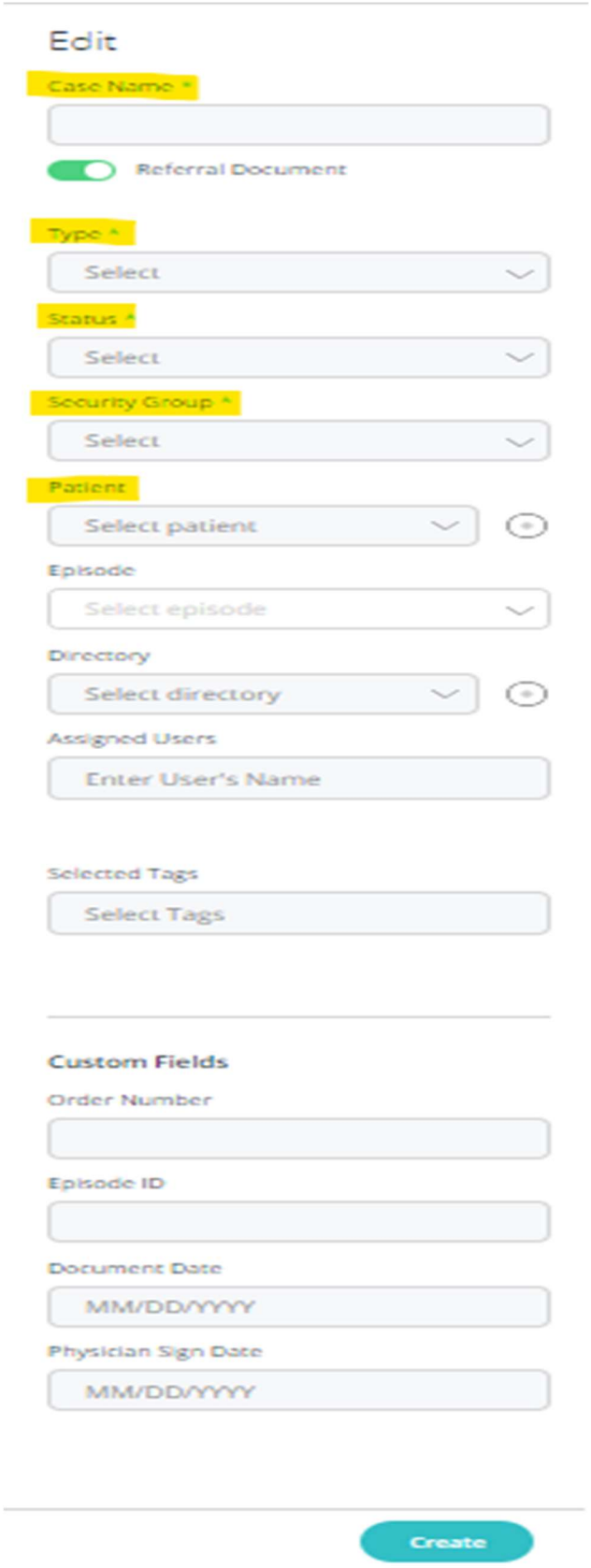
    b. Type: Drop Down box with standard choices corresponding to the HCHB "Attachment Types".
        i. There are currently 66 potential "Document Types" and 22 potential clinical "Order Types".
        ii. Master List is included in the Appendix at the end of this Document.
        iii. **Most** of these Documents are **NOT** needed to Process the Referral and Admission; rather, most are for ongoing case management. The information/documents that are needed are clearly identified throughout this process document.
        iv. Forcura is not able to limit the Documents needed to Process the Referral and Admission. Users are able to search for document **Type** by typing a portion of the document Type "Name" which may cause a pop-up in the drop-down box of the desired Document Type to assign.
        v. Should the Forcura Pending Transmissions Card receive a Fax that is 80 pages, for example, with multiple different types of documents, the HIC must separate the pages and save as separate "Documents" within Forcura, and then select the appropriate **'Type'**.
        vi. For every "Document" that is received or established, the HIC must create a **Case** within Forcura in order to attach to HCHB.

    c. Status: Drop-down box with standardized choices.

    d. Security Group (the Branch within the Site – e.g. AK1 = Akron Home Health)

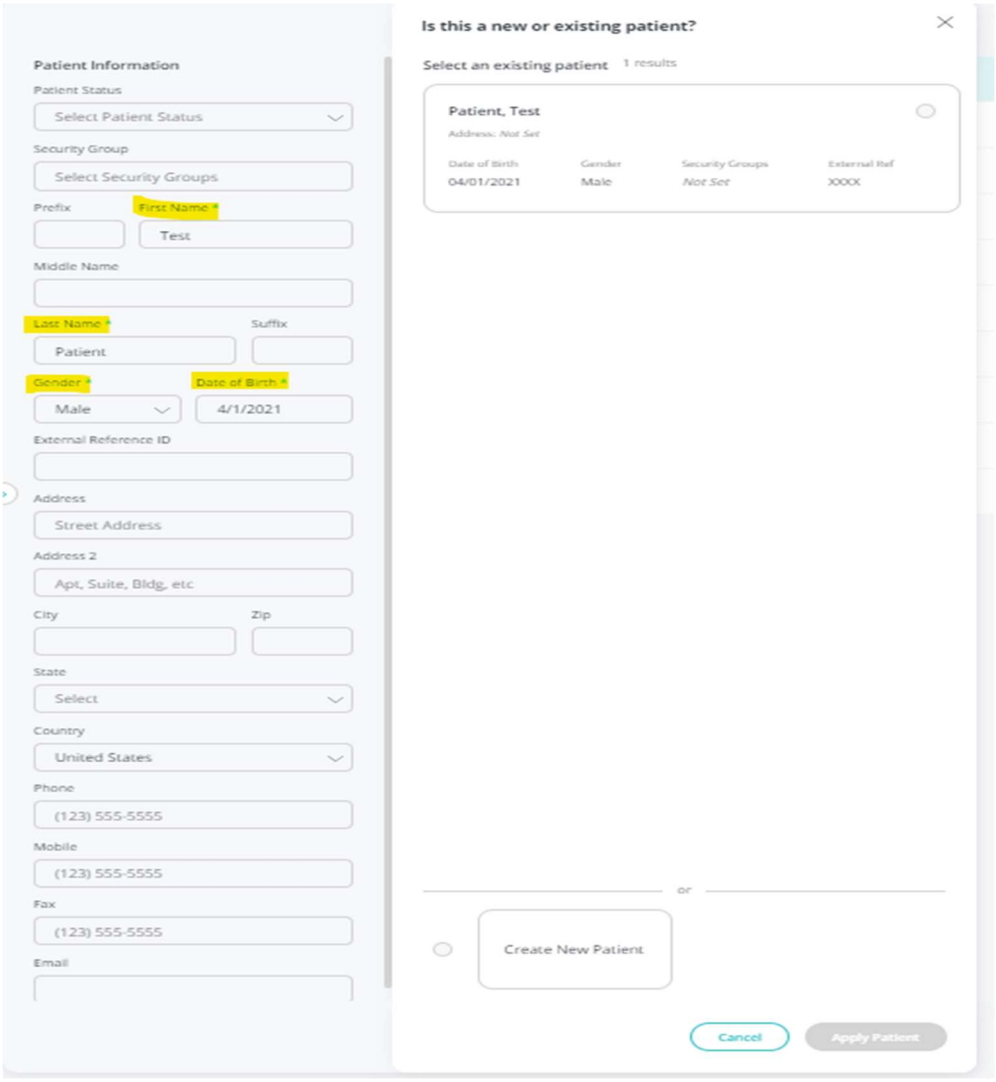
    e. Patient: This is where the patient is created.

