HOME HEALTH CARE

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OVERVIEW

This chapter applies to home health care (HHC) services for most EmblemHealth Members enrolled in the Health Insurance Plan of Greater New York (HIP) starting January 1, 2018. eviCore healthcare will manage most HHC prior approvals for HIP members.

EmblemHealth will continue to manage Personal Care Assistants and Consumer Directed Personal Assistance Programs. See Care Management chapter for rules that will continue to apply to these services, excluded members, and to Group Health Incorporated (GHI) members.

Prior approvals do not guarantee claim payment. Services must be covered by the member's health plan and the member must be eligible at the time services are rendered. Claims submitted may be subject to benefit denial.

TRANSITIONAL CARE SERVICES

eviCore will provide transitional care services for all applicable HIP members discharging from the hospital with Home Care Services. The members will be managed by the eviCore Transitional Care Program for 90 days post hospital discharge. The transitional care program comprising member support is based on identified risk factors. Core services include PCP appointment scheduling, disease coaching, social services support and member education.

MEMBERS MANAGED BY EVICORE

Starting January 1, 2018, eviCore will manage members who access the following networks:

- **Commercial and Child Health Plus**
  - Prime Network
  - Select Care Network

- **Medicaid/HARP**
  - Enhanced Care Prime Network

- **Medicare and Special Needs Plans**
  - VIP Prime Network

Exceptions to These Rules

- Health care professionals treating members whose care is managed by HealthCare Partners and Montefiore were required to contact those managing entities to verify coverage and procedures.

PRIOR APPROVAL PROCESS

Services Requiring Prior Approval

EmblemHealth will continue to manage Personal Care Assistants (PCA) and Consumer Directed Personal Assistance Program (CDPAP). See Care Management chapter.

eviCore healthcare (eviCore) will begin accepting prior approval requests for services on **December 28, 2017** for dates of service beginning **January 1, 2018** for the following HHC Services:

- Skilled Nursing
- PT/OT/ST
- Social Worker
- Home Health Aides (for members receiving skilled HHC services)

Who Requests Prior Approval

- SNF, IRF and LTAC are responsible for submitting the initial Home Health Service requests for all HIP members discharging from a PAC facility with home health services.
- HHC agencies will submit prior approval requests to eviCore for hospital discharges and community referrals.

How To Obtain a Prior Approval

All providers must verify member eligibility and benefits prior to rendering services at emblemhealth.com/Providers. The following sections describe the information you will need to submit to eviCore and the processes for submitting prior approval requests.

Required Information

The requesting provider should be prepared to submit:

- Appropriate eviCore request form - available at: **evicore.com/healthplan/emblem**
- Patient's medical records
- Details such as:
  - Background
    - Site of Care demographics
    - Patient demographics
    - Services requested (Skilled Nursing/OT/PT/ST/SW/HHA)
    - Home Health ordering physician demographics
    - Anticipated date of discharge
  - Clinical Information
    - PAC admitting diagnosis and ICD10 code
    - Clinical Progress Notes & Oasis Assessment

- Medication list
- Wound or Incision/location and stage (if applicable)
- Discharge summary (when available)

- Mobility & Functional Status
  - Prior and Current level of functioning
  - Focused therapy goals: PT/OT/ST
  - Therapy progress notes including level of participation
  - Discharge plans (include discharge barriers, if applicable)

How to Obtain Prior Approval	
Managing Entity	Methods to Submit Prior Approval Requests
eviCore	eviCore offers three convenient methods to request prior approval, depending on the Program: 1. Web Portal submissions are the most efficient way to request prior approvals. Please visit evicore.com/pages /providerlogin.aspx. 2. Telephone: Clinical information can be called in to eviCore healthcare at **866-417-2345**, choose option 3 for HIP members; then option 4 DME and prompt 1 for CPAP and BIPAP or 2 for other DME services. 3. Facsimile: DME required documentation can be faxed to 866-663-7740. For DME requests prior to January 1, 2018, fax to **1-866-426-1509**. On or after, December 28, 2017,submit requests to eviCore for anticipated dates of service on or after January 1, 2018. DME Suppliers may obtain prior approval details via the eviCore web portal at: **evicore.com/pages /providerlogin.aspx** or by calling eviCore at: **866-417-2345**, option 3 for HIP, then option 4.
HealthCare Partners	Call **(800) 877-7587** or fax your request to (888) 746-6433.
Montefiore CMO	Call **(888) 666-8326**.

Prior Approval Time Frames

eviCore will provide Prior Approval by service type in the following ways:

Prior approval	Skilled Nursing	Home Health Aide Social Worker	PT/OT/ST
Initial	7 calendar days	N/A	7 calendar days
Concurrent	14 calendar days	14 calendar days	14 calendar days

Once clinical information is received, determinations will be made within 1 business day. If a peer to peer review is requested, add an additional business day. However, eviCore's typical response time is less.

Once determination is made, eviCore will provide verbal and written notification to the

requesting facility or HHC Agency. The servicing HHC agencies may obtain prior approval details by calling eviCore at **866-417-2345**, option 3 for HIP, then 5 for Home Health Care or Transitional Care; then either 1 for Home Health Care or 3 for Transitional Care.

Initial prior approval is valid for 7 days. During that timeframe, the services must be initiated or new prior approval is required.

Home Health Care Prior Approval Criteria

Criteria used by eviCore includes, but is not limited to:

- McKesson InterQual® Criteria
- Medicare Benefit Policy Manual Chapter 7 Section 30.1,
- Evidence-Based Tools along with Clinical Findings.

