

Home Health Care Utilization Management Program Prior Approval for EmblemHealth Health Insurance Plan of Greater New York (HIP) Members

Provider Orientation



Agenda

- **Prior Approval Program Overview**
- **Prior Approval Requirements**
- **Denial and Appeals Process**
- **Prior Approval Submission Methods**
- **eviCore Provider Resources**
- **Q & A Session**

eviCore healthcare Prior Approval for HIP Members - Overview

eviCore healthcare manages all Inpatient Post-Acute Care (PAC), Home Health Care (HHC) and Durable Medical Equipment Prior Approvals for EmblemHealth Members enrolled in the Health Insurance Plan of Greater New York (HIP) which includes:

- Medicare Essential Network
- VIP Prime Network
- Select Care Network
- Prime Network
- Enhanced Care Prime Network

Exceptions: Members managed by Montefiore, Healthcare Partners and St. Barnabas

Providers should verify member eligibility and benefits on the secured provider log in section at:

<https://www.emblemhealth.com/Providers>

All HIP members discharging from the hospital or post-Acute care facility with Home Health Care services will be managed by eviCore's Transitional Care Program for 90 days post discharge.

eviCore healthcare Home Health Care Program Overview

eviCore healthcare began accepting Prior Approval requests for HHC 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)

- HHC agencies are responsible to submit the initial prior approval requests for HHC services for members discharging from the hospital or for members with a new community referral from a physician or treating practitioner.
- The initial HHC request for patients discharging from a PAC facility (Skilled Nursing, Inpatient Rehab and Long Term Acute Care Facilities) may be submitted by either the admitting HHC Agency or discharging PAC facility.
- HHC agencies should submit all concurrent review requests to eviCore.

Home Health Care Prior Approval Overview

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

Prior Approval	Skilled Nursing, PT	Home Health Aide	Social Worker, OT, ST
Initial	Up to 3 visits in 14 calendar days	Up to 40 hours in 14 calendar days	TBD based on medical necessity
Concurrent (# of visits approved based on medical necessity)	14 calendar days	Up to 40 hours in 14 calendar days	14 calendar days

➤ **Prior Approval Expiration**

- The initial Prior Approval expires 7 days from the date of issue
- If the patient is not discharged within this time frame, a new Prior Approval is required

➤ **Once Determination is Complete:**

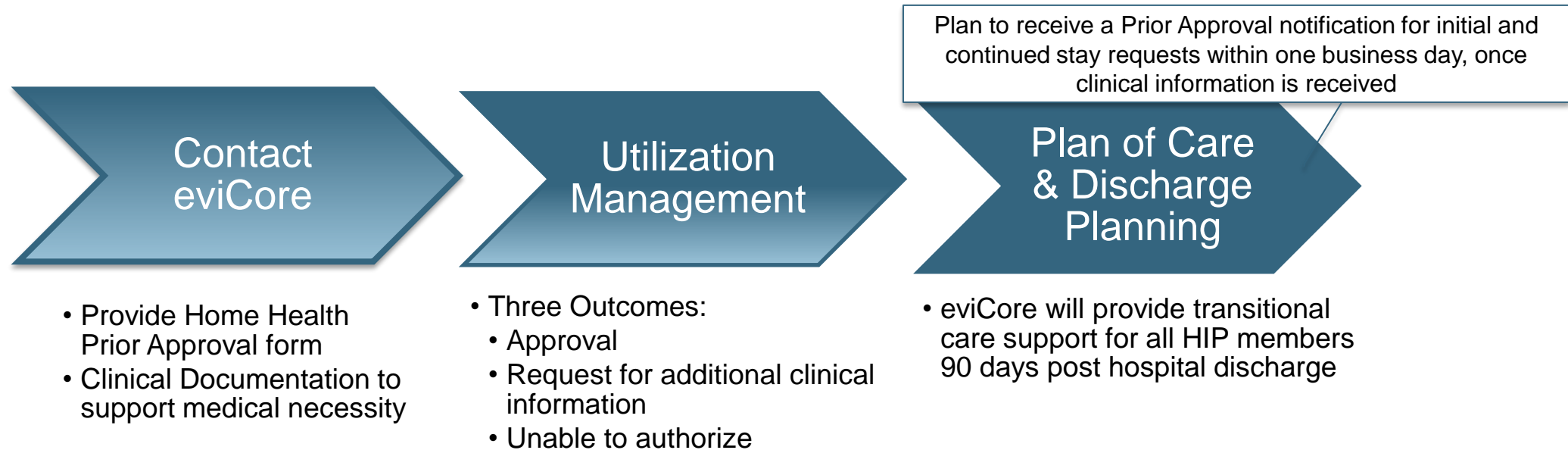
- A verbal and written notification will be provided to the requesting provider
- Servicing providers may obtain information on authorizations that have been approved by calling eviCore at: 877-773-6964

