Medical Policy

Home Health Services	
MEDICAL POLICY NUMBER	MED_Clin_Ops_020
CURRENT VERSION EFFECTIVE DATE	January 1, 2024
APPLICABLE PRODUCT AND MARKET	*Individual Family Plan:* All Plans *Small Group*: All Plans *Medicare Advantage:* All Plans

Brand New Day/Central Health Medicare Plan develops policies and makes coverage determinations using credible scientific evidence including but not limited to MCG™ Health Guidelines, the ASAM Criteria™, and other third party sources, such as peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, and expert opinion as relevant to supplement those sources. Brand New Day/Central Health Medicare Plan Medical Policies, MCG™ Guidelines, and the ASAM Criteria™ are not intended to be used without the independent clinical judgment of a qualified health care provider considering the individual circumstances of each member's case. The treating health care providers are solely responsible for diagnosis, treatment, and medical advice. Members may contact Brand New Day/Central Health Medicare Plan Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Brand New Day/Central Health Medicare Plan Medical Policy may contact the Health Plan. Brand New Day/Central Health Medicare Plan policies and practices are compliant with federal and state requirements, including mental health parity laws.

If there is a difference between this policy and the member specific plan document, the member benefit plan document will govern. For Medicare Advantage members, Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), govern. