



<b>Binder:</b>	<u>OSF HealthPlans HCM Department</u>	
<b>Policy</b>		
<b>No./Title:</b>	<u>HCM.CMG.106 Home Health Care Case Management</u>	
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<b>Revision/Review</b>		
<b>ate(s)</b>	<u>9/00; 10/01; 5/02; 10/02; 10/03; 10/04; 10/05; 10/06; 10/07</u>	
<b>Approval:</b>		<b>Title:</b> Vice President and Chief Medical Officer

**POLICY:** It is the policy of OSF HealthPlans to require preauthorization and concurrent review of home health care.

**PURPOSE:** To promote consistency in coverage of patients requiring home health care.

**PROCEDURE:**

- The ordering physician, discharge planner, or home health care provider (with a physician's order) may call to begin preauthorization of home health care. The following demographic information is needed:
  - Home Health Care agency
  - Ordering physician
  - Diagnosis and pertinent medical history
  - Dates of service
  - Requested services
  - Plan of treatment
  - Copy of Oasis form for Care Advantage members and complex cases following initial assessment visit (not applicable for pediatric patients)
- OSF HealthPlans HealthCare Management Department will review to see if the provider is participating or if there is a provider in the area that is participating.
- The case will be reviewed to see that InterQual Guidelines and/or Millman and Robertson Guidelines and/or Medicare regulations as applicable are met. The preauthorization will be entered into the Facets System.
- If additional visits are required, the home health care agency must contact OSF HealthPlans to obtain preauthorization for additional visits. Information regarding the member's current condition and treatment can be submitted by phone or fax. If the submitted information is insufficient to authorize additional visits, any records related to the home health care episode will be requested for review to include but not limited to:

- Initial assessment and plan of treatment
- Short and long term goals
- Nursing notes
- PT progress notes

5. Goals will be entered into the Facets System. When the goals are achieved, the case will be closed.
6. If the home health agency nurse requests visits that do not meet InterQual Guidelines and/or Millman and Robertson and/or Medicare regulations, records will be reviewed by the Associate Medical Director. (See PRO-8).
7. All services subject to member specific plan benefit limitations.
8. The home health care agency will be notified verbally over the telephone of all approved and denied services, followed by written notification. Provider will be notified of the number of visits and date of next review. Most cases reviewed on a weekly basis. Exceptions made on a case by case basis.
9. After normal business hours or weekend, a request via voice mail is available at the toll free number. All calls will be returned on the next business day.