➤ **Home Health Care Prior Approval Criteria includes, but not limited to:**

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

Home Health Initial Requests Overview

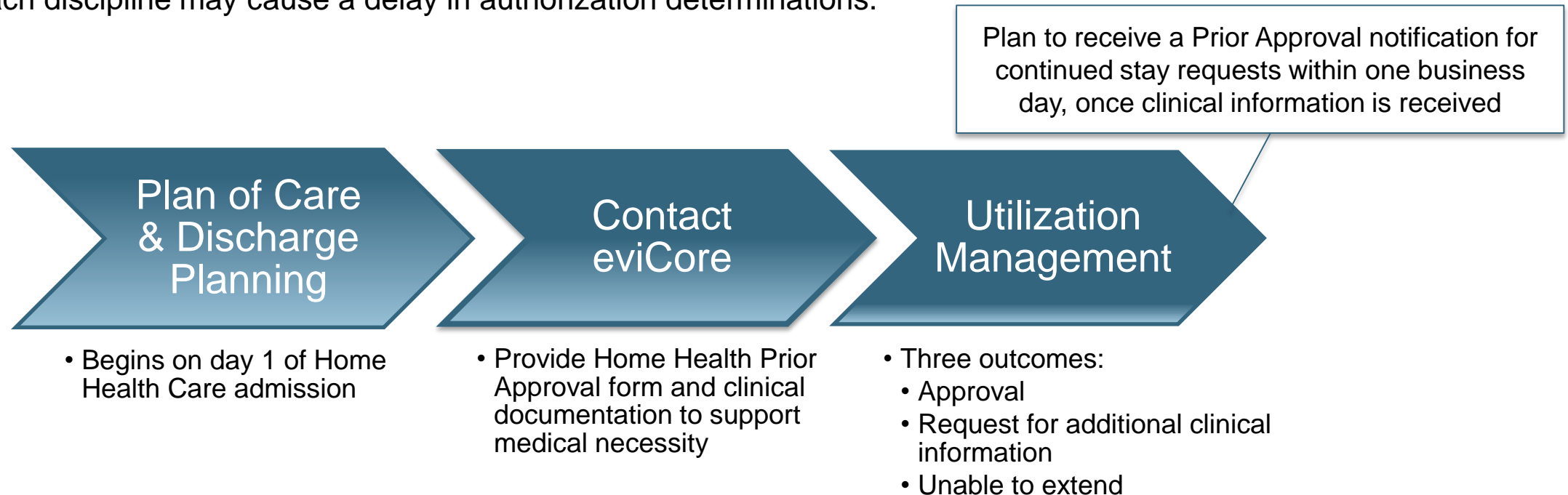
- The HHC agency is responsible to submit initial prior approval requests for Home Health Care services for patients discharging from the hospital or for members with a new community referral.
- The initial HHC request for patients discharging from a PAC facility may be submitted by either the admitting HHC Agency or discharging PAC facility.
- Please clearly state on the Prior approval form if the patient is being admitted from a Hospital, PAC facility or from a community referral to ensure members are transitioned to the Transitional Care Program, when applicable.



Important: Please ensure we receive an Ordering Physician for all initial requests with phone/fax numbers for notification purposes. eviCore recommends that ALL home health disciplines be requested at the same time. Individual requests for each discipline may cause a delay in authorization determinations.

Date extension (Home Health Concurrent review) Requests Process Overview

- The Home Health Agency is responsible to submit date extension (concurrent review) requests
- eviCore requests that the date extension review request is submitted 72 hours prior to last covered day to facilitate a timely “extension of prior approval” determination
- eviCore recommends that ALL home health disciplines be requested at the same time. Individual requests for each discipline may cause a delay in authorization determinations.



