Home health
Health plan guideline

Guideline Information

Scope	Medicare Advantage Plan-DSNP & IESNP	Effective Date	5/4/2023
Department	Clinical-Utilization Management	Revision Date	10/10/2025
Owner	Koby Mitchell, MSN, RN	Version	3.0
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

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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. **Initiation of Services and Authorization Requirement**:

1) Home health services may be initiated without prior authorization when medically necessary and appropriate. This provision is intended to prevent delays in care for members discharging from an acute facility or transitioning between levels of care. The home health agency must submit notification to the Plan no later than seven (7) calendar days from the start of care. This notification will result in an initial authorization for up to 60 days of service.
    a. Prior to initiating care, home health agencies are responsible for verifying that the member meets Medicare home health eligibility and coverage criteria as outlined in CMS Medicare Benefit Policy Manual, Chapter 7. Agencies must not initiate services unless the member satisfies all applicable CMS Chapter 7 criteria, including but not limited to:
        (i) The member is confined to the home (homebound);
        (ii) Services are medically necessary and reasonable; and
        (iii) Care is provided under a plan of care established and periodically reviewed by a physician or allowed practitioner.
    b. Failure to ensure that Medicare Benefit Policy Manual chapter 7 criteria are met prior to admission may result in denial of authorization or payment for services rendered.
2) A signed and dated order from a physician or other qualified health care provider (e.g., Physician's Assistant, Nurse Practitioner) and clinical documentation is required.
    1. Medically necessary services will be authorized as follows:
        a. Home health agencies may begin care for the initial episode when medically necessary to prevent delay in discharge or transition. Notification to Simpra is required within seven (7) calendar days of the start of care. Upon receipt, Simpra will validate CMS Chapter 7 eligibility and medical necessity before issuing authorization for the initial 60-day episode.
        b. Notification serves to initiate review, not to imply automatic approval.
3) If a home health care agency received prior authorization, but the start of care is delayed, the agency may submit a request to Simpra UM to adjust the dates of the authorization within three (3)

business days of the actual start of care. Requests to adjust start dates must be received in writing.

C. **Recertification HHC authorization requirements**:

1) A CMS-485 (or equivalent plan of care) must be submitted with any request for recertification.
    a. The CMS-485 does not have to be signed at the time of the authorization request; however, it must be signed and dated by the ordering physician or allowed practitioner prior to billing.
    b. Simpra reserves the right to audit for compliance. If services are billed without a signed and dated CMS – 485 on file, Simpra may deny or recoup payment for those services in accordance with CMS guidelines.
    c. A physician or allowed practitioner signed/dated CMS-485 must be maintained in the member's clinical record and provided to Simpra upon request.
2) A signed and dated order from MD (or other qualified health care practitioner, e.g., Physician's Assistant, Nurse Practitioner)
3) Medically necessary services will be authorized for an additional 60 days per episode of care.

D. **Visit Quantities and Utilization Monitoring**

1) Home health agencies are required to include the anticipated number of visits per discipline (e.g., skilled nursing, physical therapy, occupational therapy, speech therapy, home health aide, medical social work) when submitting requests for authorization.
2) Simpra reimburses home health services on an episodic basis, consistent with Medicare payment methodology. The reported visit quantities are not used to determine payment, but are required for care coordination, utilization management, and trend monitoring.
3) Agencies should ensure that visit projections are reasonable based on the member's condition, goals, and expected clinical progress. Simpra monitors utilization patterns both at the authorization level and retrospectively at the claim level to identify potential overutilization, underutilization, or deviations from the plan of care
4) Significant variance between authorized and rendered services may be subject to review or audit to ensure compliance with CMS guidelines and the member's individualized plan of care.

E. **Retrospective requests for HHC services (Contracted Providers)**

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

Definitions

Item	Definition
CMS 485	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
12/15/2025	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	K. Mitchell	Yes

	"retrospective request" to be defined in the "Definitions" section.		
11/25/24	Annual review completed. No changes made.	K. Mitchell	UMAC annual review
10/10/2025	Annual review. Updates made to clarify the requirements for recertification documentation and initial notification requirements. Section "D" was added to provide clarification for how HH is reimbursed and why visits/quantities must be provided with requests for authorization.	K. Mitchell	Yes/UMAC annual review