Case Panel


Edit
Case Name *
Referral Document
Type *
Select
Status *
Select
Security Group *
Select
Patient
Select patient
Episode
Select episode
Directory
Select directory
Assigned Users
Enter User's Name
Selected Tags
Select Tags
Custom Fields
Order Number
Episode ID
Document Date
MM/DD/YYYY
Physician Sign Date
MM/DD/YYYY
Create

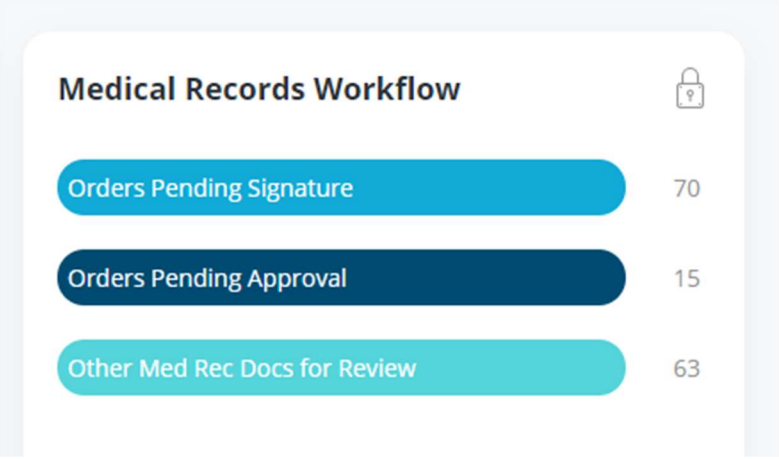
4. Once that limited **Basic Information** is entered in the **Case Panel**, the HIC will click the **Circular Icon** next to the **"Patient"** Field which will then cause Forcura to generate a **"Patient Shell Panel"** which will appear.
    a. When this appears, the additional **Basic Information** (Blue Asterisks highlighted in Yellow) is entered by the HIC.
    b. If the information entered by the HIC matches an existing patient record, then the HIC will select the patient record from the **"Select an Existing Patient"** section. Forcura IQ may have identified the Patient, in which case the HIC would see an option to **"Confirm Patient"** within the Patient Shell Panel.
    c. If the information entered does NOT match existing records, then the HIC will select the **"Create New Patient" Toggle.**
    d. Once all the information is entered and the appropriate selection is made, the HIC will click the teal **"Create/Apply Patient" Button** in the bottom-right of the panel to add the patient to the Case.

Patient Shell Panel

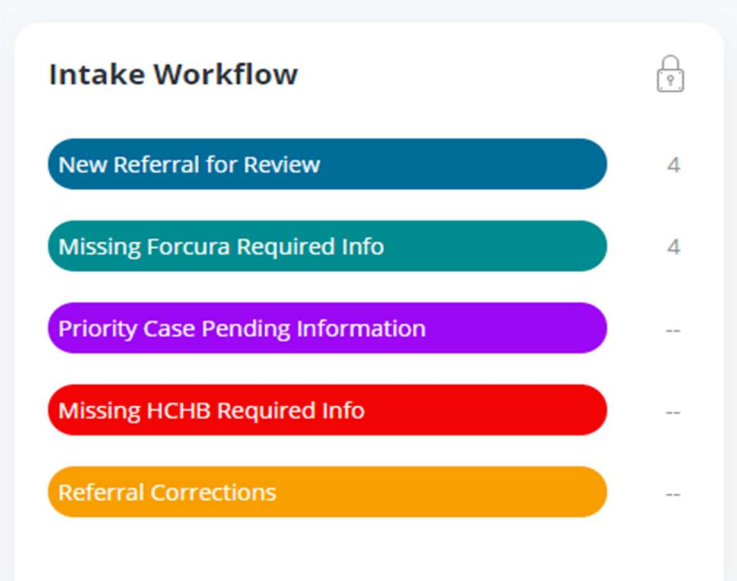


5. Forcura has available Intelligent Query (IQ), optical reader technology, that can recognize certain information that may be Referral Information.
    a. This happens automatically at the very beginning of the process.
    b. When an incoming fax arrives, Forcura scans it for recognition. If recognized and identified as a **Referral,** then Forcura will automatically send it to the "**Referrals"** Bucket within the **Pending Transmissions** Card.
        i. No staff action is necessary unless Forcura doesn't identify a referral properly.
    c. Perform remaining tasks as identified in the process above.
        i. Forcura IQ will automatically populate the **Type** and **Status** sections within the **Case Panel.** If that information is not correct the HIC can revise.
    d. IQ may populate information, but it may not be correct and should be revised by HIC.
    e. Data populated in the **"Address"** fields **will NOT be transferred** to HCHB and thus will need to be entered in HCHB.

