Homemaker Services
Medical Necessity Guideline

Medical Necessity Guideline (MNG) Title: Homemaker Services		
MNG #: 076	**☒SCO ☒One Care** **☐ MA Medicare Premier** **☐ MA Medicare Value** **☐ RI Medicare Preferred** **☐ RI Medicare Value** **☐ RI Medicare Maximum**	**Prior Authorization Needed?** **☒ Yes (always required)** **☐ Yes (only in certain situations. See this MNG for details)** **☐ No**
Clinical: ☒	**Operational: ☐**	**Informational: ☐**
Benefit Type: **☐ Medicare** **☒ Medicaid**	**Approval Date:** 7/1/2021;	**Effective Date:** 9/28/2021
Last Revised Date: 5/30/2022;	**Next Annual Review Date:** 7/1/2022; 5/30/2023;	**Retire Date:**

OVERVIEW:

Homemaker (HM): Homemaker services from an agency are provided to members where their disabilities result in a need for Homemaker services in order to live independently and prevent the unnecessary need for hospitalization or institutionalization. Homemaker Services may include the performance of general household tasks, (see list below). If the member lives with a relative or other caregiver, it is expected that when routine housekeeping, laundry, shopping, and meal preparation are performed, the IADL needs of the member will be included. Services may be temporary when an individual who regularly performs these tasks for the member is absent. Homemaker service does not include heavy chore type services. Assistance with Activities of Daily Living (ADLs) and medication reminders are not permitted.

DECISION GUIDELINES:

Clinical Coverage Criteria:

Commonwealth Care Alliance (CCA) follows applicable Medicare and Medicaid regulations and uses InterQual Smart Sheets, when available, to review prior authorization requests for medical necessity. This Medical Necessity Guideline (MNG) applies to all CCA Products unless a more expansive and applicable CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), or state-specific medical necessity guideline exists.

Clinical eligibility: In order to be eligible to receive HM, the member must have a physical, cognitive, or behavioral-related disability that impairs the member's ability to perform at least 2 IADLs of the following Instrumental Activities of Daily Living (IADLs):

- Meal preparation
- Light Housework
- Grocery shopping
- Laundry

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The care team must identify the condition or syndrome that underlies the disability, as well as the nature of the functional impairment.

Determination of need: In order to receive HM, the requestor (provider or clinical team member) and clinician must determine that HM is required for successful community living, to ensure the health and welfare of the member, and that the guidelines for limitations and exclusions have been met.

LIMITATIONS/EXCLUSIONS:

- HM is provided only when neither the member nor anyone else in the household is capable of performing essential household tasks.
- Homemaker services are not covered when the participant or someone else in the household is capable of performing the tasks or when a relative, caregiver, landlord, community/volunteer agency, or third-party payer is capable of or responsible for Homemaker tasks.
- HM may not be provided to the benefit of non-disabled household members; for example, cleaning common areas or laundry for other persons living in the home.
- HM is not provided if the member is a resident or inpatient in a hospital, nursing facility or intermediate care facility for developmentally disabled or any other medical facility.
- HM may not be provided if the member resides in a provider-operated dwelling, such as Assisted Living Services, or if the member receives another service that includes IADL assistance: Adult Foster Care, Group Adult Foster Care, Home Health Aide (HHA) other agency personal assistance services (if the authorized hours include time for IADL tasks), or Personal Care Attendant.
- HM is not allowed with the PCA program

Assessment criteria:

SCO and One Care: If member meets the min of 2 IADL needs based on a recent (within 90 days of the request) MDS or GSSC/ LTSC Assessment, a Time for Task Tool needs to be completed based on that assessment. If request for Homemaker is made after 90 days of last MDS or GSSC/ LTSC assessment an in-home assessment is required to complete the Time for Task. Documentation should support the hours identified on the Time for Task.

- In order to meet the unique IADL needs of a member a combination of services may be needed. Documentation of the medical necessity and unique member's needs must be provided when requesting multiple services.
- HM should be the first choice to consider when there is more than 1 IADL need. If a combination of services is requested, clinical rationale must be provided and eligibility for other services must be met.

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KEY CARE PLANNING CONSIDERATIONS:

- The care team should review the member's care plan/ service plan to ensure that services are non-duplicative. If member is currently receiving or Personal Care services, Homemaker tasks can be completed by this level of service.
- It is important to support and maintain the involvement of informal supports in the member's care.
- Less costly alternatives should be explored to meet the need.
- The care team should assess whether the member could be independent with assistive/adaptive devices or a home modification.
- SCO members on the Frail Elder Waiver (FEW) may require this service in their care plan to remain eligible for the waiver. This service may be approved as an exception to existing limitations/exclusions in those instances. Consult with the GSSC for additional information.

AUTHORIZATION:

The following list(s) of codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not signify that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. This Medical Necessity Guideline is subject to all applicable Plan Policies and Guidelines, including requirements for prior authorization and other requirements in Provider's agreement with the Plan (including complying with Plan's Provider Manual specifications).

HM requires prior authorization. Documentation should be included in the authorization request to support the need for service. This would include the member's functional, social and environmental status that affects the need for this service. Authorization requests are reviewed, and determinations are made by the Authorization and Utilization Management Department or Delegated entity.

S5130 Homemaker service per 15 minutes

REGULATORY NOTES:

Medical Necessity Guidelines are published to provide a better understanding of the basis upon which coverage decisions are made. CCA makes coverage decisions on a case-by-case basis by considering the individual member's health care needs. If at any time an applicable CMS LCD or NCD or state-specific MNG is more expansive than the criteria set forth herein, the NCD, LCD, or state-specific MNG criteria shall supersede these criteria. This MNG references the specific regulations, coverage, limitations, service conditions, and/or prior authorization requirements in the following:

1. 107 CMR 11.00 Massachusetts Rehabilitation Commission Homemaker Assistance Program
2. 651 CMR 3.00 Elder Affairs Home Care Program
3. 130 CMR 630: HOME- AND COMMUNITY-BASED SERVICES WAIVER SERVICES, 630.416

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RELATED REFERENCES:
N/A

Disclaimer
This Medical Necessity Guideline is not a rigid rule. As with all of CCA's criteria, the fact that a member does not meet these criteria does not, in and of itself, indicate that no coverage can be issued for these services. Providers are advised, however, that if they request services for any member who they know does not meet our criteria, the request should be accompanied by clear and convincing documentation of medical necessity. The preferred type of documentation is the letter of medical necessity, indicating that a request should be covered either because there is supporting science indicating medical necessity (supporting literature (full text preferred) should be attached to the request), or describing the member's unique clinical circumstances, and describing why this service or supply will be more effective and/or less costly than another service which would otherwise be covered. Note that both supporting scientific evidence and a description of the member's unique clinical circumstances will generally be required.

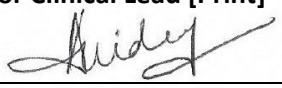
ATTACHMENTS:

EXHIBIT A	N/A
EXHIBIT B	

REVISION LOG:

REVISION DATE	DESCRIPTION
5/30/2022	Template change

APPROVALS:

Avideep Chawla	Director, Utilization Management
CCA Senior Clinical Lead [Print]	**Title [Print]**
	7/1/2021
Signature	**Date**
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CCA Senior Operational Lead [Print]	**Title [Print]**
	7/1/2021
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CCA CMO or Designee [Print]	**Title [Print]**
Lori Tishler	7/1/2021
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