Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines:

Acute Hospital-Level Care at Home

Effective: January 1, 2025

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request to the FAX numbers below.	Yes ☐ No ☒
Notification Required IF REQUIRED, concurrent review may apply	Yes ☒ No ☐

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; 800-232-0816

☒ Tufts Health Plan Commercial products; 617-972-9409

CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); 888-415-9055

☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; 888-415-9055

☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; 857-304-6404

☒ Tufts Health One Care – A dual-eligible product; 857-304-6304

Senior Products

☒ Harvard Pilgrim Health Care Stride Medicare Advantage; 888-609-0692

☒ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-673-0965

☒ Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-673-0965

☒ Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-673-0965

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

For Harvard Pilgrim Health Care Members:

This policy utilizes InterQual® criteria and/or tools, which Harvard Pilgrim may have customized. You may submit notification and complete the automated authorization questionnaire via HPHConnect at www.harvardpilgrim.org/providerportal. In some cases, clinical documentation may be required to complete a medical necessity review. Please submit required documentation as follows:

- Clinical notes/written documentation – via HPHConnect Clinical Upload or secure fax (800-232-0816)

Providers may view and print the medical necessity criteria and questionnaire via HPHConnect for providers (Select Researched and the InterQual® link) or contact the commercial Provider Service Center at 800-708-4414. (To register for HPHConnect, follow the instructions here). Members may access materials by logging into their online account (visit www.harvardpilgrim.org, click on Member Login, then Plan Details, Prior Authorization for Care, and the link to clinical criteria) or by calling Member Services at 888-333-4742.

For Tufts Health Plan Members:

To obtain InterQual® criteria

- **Tufts Health Plan Commercial Plan products:** If you are a registered Tufts Health Plan provider click here to access the Provider Website. If you are not a Tufts Health Plan provider, please click on the Provider Log-in and follow instructions to register on the Provider website or call Provider Services at 888-884-2404.
- **Tufts Health Public Plans products:** InterQual® criteria are available as part of the prior authorization or notification process.

Overview

The Centers for Medicare and Medicaid (CMS) have designated provider waivers for certain hospital providers to participate in the Acute Hospital at Home program. This program is an alternative delivery model administered by the hospital for care of acutely ill members who are stable enough to have hospital level of care safely provided at home. The home setting must be conducive to hospital level of care at home by providing a safe environment, accessibility to care, adequate cooling/heating, internet access, and social/caregiver support. In order to qualify for acute hospital at home, a Member must have an in-person physician evaluation prior to starting services at home. A Member may be referred to the program from the emergency department or inpatient unit of the credentialed acute hospital following an in-person visit by either a medical doctor or an advanced practice provider.

There are several requirements that CMS requires in order for a hospital to participate in the Acute Hospital at Home program. These include:

- Appropriate screening protocols in place before care at home begins to assess both medical and non-medical factors
- An accepted patient leveling process must be used to ensure that only patients requiring an acute level of care are treated
- All patients must be admitted from an emergency department or inpatient hospital bed. A patient cannot be sent to Hospital at Home with a status of observation.
- A physician or advanced practice provider evaluates each patient daily either in-person or remotely
- A Registered nurse evaluates each patient once daily either in-person or remotely
- Two in-person visits daily by either registered nurses or mobile integrated health paramedics based on the patient's nursing plan and hospital policies
- Capability of immediate, on-demand remote audio connection with an Acute Hospital Care at Home team member who can immediately connect either an RN or MD to the patient
- Ability to respond to a decompensating patient within 30 minutes
- Several patient safety metrics will be tracked with weekly or monthly reporting, depending on the hospital's prior experience level
- Establishment of a local safety committee to review patient safety data
- Using an accepted patient leveling process to ensure that only patients requiring an acute level of care are treated
- Providing or contracting for other services required during an inpatient hospitalization

Clinical Guideline Coverage Criteria

The Plan considers acute hospital care at home as reasonable and medically necessary when the Member is being admitted from the emergency department (ED) or inpatient level of care (and in the case of Medicare, the treating physician or an advanced practice provider (APP) at the hospital attests that the patient is going to need to stay at Inpatient level of care for at least 2 midnights), **AND** the member meets criteria for **InterQual® Hospital At Home criteria subset**.

The **InterQual® Inpatient Level of Care Subsets** may also be used to determine reasonable and medically necessary care for a Member with a diagnoses or condition that is not identified in the **InterQual® Hospital At Home criteria subset.** See payment policy for additional information**:** Payment Policy Inpatient Hospital Admissions.