6. There are **3 types of Fax Lines** that are utilized within Forcura.
    a. Certain staff positions will be assigned view/work access that are associated with a particular Fax Line. In general, those assignments are:
        i. "Referral Line" = Health Information Coordinators
        ii. "Med Rec" = Central Medical Records Coordinators and Site Medical Records Coordinators.
        iii. "Authorizations Line" = Central Authorization Coordinators
    b. Should a document be received on a Fax Line that is not pertinent to their assigned role, the staff person must recategorize to an appropriate Bucket within Forcura. For example, if the HIC sees that Forcura has identified a "Referral" within the Pending Transmissions Card, and discovers through the review of the document that it is clearly not a Referral document but instead appears to be continuing case medical records documentation (most likely discovered because the Patient already exists in HCHB having searched the "Patient" field in the Case Panel), then the HIC should:
        i. Update the **Case Name** using the standard naming convention,
        ii. Change the **Type** to **"Clinical Documentation | Client"**,
        iii. Change the **Status** to **"Other – Docs for Review"**, and
        iv. Having searched and found the existing patient under the **Patient** field, confirm the Patient and Save.
        v. Doing the above will route this document to the **Medical Records Workflow** Card and into the **Other Med Rec Docs** For Review Bucket. From there, the CMRC's will take further action.



vi. Similar action must be taken by the CMRC's should a document that is clearly a new referral be received on the Med Rec Fax Line. CMRC's may need to change the Type to "Referral Packet | Client" and change the status to "New Referral for Review". Doing so will move the document to the Intake Workflow Card and into the "New Referral for Review" Bucket



c. Current Active Fax Lines Connected to Forcura:
   i. Referral Lines
      1. Greater Akron 330.968.2596 (Old Back Office Line)
      2. Greater Columbus 855.579.4968
      3. Greater Cleveland 855.579.4968
      4. Greater Dayton 855.579.4968
      5. Greater Toledo 419.386.0536
      6. Village (Cincinnati) 855.579.4968 (Old Back Office Line)
      7. Greater Youngstown 855.579.4968
   ii. Med Rec Lines
      1. Greater Akron 330.873.3465
      2. Greater Columbus 614.433.0550
      3. Greater Cleveland 440.953.0870
      4. Greater Dayton 937.415.5690
      5. Greater Toledo 419.865.4227
      6. Village (Cincinnati) 513.681.1850
      7. Greater Youngstown 330.533.4650
   iii. Central Authorization Line 614.441.4970

d. Each Site has a "Back Office" Fax Line, which is NOT connected to Forcura, is intended primarily for Human Resources and other business matters.
   i. Those lines are not intended to receive Referrals or Medical Records related information; thus, Site personnel should not provide that number to Referral Sources and sources providing Medical Records documents.
   ii. Should Referral or Medical Records documentation be received on the Back-Office line, site personnel will need to forward that information into Forcura using

methods described above. A site representative should notify the sender that this fax line is inaccurate and provide the correct fax line to the sender.

7. If the Referral does NOT have ALL the **Basic Information** to create the New Referral, HIC changes the **Status** within the **Case Panel** to **"Missing Forcura Required Info"** which then moves the Case to the **Missing Forcura Required Info** Bucket (**TEAL**) in the **Intake Workflow** Card.
    a. See **"Tag"** functionality for missing information described in 10 below.

8. If the Referral has all the **Basic Information** entered in both the **Case Panel** and the **Patient Shell Panel**, the Referral is then ready to move to HCHB. The HIC will change the **Status** within the **Case Panel** to **"Attach to HCHB"** and then HIC selects **"Save Case"** which results in the Referral Case being transmitted to HCHB.
    a. At this point, Forcura will automatically create the **"Shell"** in HCHB.
    b. The Referral Case will now be reflected in the **HCHB Attachments** Card within the **Attached to HCHB** Bucket**.**
        i. This information only remains in the **Attached to HCHB** for a few minutes, then Forcura automatically refreshes resulting in that data held in that card to disappear from view.

9. BDs will receive an **"New Referral"** Alert that a new case is created in HCHB via **Referral Source Link (RSL),** once the initial New Referral Packet is "Attached" to HCHB and there is no other "Pending Referral Alert" that will be sent other than the "New Referral" Alert. The "New Referral" Alert does not mean that the patient has been accepted for care.
    a. Special Note: As of this draft version the RSL New Referral Alerts are not working consistently for all users. HCHB escalated ticket has been with HCHB since mid-June. Additional tools/data sources are available to the BDs:
        i. Access has been provided in Forcura to 'Search' archived referral information that has been received.
        ii. Access has been provided for HCHB Back Office RS2 so that BD's can search potential patient's names and see all supporting documentation received that has been saved to the case.
    b. Assuming that someday HCHB will fix their issue, the following would be applicable.
        i. Each BD **must subscribe** to Alerts.
        ii. There are **only 3 times** when a BD will receive and Alert via RSL, that are generated from HCHB, as follows:
            1. New Referral = HIC has initially approved the Referral, but additional information and workflow has yet to be completed, so the Referral is no approved as FINAL.
            2. New Admission = Start of Care is complete.
            3. Non-Admit.
        iii. RSL will show basic patient information including Diagnosis and Primary Physician.
        iv. BD can generate an **Activity Report** within RSL to see further patient information in detail.
        v. If there is an error identified by BDs, BDs will complete the **"Referral Correction Form"** available within **Focura Mobile Application** and document the corrections to be made. This form will be attached to the **"Referral Corrections"** Bucket within the **Intake Workflow** Card.

10. If any of the **Basic Information** (Blue Asterisk) is missing, HIC can attach a **"Tag"** for the item that is missing.
    a. The **Tags** will be prescribed/named to match all Basic Information types, available through a drop-down box.
    b. HIC will send an email using the established **"Site Referral Email Address"** and notify the set group on that email of the missing information.
        i. That group includes the CTLs and BDs.
        ii. The HIC must monitor the **Pending Additional Documents** to determine what of the Basic Information continues to be missing if the Case continues to stay in the **Intake Workflow Card**, and then follow up with whoever can obtain and provide the missing information.
    c. As additional information is received via Fax into Forcura, the information shall be identified within the **Pending Transmission**s Card by the HIC who will then select the **Status** to **Attach** to an **Existing Case**.
    d. Tags must be removed by the HIC as information is received.
    e. Once all the Basic Information is Received, then the HIC will change the **Case Status** to **"Attach to HCHB"**. Doing so will move the Case to the **HCHB Attachments Card** under the **"Attached to HCHB" Bucket**.
    f. At that point, Forcura will generate the **Shell in HCHB** (as described previously).

