

Member Qualification for Home Health Care

Objective: Provide guidance on when a member may qualify for Home Health Care by each Line of Business (LOB).

NOTE: The designation of homebound is contingent upon a patient's individual ability – not caregiver support.

Medicare and Commercial LOB

CMS defines Homebound as normally unable to leave home unassisted. To be homebound means that leaving home takes considerable and taxing effort. A person may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as a trip to the barber or to attend religious service. Due to illness or injury, member needs the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; special transportation; or the help of another person to leave their place of residence.

- Member must be under the care of a doctor, who must have a plan of care for that she or he regularly reviews.
- The in-home health agency must be Medicare-approved.
- Your doctor must certify that you're unable to leave your home without some difficulty – for example, you might need transportation and/or help from a cane, a walker, a wheelchair, and/or someone to help you. In other words, you're homebound.

Commercial LOB

Medical Conditions / Acute Illness or Injury

- A patient will be considered to be **homebound** if they have a condition due to an illness or injury that restricts their ability to leave their place of residence except with the aid of: supportive devices such as crutches, canes, wheelchairs, and walkers.
 - Absences from the home must be infrequent, of short duration and usually to receive medical care not available at home—e.g., hemodialysis or chemotherapy.

Psychiatric Conditions or Developmental Delay

- Psychiatric patients can have a homebound status if illness manifests into refusal to leave the home or leaving the home will lessen ability to obtain full benefits of therapy outside the home (such as but not limited to severe depression, paranoia, agoraphobia, anxiety).
 - Homebound applies for students with disabilities who are unable to attend school.

Clinical Judgement

- On rare occasions, there may **extenuating circumstances** that justify the need for services in the home. These types of cases should be reviewed on a case by case bases and by Medical Director for determination.
 - Members should be referred for Case Management assistance if not already in a Case Management Program.

Medicaid

There are two types of home health services:

- Acute Home Health: Home Health services provided to members who experience an acute health care need that requires skilled services such as: Skilled nursing, skilled certified nurse aide, physical therapy, occupational therapy, speech therapy and telehealth services.
- Acute Home Health services are allowed up to 60 calendar days or until the acute condition is resolved, whichever comes first.
 - Anything beyond 60 days is considered Long Term Home Health and are a wrap benefit and requests must be prior authorized with the state.
 - If a member experiences a new acute event that would warrant acute Home Health service, the agency may move the member to acute care, when:
 - At least ten (10) calendar days has elapsed since the member's last acute Home Health episode,
and
 - There is new onset of illness, injury, or disability or when the member experiences an acute change in condition from the member's past acute HH episode(s).

Health First Colorado Members qualify who:

- Require Home Health Services for the treatment or amelioration of an illness, injury, or disability, which may include mental illness (**acute**)
- Are **unable to perform** the health care tasks for him or herself, and he or she has no Family Member/Caregiver who is willing and able to perform the **skilled tasks**
- Require services that cannot appropriately or effectively be received in an outpatient treatment office or clinic or for which the member's residence is the most effective setting to accomplish the care required by the member's medical condition (**clinical judgement**)

- The services meet medical necessity criteria and are provided in a manner consistent with professional practice
- Applied Behavior Analysis (ABA) therapy is a WRAP benefit for Medicaid members.
 - Benefits are administered exclusively by the State for review and subsequent approval or denial.
 - NOTE: DHMP has no authority over any Wrap Benefit and therefore DHMP-UM cannot issue an approval or denial and requests will be returned
 - Link below to State for prior authorization requests
 - [Colorado Prior Authorization Requests Program \(CO-PAR\) | Colorado Department of Health Care Policy & Financing](#)

Long-term Home Health

Skilled Home Health services provided to members who require ongoing Home Health services beyond the Acute Home Health period. Prior authorization is required for Long-Term Home Health Services which is Covered by the state. See above

CHP+

Covered services include

- *Skilled* nursing care provided on a defined schedule
- Physical, occupational, and respiratory therapy
- Administration of oxygen
- Intravenous medications and other prescription drugs ordinarily not available through a retail pharmacy
- Physician home visits

Not covered

- Custodial care
- Care provided by a nurse who lives in the patient's home
- Food or meal services other than dietary counseling
- Care related to noncovered services
- Personal comfort or convenience items or services
- Care provided in a skilled nursing facility
- There is no EIS therapy benefit for developmental delays after the 3rd birthday for CHP+ Members.
 - Home Health is available for our members for short durations to help resolve an acute illness or injury.
- ABA is not a covered benefit for DHMP or the state for CHP+ members.

References

[Home Health Program | Colorado Department of Health Care Policy & Financing](#)

Below are questions that the Department has received regarding the Medicaid Home Health Benefit.

[Client FAQs.pdf \(colorado.gov\)](#)

[Provider Forms and Materials | Denver Health Medical Plan](#)