BCBSRI Medicare Advantage Non-Skilled Home Health Care Benefit – FAQ

Overview

The Non-Skilled Home Health Care is a benefit for 2021 and can be used by members who are enrolled in Blue Cross & Blue Shield's Medicare Advantage/- BlueCHiP for Medicare products.

The benefit is accessed to provide short-term light-duty in-home services to the qualifying member, by a Certified Nursing Assistant (CNA) or Home Health Aide (HHA), and includes such services as bathing, grooming, dressing, eating, toileting, light housekeeping, errands, and some cooking within their home.

These services are also known as Activities of Daily Living (ADLs) which may also include toileting (being able to get on and off the toilet and perform personal hygiene functions), transferring (being able to get in and out of bed or a chair without assistance), and maintaining continence (being able to control bladder and bowel functions).

Frequently Asked Questions (FAQs)

Q. What products is this benefit eligible for?

This benefit is only available to Medicare Advantage /BlueCHiP for Medicare products.

Q: What is the purpose of this benefit?

This benefit aims to reduce stress and reduce risk of adverse outcomes, such as providing support to caregivers and enhance home support to decrease/prevent member emergency room, hospital or nursing home stays and admissions or re-admissions and / or reduction in fall risk as well as improvement of the overall wellbeing of members.

Q. When did this benefit take effect?

This benefit became available to BlueCHiP Medicare Advantage members as of January 1, 2020; however, the initial benefit was through BCBSRI's Care Management Program.

On January 1, 2021 the benefit became a limited benefit outside of BCBSRI's Care Management Department and their management and no longer requires an authorization or intervention by BCBSRI.

Q. What is the limitation on this benefit?

Members have a maximum of 10 non-skilled home health agency visits per benefit year. One visit equals up to two (2) hours of Non-Skilled services. If the member is to receive over the 10 allowed units/visits, any subsequent claims will deny as a benefit maximum denial, and the member shall be responsible for the payment of any additional services provided.

BCBSRI participating providers should inform members prior to initiating services of their benefit limit and when their benefit limit is upcoming/exhausted, so they can arrange for continued services and/or plan for services ending.

The member and the home health agency should solely determine and agree the when the 10 visits will be used and the frequency prior to bringing the patient on service. An agency may provide multiple visits on the same day e.g. 2 visits a day or 4 hours a day and/or multiple days per week if that's what is decided between the agency and the member.

Q: How many hours is one unit?

One (1) unit = up to two (2) hours

Q: What if we only assisted the member for 30 minutes? How would we bill for that?

Even if you see the member for only 30 minutes, you will still file your claim with the one (1) unit which will draw 1 visit from the member benefit. The agency should inform the member if they are going to provide services for less than to two (2) hours so that member is aware that will not be maximizing their benefit. You cannot split the visit/units, unless the services are performed on the same day. In that case a provider would bill for 1 unit on a single date of service for both services performed on the same day.

Q. What does short-term mean?

Short-term means, services are typically, may be from 30-45 days, however a member's benefit can be extended beyond that timeframe depending on need and agreement with the member.

Q. Is there a written policy on this service/benefit?

No. As this benefit isn't a managed by BCBSRI and is available to our members like other covered health services e.g. an office visit, BCBSRI does not maintain a policy.

Q. What is the process for obtaining this benefit?

To obtain the Non-Skilled Home Health Services benefit, the following steps are taken:

1. A member can contact BCBSRI contracted non-skilled home health care providers directly e.g. self-refer.
    a. All BCBSRI non-skilled home health providers/agencies shall establish an intake process that meets the needs of the provider/agency. BCBSRI does NOT need to be notified of members accessing this benefit.
    b. BCBSRI Suggests, like with all care, if a member self-refers for services the agency coordinates care and communicates the results of the assessment of the member as well as a brief treatment plan to the members PCP.
2. Member may request services be initiated by contacting their PCP or another provider they are working with, so they can arrange for a referral/order for non-skilled in-home services.
    a. In that case the member will be referred to a BCBSRI participating home health care agency that offers non-skilled services by the referring/ordering provider and that provider will send a fax or otherwise contact the non-

skilled provider to establish services. BCBSRI has not established a process for such referrals and allows for BCBSRI providers to establish whatever process is acceptable between the provider and the agency they are referring to.

Q. Which providers in BCBSRI's network provide Non-Skilled Home Health Care services?
Currently, there are currently six (6) contracted providers which can provide this service.

Note: Non-Skilled home health agency services provided by a non-network provider are not covered.
Agencies that are in network with BCBSRI for non-skilled services are:

1. Nursing Placement
2. Bayada
3. Cathleen Naughton
4. Elmwood Home Care
5. Home Care Advantage
6. Visiting Angels

Q. Does this service require Prior Authorization or referral?
No. BCBSRI encourages coordination of care for all services with a member's primary care physician ("PCP"). As a result, non-skilled agencies may receive referrals from a member's PCP or other healthcare provider. BCBSRI asks that participating non-skilled agencies work with PCP's or other healthcare provider related to these referrals and subsequent communication to the referring provider related to the delivery of such services and encourages but does not require PCP involvement.

Q. What kind of documentation is necessary?
Please ensure the services provided to all members meet the following requirements for benefit coverage;

"*Services provided are intended to diagnose, compensate for physical impairments, acts to ameliorate the functional/psychological impact of injuries or health conditions, or reduces avoidable emergency and healthcare utilization…and address improvement in activities of daily living…*"

BCBSRI understands that non-skilled agencies may have some rote language in their assessments and documentation of services related to meeting benefit coverage guidelines. However, BCBSRI expects documentation to include individualized language related the/assessments and any ongoing documentation while the member is receiving / on services with the agency.

Need more details?

If you have questions, please contact ProviderRelations@bcbsri.org