Important: HHC agencies should submit clinical for date extension (HHA concurrent review) prior approval requests 72 hours prior to the last covered day to allow time for Notice of Medicare Non-Coverage (NOMNC) to be issued. eviCore will issue the NOMNC form to the provider. The provider is responsible to issue the NOMNC to the member, have it signed and returned to eviCore

eviCore healthcare
Home Health Care Prior Approval
Required Information



Required Information for Home Health Requests

Prior Approval Details

- 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
- Medication 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)

Once the patient is discharged from the HHC agency, the PCP will be notified by eviCore. Patients utilizing HHC services following a hospitalization will be managed by eviCore's Transitional Care Program for 90 days post hospital discharge.

eviCore Home Health Care Prior Approval Form



EmblemHealth®

eviCore healthcare Home Health Care Denial and Appeals Process



Unable to Provide Prior Approval of HHC Service Request

Denial • Appeals Process

Initial Prior Approval requests that do not meet Medical Necessity on Initial Nurse review will be sent to 2nd level physician for review and determination. If potential adverse determination is made by the physician, outreach is made to the requesting provider and a Peer to Peer (P2P) Review may be requested

Date extensions requests that do not meet Medical Necessity on concurrent nurse review will be sent to 2nd level physician for review and determination if the provider or attending HHC Physician are in disagreement with the decision to end skilled care. If a potential adverse determination is made by the physician, outreach is made to the HHC provider and a P2P review may be requested

<p>Home Health Care (Initial request)</p>	<ul style="list-style-type: none"> • 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.
<p>Home Health Care (Date extensions)</p>	<ul style="list-style-type: none"> • The Notice of Medicare Non-Coverage (NOMNC) will be issued no later than 2 calendar days prior to the discontinuation of coverage or the second to last day of service, 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.
<p>Member Appeals Process (Initial and Date extensions)</p>	<ul style="list-style-type: none"> • Members requesting to appeal a denial for initial HHC services should follow the instructions provided on the denial letter. • Medicaid and Commercial Members requesting to appeal the decision to end skilled care by the HHC agency should submit appeal requests to eviCore via phone at 800-835-7064 (Monday through Friday 8-6 EST) or fax to 866-699-8128. • Medicare Members requesting to appeal the decision to end skilled care by an HHC agency should follow the QIO process as outlined on the NOMNC. Providers should follow the process in the Dispute Resolution for Medicare chapter of the EmblemHealth Provider Manual.

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Prior Approval Submission
Methods for Home Health Care



Prior Approval Requests for Home Health Care Hours of Operation

eviCore offers two methods to request Prior Approvals:



Authorization
Call Center



What we need

1. **Fax:** Clinical documentation can be faxed to:
855-488-6275 Please send information for one patient per fax.
2. **Telephone:** Clinical information can be called to eviCore healthcare at
866-417-2345 option 3 for HIP, option 5, then option 1 for HHC.

Hours of Operation that eviCore staff is available:

Monday through Friday, 8 am to 6 pm EST

Saturday: 9am – 5pm EST

Sundays and Holidays: 9am – 2pm EST

24 HOUR on-call coverage for urgent needs

eviCore healthcare Provider Resources

Provider resources and contact information



Provider
Resources



Provider Services
Department:

For provider program related questions or concerns,
please email: clientservices@evicore.com

To reach a customer service representative, please call
our authorization center: **866-417-2345 option 3 for HIP,
option 5, option 1 for HHC**

For more information regarding the eviCore PAC program
and reference documents, please visit our
implementation site:

<https://www.evicore.com/healthplan/emblem>

eviCore healthcare Home Health Care Provider resources Implementation Site



Provider
Resources



Provider Services
Department:

Provider resources available on our implementation site:
<https://www.evicore.com/healthplan/emblem>

- Webinar training schedules with details on how to register
- Prior Approval Forms
- Quick reference guide (QRG)
- Frequently asked questions (FAQ) document
- Training documents and program presentations
- Recorded demo of the orientation training sessions

Thank You

