Clinical Medical Policy
Long Term Care – Home Health Aide (HHA) Hours

Benefit Coverage

Covered Benefit for lines of business including: RIte Care (MED), Substitute Care (SUB), Children with Special Health Care Needs (CSN), Rhody Health Partners (RHP), Medicare-Medicaid Plan (MMP) Integrity, Rhody Health Expansion (RHE)

Excluded from coverage: Extended Family Planning (EFP) Health Benefits Exchange (HBE)

Approval is based on review of the medical necessity documentation.

Description

Home Care Services include those services provided under a home care plan authorized by a physician including full-time, part-time, or intermittent care by a licensed nurse or home health aide (certified nursing assistant) for patient care. Long Term care is defined as Home Health Aide (HHA) or Certified Nurse Assistant (CNA) providing care in the home, per hour and is scheduled as "block hours" as opposed to intermittent "visits," and is utilized to deliver medically necessary care, which cannot be performed in a standard home care visit.

Long term care services also include homemaking services that are incidental to the client's health needs such as making the client's bed, cleaning the client's living area, such as bedroom and bathroom, and doing the client's laundry and shopping.

RIte Care, Rhody Health Expansion, Rhody Health Partners: Homemaking services are only covered for these lines of business when members also need personal care services. (per EOHHS contract)

Medicare-Medicaid Plan (MMP) INTEGRITY: Combined Personal Care/Homemaker Services: See "Authorization Requirements" on page 3 for more information.

Coverage Determination

Prior authorization and medical review is required.

(Exception: Medicare-Medicaid Plan (MMP) INTEGRITY Lines of Business; see page 3)

The criteria used to approve long term care is based on medical necessity, which allows for personal care services to be performed by a licensed HHA to assist the member and/or caregiver in obtaining a certain level of independence with their Activities of Daily Living (ADLs).

Upon receiving orders from a physician, the contracted Neighborhood Home Health Agency submits the *"Neighborhood Home Care Services Prior Authorization Request* form, indicating required services for the specific member.

The form allows member or caregiver's ability to perform activities of daily living to be classified as:

- Independent with care : able to do on their own with very minimal assistance
- Moderate dependence : needs some assistance with set-up/process and/or ambulating
- Dependent for care : cannot perform on their own without extensive assistance

Children under the age of 3 years will usually not qualify for HHA block hours as the expectation is the parent or caregiver will provide the activities of daily living. Short term HHA block hours may be considered for a transition period when there has been a recent hospitalization and/or potential for a readmission exists.

Medicare-Medicaid Plan (MMP) INTEGRITY, and members may qualify for home care services through a waiver program. Medical Management staff coordinate referrals and communicate as necessary with the waiver programs.

Criteria

Based on documentation received , from the home health agency, the following categories are evaluated for care required and time required to complete the care, with points being assigned based on amount of assistance required to complete the activity:

- Member's age, weight, and height
- Activities of Daily Living (bathing, grooming, dressing, eating)
- Hours primary caretaker available
- Hours a day member attends school
- Bowel/ Bladder – continence status
- Mobility

In addition, individual consideration is given to:

- Diagnosis and the impact on the primary caregiver's ability to care for the member.
- Recent admission and/or potential for readmission.
- Homemaking services may be considered for adult RIte Care members who are also approved for HHA services for personal care related to activities of daily living.

All points are summarized to determine number of hours the member is eligible to receive.
The *"**Neighborhood Home Health Aide Point System**"* is utilized to make this determination..

Authorization Requirements

- A physician's order, verbal or written, must be obtained prior to submitting the request for authorization and/or initiating services. (Exception: MMP lines of business; see page 3)
- If a verbal order is received, the date, the orders, and the name of the ordering provider must be documented in the member's record. The verbal order is effective on the first date the Home Health Agency renders service. The Home Health Agency must document that the written order was requested, along with any follow-up attempts to procure the signed written copy of the orders.
- The hard copy must be received by the Home Health Agency before the end date of the certification period and/or no later than 60 days from the first date of service
- An RN assessment is required before submitting the request for a HHA and/or combination services.
- All regulatory nursing assessments and re-assessments will be covered per JCAHO and Medicaid Fee For Service requirements, which allows for a reassessment every sixty (60) days.
- Re-assessments due to resumption of care will also be covered. (Example: recent hospitalization or acute change in level of care)

- If services need to be continued after the initial certification period, a new prior authorization request form needs to be submitted prior to the end of the certification period. Refer to the following link for information related to prior authorizations and retrospective authorizations: https://www.nhpri.org/Portals/0/Uploads/Documents/Provider-Manual-December2016.pdf

- If for any reason a Home Health Agency cannot fulfill their authorized hours as requested, it is the responsibility of the home health care provider to coordinate care with another Neighborhood contracted agency and notify Neighborhood immediately of the change.

Authorization Requirements Medicare-Medicaid Plan (MMP) INTEGRITY ONLY:

- For all non skilled services, (Homemaker, Certified Nursing Assistant/Home Health Aide, and combination services) physician orders are not required; however, prior authorization is required.
- Combination code is to be used when there is a need for the Certified Nurse Assistant (CNA) to provide both personal care and homemaker services.
- Enhanced Reimbursement- Home Health Agencies can receive a higher level of reimbursement for combination services, if the member is assessed to be at a high acuity level of care. The home Health agency RN must complete the *Minimum Data Set (MDS) for Homecare* form and submit to the Utilization Management department at fax number: 401-459-6023, for review.

For billing information, please review the following document: Home Health Care Services Payment Policy, which can be found at the following link:
https://www.nhpri.org/Providers/ResourcesFAQs.aspx

Exclusions

Neighborhood does not cover a HHA to perform skills that are outside their scope of practice nor does Neighborhood cover respite care, relief care or daycare for members, with the exception of MMP INTEGRITY members.

CMP Number: CMP-020
CMP Cross Reference:

References:

Functional Independent Measure (FIM) Scores – a nationally recognized rehabilitation tool based on a patient's ability to conduct basic ADLs

Contract Between State of Rhode Island and Providence Plantations Department of Human Services and Neighborhood Health Plan of Rhode Island For Medicaid Managed Care Services, September 1st, 2010, Attachement A.

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