11. HICs will monitor the "**Missing Forcura Required Info"** Bucket within the Intake Workflow Card and coordinate obtaining that information, which may involve contacting the Referral Source or BDs and requesting them to obtain.
    a. BDs, CLTs, CRCs will interact with each other to coordinate obtaining missing information or correcting information that was received in error.
    b. If there is an error identified by BDs, BDs will complete the **"Referral Correction Form"** available within **Focura Mobile Application** and document the corrections to be made. When the form is completed and saved by the BD, it will be automatically attached to the **"Referral Corrections"** Bucket (**ORANGE**) within the **Intake Workflow** Card.
    c. HIC will monitor the **"Referral Corrections"** Bucket within the **Intake Workflow** Card and make the changes to the patient's chart in HCHB following the process described above.

12. HICs will attempt to process certain referrals as **clearly identifiable** from any of the RI received as a high **Priority Case** for any of the following:
    a. Urgent/emergent hospice cases (not all hospice cases).
    b. IV's and tube feeding
    c. Wound care

13. Should a **Priority Case** be identified and if it is missing Basic Information, the HIC will add a **"Priority Case" Tag** which will cause that Case to be saved in the **"Priority Case Pending Information" Bucket** (**PURPLE**) within the "**Intake Workflow" Card** by the HIC.
    a. The HICs will focus on obtaining information for those cases first **before** addressing any other Cases that are missing Basic Information as tracked int the Missing Forcura Required Info Card.
    b. From there, the CRCs/CTLs/BDs will prioritize obtaining/correcting information using the process described above.

14. Once the Focura captured **Basic Information** is **Attached to HCHB**:
    a. The HICs will receive **HCHB Workflow** within HCHB entitled:
        i. **"Review Referral Request - HH HC"** – for home health and home care cases.
        ii. **"Review Referral Request - Hospice"** – for hospice cases.
        iii. HCHB determines which workflow is applicable based on having established the Service Line within Forcura' s "Security Group" section of the Basis Information request within the Forcura **Case Panel**.

15. The HIC will review and complete the following sections within HCHB:
    a. Review Referral Request
    b. Verify Referral Details
    c. HIC will then always select **"Approve Referral"** tab
        i. Do **NOT** select **"Decline Referral"** tab.
            1. Otherwise, the "Non-Admit" reporting and other information tracking within HCHB will not work.
            2. Selecting "Approve Referral" is a non-intuitive, HCHB design flaw when clinical team knows they are not accepting the case.
        ii. This is the **FIRST Approval** within HCHB.
            1. There is a **Final Approval** within HCHB happens later in this process.
        iii. The HIC will utilize the Ohio Living Holdings established **"Basic Protocols for Case Acceptance"** as a guide.
            1. This is the 'Red-Yellow-Green' OLH process.
        iv. It is expected that the HICs would be interacting actively with the CTLs and Schedulers regarding ability to take any particular Case.
        v. ***At this point, concerted effort needs to occur before letting the "Approve Referral" continue in the "Process Pending Referral" mode, otherwise significant additional work will unfold, and if there was no clear intent to take the Case then the HIC needs to then select "Non-Admit".***
            1. This is the site clinicians' group decision-making point as to whether the site desires to take the Patient Case.
            2. Cases may be categorized as "Non-Admit" for many reasons which are further defined below.
        vi. If the Patient Case is determined to be "Non-Admit", HCHB will prompt the CTL/CRC to complete the "Non-Admit" information.
            1. This then enables reporting from HCHB, the detail of which is an important regulatory requirement.
            2. This also includes completing the "Referral Source" information as well as the name of the BD that should receive credit for the referral, regardless of the decision to "Non-Admit".
        vii. The "Cancel" tab is not for use.
        viii. It is very important to verify the Service Line prior to acceptance.
            1. If the HIC approves the referral and subsequently discovers that the service line is not accurate , then HIC must perform the following:
                a. Save the referral attachments to a desktop or print.
                b. **"Non-Admit"** the patient and select the reason **"Incorrect Service Line - Please Delete**".
                c. Create a new referral from scratch via HCHB New Referral and attach the referral documents manually.

16. If the Patient Chart referral is approved in the previous step, HCHB will automatically generate workflow of:
    a. **"Process Pending Referral"** – for home health and home care cases.
    b. **"Process Pending Hospice Referral"** – for hospice cases.

17. **Communication Logs**
    a. Each site will have a Smartsheet Communication Log (CL).
    b. The purpose of the CL's is to provide up to date status of each referral either up through deciding to 'Non-Admit' or to the point where other HCHB workflows are complete and the patient is ready to schedule. It enables the site to have one summary where they can view the status of all pending potential cases, and thus enable staging of the staff schedule.
    c. HIC's will begin populating the CL upon identification of a New Referral upon receipt in Forcura.
    d. The following staff have access to the CL:
        i. HICs
        ii. CTLs
        iii. SMRCs
        iv. Schedulers
        v. Marketers
        vi. Executive Directors/Administrators
        vii. Certain Corporate positions
    e. The CLs have the following information in designated columns (the vast majority of which is also data entered into HCHB):
        i. Date Referral Received
        ii. Team Assigned
        iii. Zip Code of service area
        iv. Service Line
        v. First Name
        vi. Last Name
        vii. Referral Source or Location
        viii. Liaison – BD
        ix. Whether the Referral has been sent to Clinical Team for acceptance
        x. Physician or NP/PA
        xi. Whether the Face-to-Face is obtained
        xii. QRF/AVS HH Order Received
        xiii. Signing Provider Verified
        xiv. Referral Order Written
        xv. Notes about the Referral Order
        xvi. A column that indicates a checkmark if there is a Clinical Comment Note
        xvii. Services and Flags
        xviii. Liaison Updates
        xix. HIC Notes
        xx. Referral Order Date
        xxi. Start of Care (SOC) or Resumption of Care (ROC) Date
        xxii. Other Notes
        xxiii. Whether Scheduler Confirmed Date
        xxiv. Staffing anticipated to be assigned
        xxv. Whether the Team Leader Review is Complete
        xxvi. Complete – HIC Only – to indicate that the whole referral is complete and scheduled or non-admitted

18. BDs will receive an Alert generated from HCHB to RSL of "New Referral" which indicates that the Case has been created in HCHB. **(See Special Note above about delay/inconsistency of this functionality)**
    a. BD's need to recognize that this is not the FINAL Approval as described below.
    b. **They will NOT get an alert for the FINAL Approval but will get and Alert that the initial Start of Care has been completed.**
    c. BDs can identify any issues with the information received.
    d. BD can access the Activity Summary Report and view any patient information that they are assigned to.
    e. If BD identifies any errors, they will complete the **"Referral Correction Form"** within the **Forcura Mobile App** and document the corrections to be made (See process described previously).
    f. BDs will also receive an Alert generated from HCHB to RSC for **Non-Admit of Referral**. Should they choose, they can follow up with the HIC to obtain more information about why the case was declined.
    g. BDs need to routinely sync their device in order to ensure most current referral information is available for their view.
    h. RSL enables the BD's to see information entered in HCHB for a Patient Case at this point by accessing 'Features', then 'Reports', then "Activity Summary'.
        i. At that point all the Patients assigned to that particular BD are visible.
    i. BDs can send missing information using the Forcura Application.
        i. BDs can take a picture of the documents and attach in Forcura selecting the status of **"Missing HCHB Required Information".**
        ii. BDs can also complete the **Referral Correction Form** in Forcura which will attach with the status of **"Referral Corrections"**.

