



Acute Hospital Care at Home OH MCD AD-1213	<b>Date Effective</b> 09/01/2022-01/31/2024
<b>Policy Type</b> ADMINISTRATIVE	

Administrative Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

## Table of Contents

A. Subject.....	2
B. Background.....	2
C. Definitions .....	3
D. Policy .....	3
E. Conditions of Coverage.....	5
F. Related Policies/Rules .....	5
G. Review/Revision History.....	6
H. References.....	6



Archived

The ADMINISTRATIVE Policy Statement detailed above has received due consideration as defined in the ADMINISTRATIVE Policy Statement Policy and is approved.



submit appropriate screening protocols for medical necessity review before care at home begins.

### C. Definitions

- **Health Care Facilities Code (HCFC)** - A set of requirements intended to provide minimum requirements for the installation, inspection, testing, maintenance, performance and safe practices for facilities, material, equipment, and appliances.
- **Life Safety Code (LSC)** - A set of fire protection requirements designed to provide a reasonable degree of safety from fire.
- **Remote Monitoring** - Monitoring of physiologic parameters, including weight, blood pressure, heart monitoring, pulse oximetry and respiratory flow rate.

### D. Policy

- I. CareSource considers acute hospital care at home medically necessary when **ALL** of the criteria in this policy are met. A prior authorization will be required for the approval of acute hospital care at home services. Appropriate and complete documentation to support medical necessity must be presented at the time of the review. Participating hospitals should submit appropriate screening protocols for medical necessity review before care at home begins. Acute hospital care at home services are subject to subsequent reviews following initial approval. Reviews will be based on clinical status of the member, and additional documentation may be requested.
  - A. CMS-Approved Requirements for Participating Hospitals
    1. The hospital must be CMS-certified.
    2. Participating hospitals are required to have appropriate screening protocols in place before care at home begins, including:
      - a. Verification that the member's home meets their needs for safety, shelter and basic working utilities, including completion of a HCFC and LSC form;
      - b. Assessment of physical barriers; and
      - c. Screenings for domestic violence concerns and completion of form.
    3. The member's broadband service must meet 4G/5G requirements.
    4. The member needs inpatient-level of hospital care.
    5. The member must be identified and assessed by hospital staff as meeting the qualifying criteria for home admission and treatment.
    6. The member must sign a consent agreeing to receive care at home under the program.
    7. The member must meet one of the following acute conditions including, but not limited to:
      - a. Exacerbations of Congestive Heart Failure;
      - b. Community-Acquired Pneumonia;
      - c. Exacerbations of Chronic Obstructive Pulmonary Disease (COPD);
      - d. Exacerbations of Asthma;
      - e. Cellulitis;
      - f. Urinary Tract Infection (UTI) or
      - g. Volume depletions / dehydration.



ARC

The ADMINISTRATIVE Policy Statement detailed above has received due consideration as defined in the ADMINISTRATIVE Policy Statement Policy and is approved.



Archived

