



HOME HEALTHCARE

Supplementary Guidelines

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EviCore

By ~~EVERNORTH~~

EviCore healthcare Clinical Decision Support Tool Diagnostic Strategies: This tool addresses common symptoms and symptom complexes. Imaging requests for individuals with atypical symptoms or clinical presentations that are not specifically addressed will require physician review. Consultation with the referring physician, specialist, and/or individual's Primary Care Physician (PCP) may provide additional insight.

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Table of Contents

Guideline	Page
Administrative Guidelines.....	3
Definitions and abbreviations.....	4
Medical Necessity Guidelines.....	5
Home Health Aide Visits.....	6
References.....	9
Social Worker Visits.....	11
References.....	13

Administrative Guidelines

Guideline	Page
Definitions and abbreviations.....	4

Definitions and abbreviations

HHC.AD.101
v1.0.2027

Non-skilled Maintenance Care	Services not requiring assistance of a licensed nurse or therapist
Skilled Maintenance Care	Services required to maintain the individual's current condition or to prevent or slow deterioration of the individual's condition
Palliative Care	Care typically performed to manage or alleviate symptoms and does not provide corrective benefit to the condition

Medical Necessity Guidelines

Guideline	Page
Home Health Aide Visits.....	6
References.....	9
Social Worker Visits.....	11
References.....	13

Home Health Aide Visits

HHC.CU.100.A**v1.0.2027**

- When non-skilled (not requiring assistance of licensed nurse or therapist) assistance is needed for personal care or other health-related services to maintain the individual's health or facilitate treatment, a Home Health Aide (HHA) referral is indicated if **all** of the following apply:
 - Non-skilled services will support a skilled treatment plan
 - There is documentation of significant functional limitations and **both**:
 - The individual is unable to perform the service independently
 - There is no caregiver available to provide supportive care or the individual will not allow the available caregiver to perform the needed care
 - There is an expectation that the individual's condition will improve significantly in a reasonable period of time

Evidence Summary

Home health aides support older adults and individuals with disabilities by assisting with daily activities, such as bathing, eating, and dressing, so they can remain safely in their homes. The provision of home care services begins with a comprehensive client and home environment assessment typically conducted by a nurse manager (NM). During the initial intake visit, the NM develops a written plan of care that outlines the scope and nature of services to be provided. This assessment serves as a directive for both the client and their family and delineates the responsibilities of the assigned home care aide, such as assistance with personal care and/or household tasks .

The average age of home health care recipients is 79 and have chronic conditions such as heart disease (55%), diabetes (45%), depression (39%), and Alzheimer's diseases and related dementia (32%).

Home health care may be initiated following hospitalization or independently, provided a clinician identifies a need for skilled services. It can serve as an alternative to institutional care settings such as skilled nursing facilities or inpatient rehabilitation centers. Compared to individuals who do not receive home health services, home health care patients have demonstrated improved outcomes, including reduced mortality, fewer hospital re-admissions, and enhanced functional status . Home health care also aids in earlier identification of a clinical status change and prolongs independent stay at home .

Initial services

Once criteria for home health aide referral has been satisfied, visit timing and frequency for initial services is guided based on the level of functional impairment.

- For **initial services** the following visits can be approved over a 2-week period:
 - 6 visits (12 hours) for an individual with minimal functional impairment documented by one or more of the following conditions:
 - Individual requires assistance with ADLs or IADLs
 - Individual ambulates with assistance of a person or device
 - Individual requires cognitive or communication assistance from a person or device
 - Incontinence of bowel or bladder one or more times per week
 - Individual requires some assistance with transfers
 - 10 visits (20 hours) for an individual with moderate functional impairment documented by two or more of the following conditions:
 - Individual requires assistance with ADLs or IADLs
 - Individual ambulates with assistance of a person or device
 - Individual requires cognitive or communication assistance from a person or device
 - Incontinence of bowel or bladder one or more times per week
 - Individual requires some assistance with transfers
 - 14 visits (28 hours) for an individual with maximal functional impairment documented by three or more of the following conditions:
 - Individual requires total assistance with ADLs or IADLs
 - Bowel or bladder incontinence
 - Individual is non-ambulatory
 - Individual is non-communicating or unable to follow safety measures
 - Individual requires 1 or 2 people to assist with transfers
 - 28 visits (56 hours) for an individual without available caregiver support when there is maximal functional impairment documented by three or more of the following conditions:
 - Individual requires total assistance with ADLs or IADLs
 - Bowel or bladder incontinence
 - Individual is non-ambulatory
 - Individual is non-communicating or unable to follow safety measures
 - Individual requires 1 or 2 people to assist with transfers