Additional Clinical Coverage Criteria

The plan may cover acute hospital-level care at home, when **All** of the following criteria are met:

1. The Member is admitted from an emergency department or inpatient hospital bed
2. The care will be provided by a provider that has an Acute Hospital Care At Home Waiver from CMS; **and**
3. The Member is willing and agrees to participate in the program; **and**
4. The Member will have an in-person physician or an advanced practice provider (APP) evaluation required prior to starting services at home; **and**
5. The Member's medical condition and/or history does not demonstrate instances of rapid decompensation requiring immediate care; **and**
6. Member is hemodynamically stable as evidenced by systolic blood pressure (SBP) ≥ 90 mmHg and oxygen saturation level (O_2) ≥ 90%; **and**
7. The home environment has been assessed and determined to be safe based on characteristics such as climate control, running water, and social support.

Note: The plan may perform a medical necessity review to ensure the Member is receiving the right level of care at the right time. This may include when the member is going from the ED or inpatient hospital to Inpatient Hospital at home program or when the Member is going from the hospital at home episode to inpatient hospital care.

Limitations

The Plan considers Acute Hospital-Level Care at Home is not medically necessary for **Any** of the following:

1. Active or uncontrolled alcohol use disorder or substance use disorder
2. Any unresolved psychosocial concerns or history of noncompliance with medical management
3. Member's condition requires multiple or routine administrations of narcotics for pain control
4. Member's treatment plan does not require frequent testing and/or procedures that may be needed to treat the Member's condition, (e.g., magnetic resonance imaging, computed tomography, surgery, diagnostic endoscopic procedure, blood transfusion, cardiac stress test, etc.)
5. Member has a diagnosis and/or concomitant condition(s) that may likely contribute to high-risk for decompensation and/or readmission, including acute myocardial infarction, uncontrolled arrhythmia, acute cerebral vascular accident, uncontrolled seizure, acute hemorrhage, sepsis, diabetic ketoacidosis, and end-stage organ disease
6. Members in hospice care are not eligible to enroll or receive care in the Acute Hospital-Level Care at Home program
7. The Plan will not cover Acute Hospital-Level Care at Home when InterQual® Hospital At Home criteria or Inpatient Level of Care criteria is not met.

References:

1. Arsenault-Lapierre G, Henein M, Gaid D, Le Berre M, Gore G, Vedel I. Hospital-at-Home Interventions vs In-Hospital Stay for Patients With Chronic Disease Who Present to the Emergency Department: A Systematic Review and Meta-analysis. JAMA Netw Open. 2021;4(6):e2111568. Published 2021 Jun 1. doi:10.1001/jamanetworkopen.2021.11568.
2. Caplan GA, Sulaiman NS, Mangin DA, Aimonino Ricauda N, Wilson AD, Barclay L. A meta-analysis of "hospital in the home". Med J Aust. 2012;197(9):512-519. doi:10.5694/mja12.10480Centers for Medicare & Medicaid Services. (2022). Approved facilities/systems for acute hospital care at home. https://qualitynet.cms.gov/acute-hospital-care-at-home/resources.
3. Centers for Medicare & Medicaid Services . (2020) CMS Announces Comprehensive Strategy to Enhance Hospital Capacity Amid COVID-19 Surge | CMS.
4. Centers for Medicare & Medicaid Services. (n.d.-b). Acute hospital care at home individual waiver only (not a blanket waiver). QualityNet. https://qualitynet.cms.gov/acute-hospital-care-at-home.
5. Conley J, O'Brien CW, Leff BA, Bolen S, Zulman D. Alternative Strategies to Inpatient Hospitalization for Acute Medical Conditions: A Systematic Review. JAMA Intern Med. 2016;176(11):1693-1702. doi:10.1001/jamainternmed.2016.5974.
6. Desai MP, Ross JB, Blitzer S, et al. Hospital-Level Care at Home for Acutely Ill Adults in Rural Settings: Proof of Concept. Home Healthc Now. 2024;42(1):21-30. doi:10.1097/NHH.0000000000001227
7. Levine D.M., Ouchi K., Blanchfield B., et al. HospitalLevel Care at Home for Acutely Ill Adults: A Randomized Controlled Trial. Ann Intern Med. 2020 Jan 21;172(2):77- 85. doi: 10.7326/M19-0600. Epub 2019 Dec 17. PMID: 31842232. Accessed at https://www.acpjournals.org/ doi/10.7326/ M19-0600.
8. Shepperd S., Iliffe S., Doll H.A., et al. Admission avoidance hospital at home. Cochrane Database of Systematic Reviews 2016, Issue 9. Art. No.: CD007491. DOI: 10.1002/14651858. CD007491.pub2. Accessed at https://www.cochrane. org/CD007491/EPOC_hospitalhome-services-avoid-admission-hospital.

Approval And Revision History

December 18, 2024: Reviewed by the Medical Policy Approval Committee (MPAC); New Medical Necessity Guideline (MNG) to address Hospital-Level Care at Home program criteria with notification required, effective January 1, 2025

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.