19. Provided that the Patient Chart has been clinically approved to continue processing the referral, the Patient Chart will still continue in the **"Referral Pending"** status within HCHB until **ALL "Required Referral Information"** is collected, at which time it would be considered a **"Complete Referral"**. That **RRI** (which is identified by **Red Asterisks** in HCHB) is:
    a. Patient name (full legal name).
    b. Date of birth
    c. Service address
    d. Gender
    e. Social Security Number (Not Required but Strongly Preferred, some Carriers may require)
    f. Service Line (Home Health, Hospice, Home Care, Other)
    g. Site
    h. Team
    i. Payor
        1. HIC will select the Payor as one of the following:

Payor Type

Payor Source	Service Line Type
TO BE DETERMINED HH	HOME HEALTH
TO BE DETERMINED HS	HOSPICE
TO BE DETERMINED PD	PRIVATE DUTY

        2. Must do so in order for the **Payor Validations Workflow** to be released to CIC.

3. CIC's will update, validate and complete in their Payor Validations Workflow.

ii. HIC is responsible for obtaining all information to validate the Payor which includes:

1. Medicare Card, Commercial Insurance Card, etc.
2. Payor Identification Number
3. Medicare Beneficiary Identification (MBI) Data or Social Security Number
4. Subscriber Name

j. Provider: Physician, Nurse Practitioner, or Physician's Assistant
k. Admitting Diagnosis Code
l. Admitting Discipline (Note: Skilled Nursing is the 'default' but may not be applicable)

20. After the entry of the Required Referral Information that was identified at this point, the HIC will write a **Clinical Comment- Intake** Coordination Note **<u>for every patient</u>**.
    a. This note contains a template to document any items that are missing and that are preventing 100% completion of the referral.
    b. This note also has an option to select **"Not Applicable, All Information Available"**.

21. Until the Patient Chart contains ALL the above **Required Referral Information** to be considered a **Complete Referral**, the structured HCHB functionality will NOT release the Patient Chart from Pending Referral within HCHB; **<u>thus, no other Workflow within HCHB will occur</u>**. This Workflow (WF) in order includes:
    a. Payor Validations WF – Assigned to CICs
    b. Payor Authorizations WF – Assigned to CACs
    c. Benefit Period Verification WF (Hospice) – Assigned to CICs
    d. Review/Edit/Approve after Payor Verification WF – Assigned to HICs
    e. Assign Evaluation Visit WF (HH and HC) and Assign LP for Hospice Evaluation Visit (Hospice) WF – Assigned to Schedulers (and HICs and CTLs) (or **'On Call' Profile** position can be assigned to all working After Hours – HICs and CTLs).
        i. Hospice Initiation Visit – use is pending research.

22. The HICs continue to be responsible for monitoring the **Clinical Comment- Intake** Coordination Note along with the **"Process Pending Referral"** for Home Health and Home Care and **"Process Pending Hospice Referral"** for Hospice and coordinating with BD and others to obtain the information.

23. The **Clinical Comment- Intake** Coordination Note will be <u>available</u> to **Clinical Team Leaders and Schedulers** in HCHB via the Patient's Chart or the **Coordination Notes Report** select **"Apply Criteria Value", then "Clinical Comment – Intake"** for the specific note type.
    a. Both positions will have access in HCHB to generate **Coordination Note Reports** that will provide them a status regarding open Referral Patient Cases.
    b. CTL's should generate these reports frequently to monitor the status of all missing information for all pending cases.
    c. BDs have access to view this Coordination Note via the Activity Summary Report (via RSL) for patients in which they are assigned as the Admissions Coordinator (aka BDs).

24. Any missing RRI that is subsequently obtained must be faxed/routed to Forcura.
    a. HIC's must identify the information in the Forcura **Pending Transmissions** Card.
    b. HIC's will select the new document and determine whether the **Patient Case** and **Patient Shell** have previously been created.

i. If so, then HIC should review the document to determine if the information received appears accurate and, if so, then select **"Attach HCHB"**, which will cause Forcura to automatically attach the document to the Patient Chart within HCHB.
ii. If the information is not accurate, it can be deleted by the HIC and the HIC would inform the BD that they need to try again.

c. If the BDs obtain missing information, they can transmit the missing information via the Forcura Mobile App and must select **"Missing HCHB Required Info"** within the App's View Panel and Save.
i. Doing so causes Forcura to save it to the **Intake Workflow** Card under the **"Missing HCHB Required Info"** Bucket, thereby enabling the HIC to identify the information sooner.
ii. From there, the HIC will select the new document with the missing or corrected information, review the document to determine if the information received appears accurate and, if so, and then select "Attach to HCHB".
iii. If it is not accurate, it can be deleted by the HIC and the HIC would inform the BD that they need to try again.

25. Once the HIC processes/enters any missing or corrected **RRI**, HCHB will then enable HIC to save the information and "**Release"** the Patient Chart from **"Process Pending Referral"** which then generates additional HCHB workflows.

