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, RhodyHealth Expansion (RHE)
Excluded from Coverage:
Extended Family Planning (EFP)

Approval is based on review of the medical necessity documentation.

Description
Home Care Service are 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 homecare visit.

Definitions:
Personal Care Assistance Services–Direct support in the home or community in performing tasks that individuals are functionally unable to complete independently due to disability (e.g., Assistance with Activities of Daily Living, monitoring health care status, assistance with housekeeping activities and meals preparation, assistance with transferring and use of mobile devices, and in providing and arranging for transportation).

Homemaker–Services that consist of the performance of general household tasks (e.g., Meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for those activities are temporarily absent or unable to manage the home and care for him/herself or others in the home. Homemakers shall meet such standards of education and training established by the State for the provision of these activities.

Combination Care–Services that consist of a Certified Nurse Assistant (CNA) providing both personal care and homemaker services during the same shift.

Coverage Determination
Members may qualify for homecare services through a Home and Community Based waiver program. Home and Community Based Services (HCBS) are types of person-centered care delivered in the home and community. HCBS address the needs of people with functional limitations who need assistance with everyday activities and enable people to stay in their homes, rather than moving to a facility for care. Rhode Island Medicaid covers an array of Long-Term Services and Supports (LTSS) for adults eligible for HCBS. To be eligible for LTSS-HCBS, an individual must meet Medicaid LTSS eligibility requirements for specific programs and have at least a high level of care need for these services.

For Medicare-Medicaid Plan (MMP) INTEGRITY members, medical management staff coordinate referrals and communicate as necessary with the waiver programs. The medical necessity and quantity of home care hours for MMP members is determined by assessments done by NHP medical management staff. Members who do not yet need LTSS but are at risk for the nursing facility institutional level of care have access to LTSS preventive services through their managed care plan. Preventive services include up to six (6) hours of homemaker and/or personal care services per week for a single member or ten (10) hours per week for a household with two (2) or more members.

Neighborhood Health Plan of RI-910 Douglas Pike, Smithfield, RI 02917. www.nhpri.org. Authorization Line-401-459-6060. Authorization Fax- 401-459-6023

Successful completion and approval of a LTSS-HCBS waiver application is required in order for a member to receive more than Preventive services, as defined above, on a long-term basis.

Criteria
Prior authorization and medical review are required.
Based on documentation received from the member's physician, the home health agency, and/or any NHP Care Manager Assessments or NHP Service Calculator, the following categories are evaluated for care required and time required to complete the care:

- Member's age, weight, and height
- Level of assistance needed with Activities of Daily Living (e.g., Bathing, grooming, dressing, eating) Level of assistance needed with Instrumental Activities of Daily Living (e.g., Housekeeping, laundry) 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.

Authorization Requirements

- A signed NHP Home Care Services Form and all supporting documentation must be submitted.
- A physician's order is required for personal care and homemaking services for the Medicaid and Health Benefits Exchange lines of business.
- All regulatory nursing assessments and re-assessments will be covered per any CMS, EOHHS, and Medicaid Fee-for-Service requirements, which allows for a reassessment every sixty (60) days and with resumption of care. A nurse assessment is required before submitting an authorization request and before the end date of the certification period and/or no later than 60 days from the first date of service.
- Close collaboration between Home Health Agencies and NHP case management for MMP members is strongly encouraged to reduce delays in the authorization process.
- If services are required to continue beyond the time period authorized on the initial certification, anew request must be provided and authorized. Refer to the link below for information related to prior authorizations and retrospective authorizations: https://www.nhpri.org/wp-content/uploads/2023/01/PM-2023-Final_pub-1.6.23.pdf
- If for any reason a Home Health Agency cannot fulfill all the hours authorized per request, the agency must immediately notify Neighborhood (within one business day) and coordinate with another Neighborhood contracted agency to meet the member's needs.
- Combination care modifier is to be used when there is a need for the Certified Nurse Assistant (CNA) to provide both personal care and homemaker services during the same shift.
- Enhanced Reimbursement-Home Health Agencies can receive a higher level of reimbursement for combination services if the member is assessed to beat 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.

