Coverage Summary

Solutions for Caregivers

<table>
<thead>
<tr>
<th>Policy Number: S-009</th>
<th>Products: UnitedHealthcare Medicare Advantage Plans</th>
<th>Original Approval Date: 02/18/2009</th>
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<tbody>
<tr>
<td>Approved by: UnitedHealthcare Medicare Benefit Interpretation Committee</td>
<td>Last Review Date: 02/19/2019</td>
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The benefit information in this Coverage Summary is based on existing national coverage policy, however, Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

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I. COVERAGE

Coverage Statement: Medicare does not cover caregiver benefits. Some UnitedHealthcare Medicare members have Solutions for Caregivers. Contact the Customer Service Department to determine coverage eligibility. If the member has Solutions for Caregivers, the following guidelines apply.

Guidelines/Notes:

1. Covered Benefits
   a. Telephonic Care Resource Center (CRC) services
      1) Coaching and support
         • Unlimited toll-free access to geriatric experts
         • Unlimited coaching on dealing with family issues and stresses of caregiving
      2) Personalized research and identification of services
         • Unlimited access to personalized research on caregiver and elder care topics by geriatric specialists
• Research into community and government funded programs to fit a family’s care giving needs
• Identification and screening of local public and private care services such as meal delivery, transportation, housekeeping, etc.

b. Geriatric care case manager services for one in person assessment package or up to 6 hours of telephonic caregiver consultation hours per calendar year that can be used for the specific needs of the caregiver. Typical uses include:
   1) At-home assessment to review the current situation and plan for future care
   2) Detailed plan care to help the caregiver understand the present care needs and help them select care services
   3) Extensive review of local support services available in the community with suggested next steps for the caregiver to consider
   4) Care planning and coordination of a variety of care services from community-based private and public agencies that may meet the elder’s needs
   5) Review of alternative living facilities, such as assisted living or skilled nursing.

2. Not Covered
   a. Community, private or government-funded programs chosen by the member as a result of receiving personalized research
   b. Public or private care services chosen by the member as a result of receiving identification and screening services
   c. Medical services obtained at the recommendation of Caregiver Geriatric Care Managers or the Care Resource Center except those covered services described in the Schedule of Benefits and the Evidence of Coverage.
   d. Alternative living facilities, custodial care, domiciliary care or other facility charges
   e. Geriatric Care Manager services that are not arranged for or provided by the Solutions for Caregivers benefit
   f. Respite care services unless provided by the member’s Solutions for Caregivers benefit.

Some members (LACERS Enhanced Members Only) have coverage for respite care through Solutions for Caregivers. Contact the Customer Service Department to determine coverage eligibility for respite care.

If the member has the respite care benefit through Solutions for Caregivers, the following benefits apply:

a) Respite care is covered for up to 40 hours per calendar year when the following criteria are met:
   ☑ Member must be a homebound, dependent adult who lives in the same household as the caregiver
   ☑ Member must not require skilled care during the respite visit
   ☑ Member must be assessed by a home health nurse supervisor of the contracted provider, who will determine eligibility and the level of care required
   ☑ Member must not provide monetary compensation to the caregiver for assistance

b) Respite care services that can be performed include companionship, light meal prep, medication reminders, bathing, dressing and toileting.
c) The respite care program can be used by a UnitedHealthcare Medicare member who is caring for another or by the caregiver of a UnitedHealthcare Medicare member.

d) The respite care services are provided by a home health aid or certified nurse’s aide under nursing supervision.

e) Respite services (unskilled services) that are not arranged for or provided by the Care Resource Center are not covered.

Note: Initial assessment and visits must be scheduled 48 hours in advance. Minimum visit is two hours. Visits longer than two hours require 72-hour scheduling and are subject to availability. Respite services are arranged by calling the CRC and are only available through the contracted provider.

- For respite care benefit information, contact the Solutions for Caregivers Program at 1-866-896-1895.
- For Medicare hospice benefit, see the Coverage Summary for Hospice Services.

II. DEFINITIONS

III. REFERENCES

IV. REVISION HISTORY

04/01/2019  Updated policy introduction; added language to clarify:
- There are instances where [the Coverage Summary] may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG)
- In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5)

02/19/2019  Annual review; no updates.

02/20/2018  Annual review; no updates.

02/14/2017  Annual review; no updates.

02/16/2016  Annual review; no updates.

03/24/2015  Annual review with the following updates:
- Guideline #1.a.2 – Added “caregiver and” to statement.
- Guideline #1.b. – Added “one in person assessment package or up to 6 hours of telephonic caregiver consultation hours” to statement.
- Guideline #2.d – Deleted “Geriatric care manager services beyond the 6 hours maximum coverage limit”
- Guideline #2.e – Deleted “Caregiver services, including” and “Care Resource
• Guideline #2.g – Added “provided by the member’s” and deleted “member has purchase coverage for respite care through” from statement. Also included “LACERS Enhanced Members Only” to special statement box.

• Guideline #2.f.e – Updated contact language.

• Definitions:
  - Care Resource Center- deleted, not in body of coverage summary.
  - Geriatric Care Manager- deleted, not in body of coverage summary.

02/18/2014 Annual review; no updates.
02/19/2013 Annual review; no updates.
02/27/2012 Annual review; no updates.
02/21/2011 Annual review; no updates.