26. Within the **Process Admission** HBCB workflow tasks, the following will be performed:
a. **Payor Information Verifications** – performed by CICs.
i. These cases will be worked in order received, first-in, first-out. The HIC is responsible to coordinate the Priority Case order as it relates to this stage of the workflow.
ii. If the CIC identifies any missing or incorrect information, the CIC will complete a "**HIC Notification"** Coordination Note within HCHB that <u>will route</u> to the HIC within workflow.
iii. The Coordination Note will populate in the HIC "Review Coordination Notes" tab and require action by the HIC to resolve.
1. HIC will send email to the group Central Intake email notifying CI of the updated payor information.
2. Eligibility is verified by the CIC's on the first of the month. If a patient is discovered to no longer be eligible under the admitted payor, a **HIC Notification** Coordination Note will be prepared by the CIC. The HIC will coordinate updating support for updated payor information and follow process noted above.
iv. Performance Timing:
1. It is the general expectation that confirmation of payor or preparation of a HIC Notification will occur within 1 hour when Workflow is released between the hours of 8 am and 5 pm.
a. The general expectation is 5 to 15 minutes to verify (either valid or not valid) a payor depending on the payor.
b. Exceptions may occur if unusually high volume were to be released to Workflow within any given hour.
2. If the 'Process Pending Referral' workflow is released <u>**after 6:30 pm**</u>, the payor verification will occur the next day.
3. If the 'Process Pending Referral' workflow releases **more than 70 referrals** in aggregate for all sites, <u>**between 5:00 pm and 6:30 pm**</u>, **only the first 70**

referrals will be worked on a First-In First-Out basis either to the point of confirmation of payor or preparation and release of "HIC Notification" Coordination Note indicating an issue with the data preventing confirmation. Any overage will be worked the next morning by the first shift CICs (section is pending Go-Live performance and stabilization of process into the Q1 of FY22).

a. Priority cases are the only exception to the above and would be covered by the last shift CIC's or by the On-Call CIC. Those cases should be limited and include only the following: Urgent/emergent hospice cases (not all hospice cases).
b. IV's and tube feeding
c. Wound care

b. **Benefit Period Verification (Hospice only)** – performed by CICs.
   i. If the CIC identifies any missing or incorrect information, the CIC will complete a **HIC Notification** Coordination Note within HCHB.
   ii. If a 3rd Benefit Period, a Face-to-Face most be obtained before any other workflow can happen.
   iii. Benefit Periods are double checked by the Hospice Accounts Receivable Coordinators at the time they are processing the Notice of Election.
   iv. Performance Timing: matches that referred to in the Payor Information Verifications section.

c. **Obtain Initial Authorization** – performed by CACs.
   i. Clinical documentation must be sufficient to justify why the patient needs the services for which the authorization is being requested in order to receive authorizations on a timeline that the site personnel desire.
   ii. See process described below regarding Forcura use for obtaining Authorizations.
   iii. Performance Timing – Initial Authorizations (pending further development after implementation and observation in Q1 FY22).

27. The HICs/CTLs/BDs will be working to obtain the following **Additional Medical Records** information. Unless this information is received, the Patient Chart **<u>will NOT be considered complete</u>** under Ohio Living established standards.
    a. **Appropriately completed Face-to-Face Document** – This will be part of the Review and Approve Face-to-Face Encounter Workflow generated by HCHB and assigned to the HIC for Home Health and the CTL for Hospice.
    b. **Referral Orders – from referring physician**
       i. This may be "Verbal Orders" obtained from the Physician, or documentation prepared by the physician's staff and included in the referral information sent with the referral package.
       ii. Referral Orders are generally obtained and written by Site LPN clinical staff, but the Orders must be approved by a site RN. This will be a duty of the HIC licensed staff.
           1. HIC LPNs will be responsible for calling to obtain any verbal referral orders and then writing the order in HCHB.
           2. Once the order is written, it goes into CTL workflow for approval by an RN.
       iii. An actual signed Physician's Referral Order is not necessary at this time, thus once the site RN approves, HCHB will complete the workflow for this section.
       iv. When the Referral Order has been obtained, the Referral Date will be verified and changed by the HIC if necessary.

1. **This is important because the 48 Hours to Start of Care clock starts running at this point.**

28. Once the **Payor Verification** workflow and **Benefit Period Verification** (Hospice only) workflow is complete, as well as the **Payor Authorization** workflow, the last stage before the admission is assigned is the **"Review/Edit/Approve Referral after Payor Verification" HCHB workflow.**

29. HICs will perform the **"Review/Edit/Approve Referral after Payor Verification"** HCHB workflow.
    a. There are several additional **Tabs** each having several fields of data within this WF that the HICs need to complete, some of the information having been populated in previous steps, including:
        i. Basic Info
        ii. Demographics
        iii. Referral Source
        iv. Payor Sources
        v. Physician
        vi. Diagnosis
        vii. Scheduling – Discipline needed for SOC - RN, or PT.
        viii. Clinical – Allergies
        ix. Coordination Notes
    b. The HICs will review and determine the care needs of all SOC/ROCs and will enter a **Pointcare Visit Alert** that includes:
        i. All ordered disciplines
        ii. The name of the Provider who has agreed to follow for home health
        iii. Any care needs such as labs ordered for certain dates, and wound care orders.
        iv. A note for the SOC clinician to assess the patient for Telehealth or Palliative care if the patient has a diagnosis such as COPD, CHF, new dx of DM, or HTN.
        v. Infusion or enteral company and phone number if applicable and the timing of deliveries or the visit time needed for the next infusion dose.
        vi. Determination of same day or next day SOC/ROC.
        vii. HICs will contact infusion and enteral companies and coordinate deliveries.
        viii. HICs will keep CTLs and schedulers updated on the scheduling needs of wound care, infusion, or enteral cases.
        ix. HIC will add infusion or any other special Care Type.
    c. Additional items to consider during review:
        i. It is important to be checking Forcura prior to approval to ensure that the **Referral Corrections** or the **Missing HCHB Required Information** buckets are not containing information for the specified patient.
        ii. If the information is not correct, a Coordination Note **"Clinical Comment- Intake"** will be documented in HCHB by the HICs. In this note they will identify the corrections necessary. They will need to reach out to the responsible positions to receive the necessary information.
            1. HICs will monitor the "**Review/Edit/Approve Referral after Payor Verification"** task until information is received and corrected.

30. If HIC is satisfied with the information, then HIC **"Approves"** by selecting **"Stage Complete"** within HCHB which will then generate the **"Assign the Evaluation Visit"** HCHB workflow to the site Schedulers which enables scheduling the admission visit.

31. If the HIC is not satisfied with the Case information and does not want to admit the case, or has been instructed by the CTL to not admit the case, or was informed by Central Intake or Central Authorizations that the case may not be accepted, then the HIC will still select "Stage Complete" (because it is the only option to choose at this point in the HCHB workflow).
    a. The HIC should then go to the HCHB "Workflow Summary", right click on the patient Case and select "Non-Admit".
    b. BD's will receive and Alert on RSL via HCHB that the Referral was Non-Admitted at this stage.
    c. After selecting "Non-Admit" the HIC must document the reason for the "Non-Admit", by selecting one of the established reasons in the drop-down option or selecting 'Other' and then writing a descriptive Coordination Note.
        i. Standard Non-Admissions Options presented in the Appendix.