Limitations and Exclusions:

- Homemaking Services are not covered for Health Benefits Exchange (HBE) and are only covered for all Medicaid lines of business if the member also needs personal care services.
- Combination Services are not covered for HBE.
- Respite care or relief care is only covered for members in the Medicare-Medicaid Plan (MMP) Integrity and for children (21 and younger) in the Medicaid (MED, SUB, CSN) lines of business.
- Home Care Services, as defined in this policy, are not covered for members receiving LTSS waiver services from the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH).
- Personal care and homemaking services for Medicaid-only adult members with a LTSS-HCBS waiver are not billable to Neighborhood. Claims for these services should be submitted to Medicaid FFS for reimbursement.
- Parents or any individual with legal or financial responsibility for the member are not eligible to be reimbursed to provide home care services.
- Home care services are not covered if the member is a resident of a nursing facility, hospital, or licensed residential care facility.
- Members without a LTSS-HCBS waiver are not eligible for more than six (6) hours of homemaker and/or personal care services per week for a single member or ten (10) hours per week for a household with two (2) or more members.
- For billing/benefit information, please review the Home Health Care Services Payment Policy, which can be found at the following link: https://www.nhpri.org/wp-content/uploads/2020/11/Home-Health-Services-Payment-Policy-11.03.20.pdf

Authorization Forms

Please access Prior Authorization forms by visiting Neighborhood's website at www.nhpri.org

1. Go to the section for Providers
2. Click on "Resources & FAQ's"
3. Click on "Medical Management Request Forms"- forms are listed alphabetically by program.

Prior Authorization Forms

For assistance with prior authorizations please contact Clinical Administrative Support at 401-459-6060.
Fax authorization forms to 401-459-6023.

Covered Codes: For information on Coding please reference the Authorization Quick Reference

CMP Number:	**CMP-020**
CMP Cross Reference:	
Created:	**12/2006**
Annual Review Month:	**December**
Review Dates:	11/09, 1/10/12, 2/26/13, 3/1/13, 7/1/13, 2/26/14, 11/18/2014, 9/1/15, 10/18/16, 11/7/17, 11/9/18, 12/4/19, 1/24/20, 12/9/20, 12/8/21, 8/17/22, 12/7/22, 12/7/23
Revision Dates	11/10/09, 1/10/12, 3/12/13, 7/16/13, 2/26/14, 6/30/16, 10/24/17, 11/7/17, 11/9/18, 1/24/20, 12/8/21, 8/17/22, 12/7/22, 12/7/23
CMC Review Date:	12/14/06, 1/12/09, 1/12/10, 1/11/11, 1/10/12, 3/12/13, 7/16/13, 11/18/2014, 9/1/15, 11/1/16, 11/14/17, 11/14/18, 12/4/19, 12/9/20, 12/8/21, 12/7/22, 12/7/23
Medical Director Approval Dates:	12/14/06, 1/12/09, 1/12/10, 2/14/11, 4/05/12, 3/26/13, 7/18/13, 12/29/2014, 9/30/15, 11/14/16, 12/28/17, 11/14/18, 12/4/19, 12/9/20, 12/8/21, 12/7/22, 12/7/23
Medical Director Approval Dates:	12/14/06, 1/12/09, 1/12/10, 2/14/11, 4/05/12, 3/26/13, 7/18/13, 12/29/2014, 9/30/15, 11/14/16, 12/28/17, 11/14/18, 12/4/19, 12/9/20, 12/8/21, 12/7/22, 12/7/23

Neighborhood reviews clinical medical policies on an annual base.

Disclaimer:

This medical policy is made available to you for informational purposes only. It is not a guarantee of payment or a substitute for your medical judgment in the treatment of your patients. Benefits and eligibility are determined by the member's coverage plan; a member's coverage plan will supersede the provisions of this medical policy. For information on member-specific benefits, call member services. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. Neighborhood reserves the right to review and revise this policy for any reason and at any time, with or without notice.