EmblemHealth

Chapter 14: Home Health Care

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Return to Provider Manual

Search the Provider Manual

Overview

This program applies to home health care (HHC) services for EmblemHealth members (see the section below for Excluded Members). EmblemHealth manages most HHC preauthorizations.

Preauthorization may be needed before certain services can be rendered. Depending on which networks members access and who has financial risk for their care, preauthorization requests are evaluated by either EmblemHealth or a Managing Entity. For the list of services requiring preauthorization, refer to **Clinical Corner**.

HHC must be provided by a contracted HHC provider. To locate an appropriate HHC provider for a patient, visit **emblemhealth.com/find-a-doctor**.

Preauthorizations do not guarantee claims 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. Before rendering services, all providers must verify member eligibility and benefits by signing in to our provider portal at **emblemhealth.com/providers** and using the Eligibility drop-down under the Member Management tab

Excluded Members

Members whose ID card indicates a primary care provider (PCP) from HealthCare Partners (HCP) are excluded from the EmblemHealth HHC preauthorization process.

Excluded members are medically managed in the same way as they are for other services by the assigned Managing Entity. To determine the Managing Entity, check the member's ID card or eligibility information by signing in to our secure portal at **emblemhealth.com/providers** and using the Eligibility drop-down under the Member Management tab. You may also use the Preauthorization **Lookup Tool** to determine if a preauthorization is required and who is responsible for conducting the review. See the **Utilization and Care Management** chapter of the Provider Manual for applicable rules and preauthorization processes.

Preauthorization Process

Services Requiring Preauthorization

EmblemHealth performs preauthorization review for the following HHC services:

- Skilled Nursing (SN)
- Physical Therapy (PT)
- Occupational Therapy (OT)
- Speech Therapy (ST)
- Social Worker (SW)
- Home Health Aides (HHAs) (for members receiving skilled HHC services)

Who Requests Preauthorization

- Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs), and Long-Term Acute Care facilities (LTACs) are responsible for submitting:
  - The initial HHC service requests for members discharging from a post-acute care (PAC) facility with home health services.
- HHC agencies may submit preauthorization requests for:
  - Hospital discharges
  - Community referrals

How to Obtain a Preauthorization

Below is the information and process you need for submitting preauthorization requests.

The requesting provider should be prepared to submit:

- Patient's medical records
- Details such as:
  - Background
    - Site of care demographics
    - Patient demographics
    - Services requested (SN/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 and Outcome and Assessment Information Set (Oasis)
    - Medicine list
    - Wound or incision/location and stage (if applicable)
    - Discharge summary (when available)
  - Mobility and 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)

EmblemHealth offers two (2) convenient methods to request preauthorization – online (fastest option), and by phone. See the **Who to Contact for Preauthorization** section of the Directory chapter.

Preauthorization Time Frames

Once determination is made, EmblemHealth provides verbal and written notification to the requesting facility or HHC agency.

Initial preauthorization is valid for seven (7) days. During that time, services must be initiated, or a new preauthorization is required.

Home Health Care Preauthorization Criteria

Criteria used by EmblemHealth include, but are not limited to:

- MCG Health (fka Milliman Care Guidelines)
- Medicare Benefit Policy Manual Chapter 7 Section 30.1
- Evidence-based tools along with clinical findings

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 HHC agency should notify the primary care provider (PCP).

From a Hospital: HHC agencies are responsible for submitting preauthorization requests to EmblemHealth for hospital discharges.

From an 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) requests, HHC agencies should submit clinical information before the second to last covered visit, but no less than 72 hours prior to that visit. This allows time to issue the Notice of Medicare Non-Coverage (NOMNC). The provider is responsible for completing and issuing the NOMNC to the member, having it signed and returning it to EmblemHealth. If the provider issues a NOMNC during a period where the member is authorized, the provider should notify EmblemHealth as soon as possible and submit a copy of the notice.

In accordance with Centers for Medicare & Medicaid Services (CMS) guidelines, the servicing provider issues the NOMNC no later than two (2) calendar days before the discontinuation of coverage if care is not being provided daily. The following calendar day after services end is not covered unless an adverse determination is overturned or the NOMNC is withdrawn.

The servicing provider is responsible for informing the health care proxy of the end-of-service dates and the appeal rights for members who are cognitively impaired. If the proxy is unable to sign and date the NOMNC, the staff member and witness who informed the proxy of the end date and appeal rights should sign and date the form, document that the form was reviewed verbally with the proxy, and return it to EmblemHealth.

Denial and Appeals Process

Denial of Preauthorization

Cases that do not meet medical necessity on initial nurse review are sent to a physician for second-level review and determination. If the EmblemHealth physician makes an adverse determination, the requesting provider is contacted regarding the denial and may appeal according to the appeal rights contained within the letter.

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

Denial to Extend Services

Cases that do not meet medical necessity on concurrent nurse review are sent to a physician for second-level review and determination. If the EmblemHealth physician makes an adverse determination, the requesting HHC agency is contacted and the appropriate denial letter will be issued by EmblemHealth.

Home Care Date Extensions (concurrent review requests) for Medicare Members: The NOMNC is issued no later than two (2) calendar days prior to the discontinuation of coverage. The third (3^{rd}) calendar day is not covered unless the decision is overturned or the NOMNC is withdrawn.

If a member appeals the end-of-stay decision through a Medicare-contracted Quality Improvement Organization (QIO), the Home Care Agency is responsible for sending the medical records to the QIO by the time indicated on the request for records. QIO is open seven (7) days a week to take appeal information.

Appeals Process

Refer to the applicable Dispute Resolution chapters for **Commercial/CHP plans**, **Medicaid plans**, and **Medicare plans**.