Home health
Health plan guideline

Guideline Information

Scope	Medicare Advantage Plan-DSNP & IESNP	Effective Date	5/4/2023
Department	Clinical-Utilization Management	Revision Date	4/30/2024
Owner	Koby Mitchell, MSN, RN	Version	2.0
Executive Sponsor	Clare Hays, MD, CMD	Status	Active
Exceptions to Scope	Non-contracted Providers		

Guideline Statement

Simpra Advantage health plan performs utilization review for the medical necessity of home health services and treatment. Utilization review is performed by licensed personnel as outlined within the "Clinical Decision-Making P&P_UM-003".

To qualify for the Medicare home health benefit, a Medicare beneficiary must meet the following requirements:

- Be confined to the home (homebound);
- Under the care of a physician or allowed practitioner;
- Receiving services under a plan of care established and periodically reviewed by a physician or allowed practitioner;
- Be in the need of skilled nursing care on an intermittent basis (intermittent means skilled nursing care that is either provided or needed on fewer than seven (7) days each week or less than eight (8) hours of each day for periods of twenty-one (21) days or less) for physical therapy or speech-language pathology; or
- Have a continuing need for occupational therapy.

Confined to the Home

- The member must either:
  - Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person to leave their place of residence, or
  - Have a condition such that leaving his or her home is medically contraindicated.
- If the member meets one of the conditions above, then the member must also meet two additional requirements defined in criterion below:
  - There must exist a normal inability to leave home, and
  - Leaving home must require a considerable and taxing effort

ASSOCIATED CARE VENTURES

HOME HEALTH
HEALTH PLAN GUIDELINE

Rules

- Medicare Benefit Policy Manual, Chapter 7- Home Health Services, Section 20- Conditions to be Met for Coverage of Home Health Services, Section 30- Conditions Patient Must Meet to Qualify for Coverage of Home Health Services

Guidelines

A. Prior authorization is required for home health care (HHC). Simpra Advantage receives HHC requests from a member's Primary Care Provider (PCP) or upon discharge from an inpatient admission, or SNF A admission.

B. Initial HHC authorization requirements:

1. A signed order from a physician or other qualified health care provider (e.g., Physician's Assistant, Nurse Practitioner) and clinical documentation is required.
2. Medically necessary services will be authorized as follows:
    a. An initial authorization for six (6) HHC visits per discipline will be issued with notification only. Notification to the health plan is required no later than seven (7) calendar days of starting care.
    b. If more than six (6) visits per discipline are needed, the home health agency must request the visits and receive prior authorization in advance of providing the additional visits.
3. If after the home health agency receives authorization for the initial certification period the agency finds that additional visits are needed, the home health agency will submit a prior authorization request with clinical to substantiate the need for additional visits not previously included with the initial request. The additional visits must be authorized before they are rendered.
4. If a home health care agency received authorization, but the start of care is delayed, the agency may submit a request to Simpra Advantage UM to adjust the dates of the authorization within three (3) business days of the actual start of care.

C. Recertification HHC authorization requirements:

1. A CMS-485 (does not have to be signed to request the authorization)
    a. CMS-485 must be signed by a physician before billing. Simpra reserves the right to audit all contracted providers. A physician signed 485 is required to be on file with the rendering agency and must be provided upon request.
2. A signed order from MD (or other qualified health care provider, e.g., Physician's Assistant, Nurse Practitioner)
3. Medically necessary services will be authorized as follows:

a. Number of visits ordered by physician.
b. Dates of service for 60-day span

D. Retrospective requests for HHC services (Contracted Providers)

1. Retrospective requests for home health services will be subject to review per Simpra Health Plan UM's retrospective review policy and procedure (UM-017_Retrospective Review Request).

Definitions

Item	Definition
CMS 485	The CMS 485 is used to establish the patient's treatment plan for the initial certification period and any continued sixty day 'recertification' periods.
Retrospective request	A post-service review request where medical necessity review for the service is conducted after the service has been provided to the member. Retrospective review does not include subsequent review of services for which prospective or concurrent review for medical necessity and appropriateness were previously conducted.

Document Approval

Date	Approver	Role	Approved
5/4/2023	Dr. Clare Hays, MD, CMD	Chief Medical Officer	Yes
12/22/2023	UM Committee	UM activity oversight	Yes
4/30/2024	Dr. Clare Hays, MD, CMD	Chief Medical Officer	Yes
4/30/2024	UM Committee	UM activity oversight	Yes
12/27/2024	UM Committee – Annual Review	UM activity oversight	Yes

Review & Revision History

Date	Revision Summary	Author	Approval Required?
1/2/2024	Annual review completed	K. Mitchell	No
4/30/2024	Clarified the scope of the P&P to exclude non-contracted providers. In addition, updated the language under section "D" regarding retrospective reviews to clarify the circumstances for which retrospective review for home health care services will be accepted. Added "retrospective request" to be defined in the "Definitions" section.	K. Mitchell	Yes
11/25/24	Annual review completed. No changes made.	K. Mitchell	UMAC annual review