32. HCHB does have a function of "Undo Non-Admit" but it is not functional and creates numerous "ERRORS" though out the workflow.
    a. If the site really wants to admit, then they must start the entire referral process over, beginning in Forcura.
    b. The goal is that the site should be relatively certain that they will take the Case at the step defined in **13**.

33. After the **Assign the Evaluation Visit** workflow is complete and the **Initial Visit** has occurred and been synced in HCHB, the **Start of Care** will have been completed.
    a. The BD's will receive and RSL Alert of **"New Admission"** after the Start of Care occurs and has been synced in HCHB.

Initial Authorizations Process

1. Authorizations documents will be prepared by the Central Authorization Coordinators (CAC). There are 2 methods for Initial and Re-Authorization Request transmittals.
    a. Insurance Carrier Website Portal
        i. Not all carriers avail portal options.
    b. Insurance Carrier Fax Line
        i. All carriers avail fax option.

2. Portal Outbound Requests:
    a. CAC reverifies Patient Name, Date of Birth, Gender, Payor, Payor Identification Number.
    b. Accesses portal:
        i. Enters information in 2, a.
        ii. Selects "Initial" or "Re-Authorization" or something to that extent if not the Initial.
        iii. Requests number of visits over service period.
            1. Certain carriers specifically prescribe the maximum service period for Initial and Re-Authorizations as well as maximum visits allowed.
        iv. If required, selects Medical Records documentation from Patient Chart in HCHB and uploads to the carrier portal.
        v. Saves/Submits within the portal.
        vi. Print/Saves a copy of the authorization request sent to the Carrier and attaches to the Patient Chart within HCHB.

3. Fax Outbound Requests:
    a. CAC reverifies Patient Name, Date of Birth, Gender, Payor, Payor Identification Number.
    b. CAC accesses Forcura and navigates to the **Shared Authorizations Drive** established for each of the Sites (e.g. Toledo).
    c. Within the **Shared Authorizations Drive**, the CAC selects the **Quick Send** (also referred to as Quick Fax) option to prepare the Authorization to be sent to the appropriate insurance carrier.
        i. Within the **Quick Send Window,** the **Subject Line** and **Comments** will be free text based on the needs for the authorization and will populate on the **Cover Sheet** that will be available in Forcura.
        ii. The Fax Line for the particular Branch/Site should be pre-established. If a particular staff person has CAC access to multiple fax lines, then the CAC will need to determine whether the Fax Line should be changed to "Central Authorization Fax Line" within the Quick Send Window. This would only be the case.
    d. CAC should select the appropriate carrier outgoing fax number from a pre-established list available in the drop-down box; and press the "Enter" key on their keyboard to submit the number.
        i. Clicking the Enter key will cause the fax number to display in a blue bubble, which is confirmation that the number was entered correctly.
    e. CAC will then change the Fax Cover Sheet to select the **"Authorizations Fax Cover Sheet"**.
    f. Any additional supporting documentation that needs to be included with the Authorization Request (i.e. medical records supporting the need for the care being requested to be authorized) would also be uploaded into the **Forcura Shared Authorizations Drive.**
        i. The CAC then attaches that additional supporting documentation via the Quick Fax function.
    g. Click "Send" to transmit the Authorization Request and supporting documents.

4. CAC can monitor outstanding Authorizations that have been sent by navigating to the **"Authorization Requested"** Bucket within the **"Authorization Workflow"** Card on the Forcura Dashboard.

5. All **Authorization Responses** from the Carrier will route into Forcura regardless of whether the request was sent via Portal or Fax.
    a. CAC will monitor the **"Pending Transmissions"** Card under **"Inbound"** within Forcura.
    b. Once the **Authorization Response** is received back, CAC will see it populate into the
    c. CAC should access the individual Authorization Response documents and review.
    d. Regardless of whether the Authorization Request was **Approved or Denied**, the CAC must create a **Case** for that Authorization document and ender the following data:
        i. Case Name: CAC uses the standardized Case Name convention established upon entering the Basic Information, but also including a discipline indicator for Skilled Nursing (SN), Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST), Social Work (SW) as well as denoting "Auth" so that it is searchable in HCHB (e.g. **Smith.Joseph.PTAuth.05.12.2021**) with the date being the date that the Authorization Request was received.
        ii. Document Type: will be "INSURANCE AUTHORIZATION | CLIENT".
        iii. Document Status: will be "Authorization Requested".
        iv. Security Group: the Branch within the Site (e.g. AK1 = Akron Home Health)
        v. Patient: Should be selected from the dropdown/search feature because the Patient Chart was already established during the initial referral processing activities.
    e. The CAC then attaches the returned **Authorization Response** to the **Authorization Case** and updates the **Status** of the case to **"Authorization Returned"**.

i. CAC needs to select "Attach to HCHB" for the document to move to HCHB.

f. If the Authorization Response **Approved** the Authorization Request, then CAC will finish the Authorization Workflow within HCHB.
   i. At this point, HIC will receive the "Review/Approve Referral after Payor Verification" for Home Health and "Review/Approve Hospice Referral after Payor and Benefit Verification".
   ii. Refer to process above.

g. If the Authorization Response **Denied** the Authorization Request, then the CAC will prepare a **"Missing Authorization Information" Coordination Note** within HCHB indicating the reason for denial and whether providing additional documentation would increase the chances of acceptance.
   i. The Coordination Note will be available to the **CTL and Scheduler** within the "Coordination Note" Tab.
   ii. The CTL will need to monitor this Tab frequently and coordinate obtaining or improving the clinical documentation. Once obtained, the CTL will prepare a Coordination Note indicating that the updated information is available.
      1. This Coordination Note will route to the Coordination Note Tab available to the CAC's.
      2. CAC's will review the information, and if sufficient, reperform the Authorization Request as described above.

6. Additional Authorizations, New Orders Authorizations and Reauthorizations are covered under a separate process document.