Continued services

- Once criteria for home health aide referral has been satisfied, visit timing and frequency for continuing services is guided based on the level of functional impairment.
 - For **continued services** the following visits can be approved over a two-week period:
 - 5 visits (10 hours) for an individual with minimal functional impairment documented by one or more of the following conditions:
 - Individual requires assistance with ADLs or IADLs
 - Individual ambulates with assistance of a person or device
 - Individual requires cognitive or communication assistance from a person or device
 - Incontinence of bowel or bladder one or more times per week
 - Individual requires some assistance with transfers
 - 10 visits (20 hours) for an individual with moderate functional impairment documented by two or more of the following conditions:
 - Individual requires assistance with ADLs or IADLs
 - Individual ambulates with assistance of a person or device
 - Individual requires cognitive or communication assistance from a person or device
 - Incontinence of bowel or bladder one or more times per week
 - Individual requires some assistance with transfers
 - 14 visits (28 hours) for an individual with maximal functional impairment documented by three or more of the following conditions:
 - Individual requires total assistance with ADLs or IADLs
 - Bowel or bladder incontinence
 - Individual is non-ambulatory
 - Individual is non-communicating or unable to follow safety measures
 - Individual requires 1 or 2 people to assist with transfers
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 - Bowel or bladder incontinence
 - Individual is non-ambulatory
 - Individual is non-communicating or unable to follow safety measures
 - Individual requires 1 or 2 people to assist with transfers

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Social Worker Visits

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For the purpose of this guideline, social service visits are considered to be medically necessary when there are social or emotional barriers to the effective medical treatment or rate of recovery of an individual and there is a plan of care defining intervention that requires services of a social worker in order to be performed safely and effectively.

Social Worker Visits

- An individual qualifies for two visits with a licensed social worker during a two-week period when both of the following apply
 - To qualify for home health care, the patient must be:
 - Confined to the home
 - Under the care of a physician
 - Receiving services with an established plan of care that is periodically reviewed by a physician
 - In need of skilled care on an intermittent basis by a nurse, physical therapist, or speech-language pathologist
 - In need of continued treatment by occupational therapy
 - There is a care plan establishing the required services for:
 - Evaluation of barriers to the individual's medical treatment or recovery due to:
 - home environment
 - financial resources
 - community resource needs
 - Assistance with obtaining community services
 - Assistance with long-term planning, durable power of attorney, or legal guardian
- Two visits with a licensed social worker during a two-week period can be approved for patient, family, or caregiver evaluation and intervention when
 - Previously established caregiver is no longer available
 - There is suspected or identified abuse or neglect
 - There is increased interpersonal conflict or other evidence of ineffective coping

Evidence Summary

Integrating social services into health care delivery is increasingly viewed as an effective approach to enhancing health outcomes and minimizing reliance on acute care. Collaborative models that support older adults through case management, connections

to social resources, and guidance in navigating the health care system are emerging as promising solutions.

A multicenter survey conducted by You et al. (2017) identified several key obstacles to effective goals-of-care discussions in individuals with advanced heart failure. These included difficulty accepting a poor prognosis, limited understanding of the potential burdens associated with life-sustaining treatments, and conflicting perspectives among family members regarding care decisions. These challenges underscore the importance of involving social workers who can facilitate communication, support emotional processing, and help families navigate complex care decisions. Social workers are also instrumental in working with healthcare teams to develop care goals and assess individuals' understanding of their health and necessary action steps.

A randomized clinical trial involving veteran outpatients with COPD, heart failure, and interstitial lung disease led by Bekelman et al. (2023) sought to identify whether a nurse and social worker working collaboratively via telecare could improve quality of life for trial participants. Results yielded clinically meaningful improvements in quality of life, anxiety, and depression compared to usual care. After six months, the primary outcome of mean Functional Assessment of Chronic Illness Therapy–General (FACT-G) scores showed an improvement of six points ($P=0.01$.) and found the health status for individuals with COPD to be improved ($P=.01$).

A 2016 Cochrane review by Reeves et al. (2017) found that collaboration between healthcare and social care professional groups can positively impact the delivery of care to individuals as well as improve their functional status.

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