Medical Coverage Policy | Home Health Services: Non-Skilled

EFFECTIVE DATE: 01|01|2019
POLICY LAST UPDATED: 03|19|2020

OVERVIEW

Home health care covers a wide range of services. This policy addresses the non-skilled home health services that are covered for BlueCHiP for Medicare members that are engaged in a Care Management Program. This benefit is not applicable or appropriate when skilled services are in place.

This policy is not applicable to Commercial Products

MEDICAL CRITERIA

Non-skilled home health services are covered when **all** the following criteria are met:

1. The member is engaged in the Care Management Program
2. The nurse case manager has established a care plan with the member, contracted provider, and care givers that includes short term home health aide interventions and expectations.
3. The member has had/ will have a change in status (functional, emotional, or cognitive)
4. These services are intended to prevent, avoid and/or shorten an institutional stay
5. Support is needed to perform activities of daily living (ADLs) and/or household assistance such as light housekeeping or light meal preparation and/or to support care givers due to a change in status

Note: Decision regarding approval for services are made as part of a collaborative process with the Interdisciplinary Care Team.

Request for additional Home Health Services

The nurse case manager will contact the provider regarding the member's progress and to determine if continued services are needed using the medical criteria listed.

PRIOR AUTHORIZATION and NOTIFICATION

Prior Authorization is required for BlueChip for Medicare only.

POLICY STATEMENT

BlueCHiP for Medicare

Effective January 1, 2019, non-skilled home health care services are covered when the criteria is met for a limited time period. Services must be obtained from a Blue Cross and Blue Shield provider contracted for non-skilled home health services.

BACKGROUND

Effective January 1, 2019 Centers for Medicare and Medicaid Services (CMS) issued the following memo to Medicare Advantage plans

> *Beginning in CY 2019, CMS is expanding the definition of "primarily health related" to consider an item or service as primarily health related if it is used 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. A supplemental benefit is* ***not*** *primarily health related under the previous or new definition if it is an item or service that is solely or primarily used for cosmetic, comfort, general use, or social determinant purposes. In order for CMS to approve a supplemental benefit, the benefit must focus directly on an enrollee's health care needs and be recommended by a licensed medical professional as part of a care plan, if not directly provided by one. We expect organizations will establish reasonable safeguards to ensure enrollees are appropriately directed to care. CMS anticipates organizations*

will use this expanded definition to address health care needs and make adjustments to their annual supplemental benefit offerings based on the expected needs of their plan population. For example, organizations may decide to offer some items and services that may be appropriate for enrollees who have been diagnosed with needing assistance with Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL).

Care Management Program

The Care Management Program provides services to eligible members either directly or arranges for services to be provided by other collaborative partners or caregivers. Typical services may include but are not limited to functional capability assessment and monitoring. This is accomplished through BCBSRI's standardized assessments used when outreaching members. When assessing the member's setting, BCBSRI case managers work in conjunction with the members themselves as well as their providers, caregivers, and clinical or community-based services to determine appropriateness of their setting. Every effort is made to ensure the member is thriving in the most appropriate and least restrictive environment.

Following the initial assessment, the case manager develops an individualized care plan, consisting of goals and interventions and is driven by member preference. The care plan is comprehensive and includes varying types of prioritized goals such as clinical milestones, pain management, addressing care gaps, and self-care.

Once goals are identified, interventions are developed to support member self-management plans. These self-management plans may include both verbal and written instructions and educational materials, which are communicated at the onset and throughout management of the case.

Care Management Discharge criteria (one or more is met):

- Member no longer wishes to participate in case management
- Member achieves all goals
- Case Manager believes case management will no longer benefit the member
- Member enters hospice care
- Member demise occurs
- Member no longer has coverage by BCBSRI. If notified in this situation, the case manager works with the member and practitioners to identify community resources and transition the care plan.

Definitions

Case Plan goals are established with the following characteristics:

- Goals are prioritized.
- Goals have specific time frames for re-evaluation. When establishing a goal, the case manager sets a specific date for follow-up on progress toward that goal. Upon re-evaluation the goal may be on track, may require revision, or may no longer be appropriate due to changes in condition or circumstance. When a goal is retained as is or revised the case manager establishes a new follow-up date in CCMS.
- Goals have identified resources to be utilized, including the appropriate level of care when applicable.
- Goals include documentation of any collaborative approaches to be used, including family participation, to achieve the goal.
- Goals have an assessment of barriers. Barriers may be assessed at the individual goal level (such as limited transportation to physical therapist) or at the case level (such as member is in denial about prognosis).

Place of Residence

A patient's residence is wherever he or she makes his or her home. This may be their own dwelling, an apartment, a friend/relative's home, or an institution such as an assisted living facility or group home.

Interdisciplinary Team
The BCBSRI Interdisciplinary Team includes the care managers and BCBSRI Medical Director. The purpose of the Interdisciplinary Team is to foster frequent, structured, and documented communication. The team attempts to:

- Establish, prioritize and achieve treatment goals.
- Assess the patient's progress toward goals.
- Consider possible resolution to problems that could impede the Member's progress toward their goals.
- Reassess the validity of the goals previously established.
- Monitor and revise the care plan and interventions, as needed.

COVERAGE

Benefits may vary between groups and contracts. Please refer to the appropriate Evidence of Coverage for applicable Non-Skilled Home Health Care coverage.

CODING

BlueCHiP for Medicare
The following code is covered when the criteria is meet.
T1021 Home health aide or certified nurse assistant, per visit
Note: The code is applicable for services obtained from a Blue Cross and Blue Shield of Rhode Island provider contracted for non-skilled home health services.

RELATED POLICIES

Home Health Services – Skilled

PUBLISHED

Provider Update, May 2020
Provider Update, June 2019
Provider Update, February 2019