

# Home Health Services for Children With Medical Complexity

Children With Medical Complexity Steering Committee

Lenaye Lawyer, M.D.

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Delivering the Next  
**Generation**  
of Health Care

# Home Health Services

- Skilled nursing.
- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Home health aide.
- Private-duty nursing.



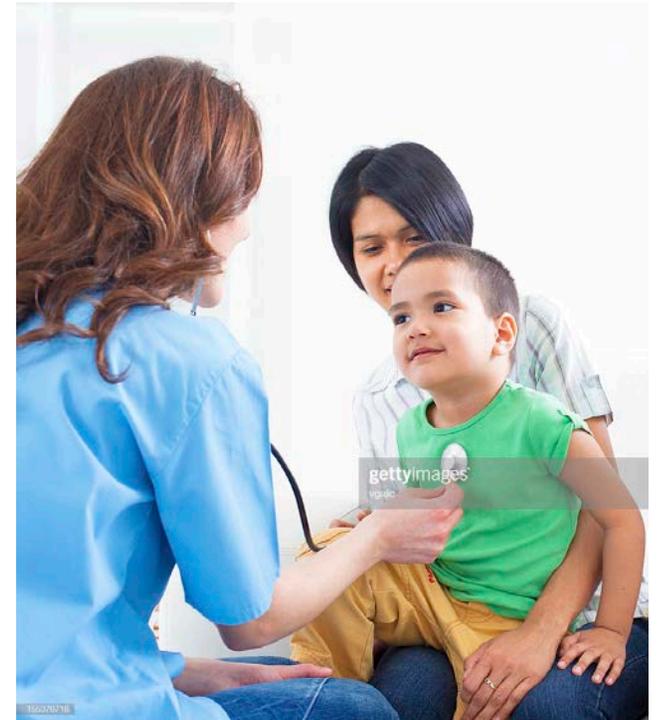
# Home Health Services Must Be Medically Necessary

Medical necessity is defined as the essential need for health care or services that — when delivered by or through authorized and qualified providers — will:

- Directly relate to the prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability (the physical or mental functional deficits that characterize the member's condition), and be provided to the member only.
- Be appropriate and effective to the comprehensive profile (e.g., needs, aptitudes, abilities, and environment) of the member and the member's family.
- Be primarily directed to the diagnosed medical condition or the effects of the condition of the member, in all settings for normal activities of daily living (ADLs), but will not be solely for the convenience of the member, the member's family, or the member's provider.
- Be timely, consider the nature and current state of the member's diagnosed condition and its effects, and be expected to achieve the intended outcomes in a reasonable time.
- Be the least costly and most appropriate available health service alternative that represents an effective and appropriate use of funds.
- Be the most appropriate care or service that can be safely and effectively provided to the member, and will not duplicate other services provided to the member.
- Be sufficient in amount, scope, and duration to reasonably achieve its purpose.
- Be recognized as either the treatment of choice (i.e., prevailing community or statewide standard) or common medical practice by the provider's peer group, or the functional equivalent of other care and services commonly provided.
- Be rendered in response to a life-threatening condition or pain, or to treat an injury, illness, or other diagnosed condition, or to treat the effects of a diagnosed condition that has resulted in or could result in a physical or mental limitation, including loss of physical or mental functionality or a developmental delay.
- Provide the opportunity for members enrolled in DSHP-Plus LTSS to access the benefits of community living, achieve person-centered goals, and live and work in the setting of their choice.

# Home Health Services Must Be Medically Necessary (continued)

- Medically necessary services allow that the member might attain or retain independence; self-care; dignity; self-determination; personal safety; and integration into all natural family, community, and facility environments and activities.
- In accordance with 42 CFR 438.210, the contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a medically necessary service solely because of member's diagnosis, type of illness, or condition.
- The contractor shall determine medical necessity case by case and in accordance with this section of the contract.



# Home Health Services: Skilled Nursing, Aide, or Therapy

- Prior authorization is needed for the services.
- The services must be medically necessary.
- The need for the services must be clearly documented in the member's medical record.
- Criteria used include InterQual home care criteria (for skilled nursing, home health aide, and therapies) and other standardized tools such as the MNA<sup>SM</sup>, FNA<sup>SM</sup> and SNA<sup>SM</sup>.
- When applying the criteria, the plan staff also considers the individual member factors and characteristics of the local health delivery system, including the member's age, comorbid conditions, complications, progress of treatment, psychosocial situation, and home environment.
- Any request that does not meet medical necessity criteria is referred to a Medical Director.

# Home Health Services: Private-Duty Nursing

A letter of medical necessity from the provider is submitted with the prior authorization request to include:

- Diagnosis.
- What is being requested and specific care needs, such as functional status, needs for activities of daily living, respiratory status, and nutritional status.
- Plan of care.
- Goals of the treatment plan.
- Duration of the requested services.



# Home Health Services: Peer-to-Peer Review

- If medical necessity is not met with the documentation provided and an adverse benefit determination is made by a Medical Director, the provider may discuss the determination with a Medical Director.
- Providers must call within two business days of notification of the determination or within two business days of the member's discharge from an inpatient facility.



# Home Health Services: Determinations

- The plan will notify the member of its determination as expeditiously as the member's health condition requires, or no later than 10 calendar days after the request is received.
- The time frame may be extended up to 14 additional calendar days if both of the following occur:
  - The provider or the member requests an extension.
  - The plan justifies the need for additional information and the extension is in the member's best interest.



# Home Health Services: Adverse Benefit Determination

- If a member does not agree with the determination, they may file an appeal.
- The member may ask an authorized representative (a family member, friend, or health care provider) to file the appeal for them.
  - Standard appeal — The member requests an appeal within 10 days of the decision and the plan must render a decision within 30 calendar days after receiving the appeal.
  - Expedited appeal — If the standard resolution time frame could jeopardize the member's life; health; or ability to attain, maintain, or regain function, the member or authorized representative may request an expedited appeal.
- The member or authorized representative may seek a Fair Hearing after the appeals process has been exhausted. The Fair Hearing must be requested within 90 days of the appeal decision letter.

# Home Health Services: Adverse Benefit Determination

A member may continue to receive services while waiting for the appeal or the Fair Hearing decision if **all** of the following apply:

- The appeal is filed within 10 calendar days of the date on the decision, or before the intended effective date of the proposed action, whichever is later.
- The appeal is related to reduction, suspension, or termination of previously authorized services.
- The services were ordered by an authorized provider.
- The authorization period has not ended.
- The member requested that the services continue.

The member's services continue to be covered until one of the following occurs:

- The member decides not to continue the appeal or request for a state Fair Hearing.
- Ten calendar days have passed from the date of the notice of resolution of the appeal, unless the member has requested a Fair Hearing within that time frame.
- The time covered by the authorization has ended or the limitations on the services are met.
- The Fair Hearing office issues a hearing decision adverse to the member.

# Home Health Services

Questions?



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