Appendix

Document Types

Type	Name	Attachment Location
Attachment	WOUND IMAGE	EPISODE
Attachment	FACE-TO-FACE	CLIENT
Attachment	FACE-TO-FACE	EPISODE
Attachment	SIGNATURE FORMS	CLIENT
Attachment	HHABN	CLIENT
Attachment	HHABN	EPISODE
Attachment	PROFILE PICTURE	EPISODE
Attachment	PRE-CLAIM REVIEW DOCUMENTATION RECEIVED	EPISODE
Attachment	LAB RESULTS	CLIENT
Attachment	LAB RESULTS	EPISODE
Attachment	PHOTOGRAPH	EPISODE
Attachment	PHOTOGRAPH	CLIENT
Attachment	DOCUMENTATION	CLIENT
Attachment	DOCUMENTATION	EPISODE
Attachment	SIGNED ORDERS	EPISODE
Attachment	CONTINUITY OF CARE DOCUMENT	EPISODE
Attachment	RADIOLOGY RESULTS	CLIENT
Attachment	RADIOLOGY RESULTS	EPISODE
Attachment	ADVANCE DIRECTIVES	EPISODE
Attachment	ADVANCE DIRECTIVES	CLIENT
Attachment	REFERRAL PACKET	CLIENT
Attachment	REFERRAL PACKET	EPISODE
Attachment	PHYSICIAN WEBSITE REFERRAL	EPISODE
Attachment	PHYSICIAN WEBSITE REFERRAL	CLIENT
Attachment	PHYSICIAN WEBSITE ENCOUNTER	CLIENT
Attachment	PHYSICIAN WEBSITE ENCOUNTER	EPISODE
Attachment	REVERSE NON-ADMIT DOCUMENTATION	EPISODE
Attachment	OPTUM PHARMACY	CLIENT
Attachment	OPTUM PHARMACY	EPISODE
Attachment	PAYOR ELIGIBILITY	CLIENT
Attachment	PAYOR ELIGIBILITY	EPISODE
Attachment	EPISODE REALIGNMENT DOCUMENTATION	CLIENT
Attachment	INSURANCE AUTHORIZATIONS	CLIENT
Attachment	PRE-CLAIM REVIEW DOCUMENTATION	EPISODE
Attachment	HH FACE-TO-FACE ENCOUNTER	EPISODE
Attachment	HH FACE-TO-FACE ENCOUNTER	CLIENT
Attachment	ABN	CLIENT

Attachment	ABN	EPISODE
Attachment	CCN	CLIENT
Attachment	CCN	EPISODE
Attachment	NOMNC	CLIENT
Attachment	NOMNC	EPISODE
Attachment	PLAN OF CARE	CLIENT
Attachment	PLAN OF CARE	EPISODE
Attachment	MED LIST	EPISODE
Attachment	MED LIST	CLIENT
Attachment	ADDMISSION PACKET	EPISODE
Attachment	DNR	CLIENT
Attachment	ADMISSION AGREEMENT	CLIENT
Attachment	DISPOSAL OF MEDICATIONS	CLIENT
Attachment	AUTHORIZATION FOR USE & DISCLOSURE	CLIENT
Attachment	HOSPICE REVOCATION STATEMENT	CLIENT
Attachment	NOTICE ELECTION STATEMENT (NOE)	CLIENT
Attachment	HOSPICE TRANSFER FORM	CLIENT
Attachment	VOLUNTEER VISIT	EPISODE
Attachment	CLINICAL DOCUMENTATION	CLIENT
Attachment	PREFERRED PROVIDER FORM	CLIENT
Attachment	PAS/RR	CLIENT
Attachment	NURSING FACILITY ORDERS	EPISODE
Attachment	HOSPICE FACE-TO-FACE	EPISODE
Attachment	HOSPICE FACE-TO-FACE	CLIENT
Attachment	OARRS	CLIENT
Attachment	NARCOTIC COUNT	CLIENT
Attachment	HOSPICE ELIGIBILITY CHECKLISTS – ADMISSION	CLIENT
Attachment	HOSPICE ELIGIBILITY CHECKLISTS – RECERTIFICATION	CLIENT
Attachment	HOSPICE ADDENDUM	CLIENT
Orders	485 ORDERS	Order
Orders	PLAN OF CARE UPDATE	Order
Orders	RESUMPTION OF CARE	Order
Orders	PHYSICIAN ORDER	Order
Orders	DISCHARGE FROM AGENCY	Order
Orders	HOSPITAL HOLD	Order
Orders	FOLLOW UP (SCIC)	Order
Orders	CERTIFICATION PERIOD ADJUSTMENT ORDER	Order
Orders	EMERGENT PRN ORDER	Order
Orders	ADD ON DISCIPLINE	Order
Orders	SCHEDULE ROC VISIT	Order
Orders	HOSPICE PLAN OF CARE	Order
Orders	HOSPICE PHYSICIAN ORDER	Order

Orders	HOSPICE RECERTIFICATION	Order
Orders	HOSPICE ADD-ON	Order
Orders	HOSPICE DISCHARGE	Order
Orders	HOSPICE CERTIFICATION PERIOD ADJUSTMENT ORDER	Order
Orders	WAIVER RESUMPTION OF CARE	Order
Orders	HOSPICE EMERGENT PRN ORDER	Order
Orders	HOSPICE CTI	Order
Orders	HOSPICE RECERTIFICATION PLAN OF CARE UPDATE	Order
Orders	REFERRAL ORDER	Order

Non-Admission Types

Code	Non-Admit Reason
01	NO SKILLED NEED
02	NOT HOMEBOUND
04	REFERRED/ADMITTED TO SKILLED NURSING FACILITY OR LTAC
05	REFERRED/ADMITTED TO HOSPICE
07	PATIENT CHOSE ANOTHER AGENCY
08	PATIENT REFUSED CARE
10	EXPIRED
12	NO PAYOR SOURCE
13	OUT OF SERVICE AREA
14	UNABLE TO LOCATE
16	UNABLE TO ACCEPT PAYOR
17	NO PCP TO FOLLOW
19	INSUFFICIENT STAFFING
20	COVID 19
21	PATIENT IS ON OUR DO NOT TAKE BACK LIST
22	HISTORY OF NON-COMPLIANCE
23	SERVICES NEEDED ARE BEYOND THE SCOPE OF THE AGENCY
24	PATIENT ON SERVICE WITH ANOTHER AGENCY
26	FAMILY REFUSED CARE
27	UNSAFE HOME ENVIRONMENT/SERVICE LOCATION UNACCEPTABLE
28	UNABLE TO VALIDATE PAYOR
29	UNABLE TO OBTAIN AUTHORIZATION
30	UNABLE TO OBTAIN REFERRAL ORDER
31	UNABLE TO OBTAIN FACE-TO-FACE