Retrospective Reviews

eviCore will accept requests for retrospective reviews for medical necessity. Requests must be submitted within 14 calendar days from the date the initial service was rendered.

Discharge Planning

The discharge planning process should begin as early as possible. This allows time to arrange appropriate resources for the member's care.

From Home Care: Once the patient is discharged from the HHC agency, the PCP will be notified by eviCore.

From a Hospital: HHC agencies are responsible for submitting prior approval requests to eviCore for hospital discharges. For post-acute care services, (acute rehabilitation, skilled nursing facility stay, home care, durable medical equipment), the eviCore concurrent review nurse will facilitate prior approvals of medically necessary treatments if the member's benefit plan includes these services. Patients utilizing HHC services following a hospitalization will be managed by eviCore's Transitional Care Program for 90 days post hospital discharge.

From a SNF, IRF or LTAC: The discharging facility is responsible for submitting the initial Home Health Service requests.

Notice of Medicare Non-Coverage (NOMNC) for Medicare Members

Important: For date extension (concurrent review) prior approval requests, HHC Agencies should submit clinical information 72 hours prior to the last covered day. This allows time for Notice of Medicare Non-Coverage (NOMNC) to be issued. eviCore will issue the NOMNC form to the provider. The provider is responsible for issuing the NOMNC to the member, having it signed and returning it to eviCore.

In accordance with CMS guidelines, the Notice of Medicare Non-Coverage (NOMNC) will be issued by the servicing provider no later than 2 calendar days before the discontinuation of coverage, if care is not being provided daily.

If the member is cognitively impaired, the servicing provider is responsible for informing the health care proxy of the end-of-service dates and the appeal rights. If the proxy is unable to sign and date it, the staff member and witness who informed the proxy of the end date and appeal rights should sign and date the form, then fax it back to eviCore or send via the eviCore PAC Web Portal.

DENIAL AND APPEALS PROCESS

Unable to Provide Prior Approval for Initial HHC Request

Cases that do not meet medical necessity on initial nurse review will be sent to a second level physician for review and determination. If a potential adverse determination is made by the physician, they will reach out to the requesting provider and a Peer to Peer (P2P) Review will be offered.

Reconsiderations Process (Commercial and Medicaid only)	• A Reconsideration is a post-denial, pre-appeal opportunity to provide additional clinical information. • Reconsideration must be requested within 14 days of the Initial Denial Date. • Peer to peer (P2P) requests can be made via a Verbal or Written request. • P2P is conducted with the referring MD and one of eviCore's Medical Directors. • P2P results in either a Reversal or an Uphold of the original decision. • The DME Supplier and the Member are notified via Mail and Fax.

Peer to Peer (P2P) must be requested within 1 business day, or additional clinical information that supports medical necessity must be received within 1 business day, or the determination is final and the case will be closed. Note: P2P must occur within 1 business day or a denial letter will be issued.

If the P2P process does not result in a reversal of the denial, eviCore will issue a denial letter. The physician reviewer may suggest an alternate level of care and/or the appeals process.

Once a service has been denied, members and providers must file an appeal to have the request reviewed again.

Medicaid or Commercial Members requesting to appeal a denial for initial HHC services should follow the instructions provided on the denial letter. Appeal requests must be submitted to eviCore via phone at **800-835-7064** (Monday through Friday, 8 a.m. – 6 p.m. EST) or fax to 866-699-8128.

Medicare Members may request an appeal of a denial for initial HHC services by following the instructions provided in the denial letter. Providers should follow the process outlined in the Dispute Resolution for Medicare chapter.

Unable to Extend HHC Services

Cases that do not meet Medical Necessity on concurrent nurse review will be sent to a 2nd level physician for review and determination.

If a potential adverse determination is made by physician, outreach is made to the HHC Agency and a peer to peer review may be requested by the provider.

Appeals Process (Medicare, Medicaid and Commercial)	• 1st level Commercial and Medicaid appeals will be handled by eviCore. • Medicaid or Commercial members requesting to appeal a denial should follow the instructions provided on the denial letter. Appeal requests must be submitted to eviCore via phone at **800-835-7064** (Monday through Friday, 8 a.m. - 6 p.m. EST) or faxed to 866-699-8128. • Medicare appeals will be handled by EmblemHealth. • Medicare members may request an appeal of a denial by following the instructions provided in the denial letter. Providers should follow the process in the Dispute Resolution for Medicare chapter.
Member Appeals Process	• Medicaid and Commercial members requesting to appeal the decision to end HHC services should contact eviCore via phone at **800-835-7064** (Monday through Friday 8 a.m. - 6 p.m. EST) or fax to 866-699-8128. • Medicare Members requesting to appeal the decision to end HHC services should follow the QIO process outlined on the NOMNC. Providers should follow the process outlined in the Dispute Resolution for Medicare chapter. • Medicare Members may request an appeal of a denial based on the decision to end skilled care for concurrent IRF services by following the instructions provided in the denial letter. Providers should follow the process in the Dispute Resolution for Medicare chapter.
Home Health Care (Date extensions)	The Notice of Medicare Non-Coverage (NOMNC) will be issued no later than 2 calendar days prior to the discontinuation of coverage, if care is not being provided daily. The following calendar day after services end will not be covered unless the decision is overturned or the NONMC is withdrawn.

Turn-Around Time after an Appeal has been requested by the member:

- Expedited – up to 72 hours
- Standard – up to 30 days

GROUP HEALTH INCORPORATED MEMBERS

The management of home health care is not transitioning to eviCore. See **Care Management** chapter for applicable prior approval processes.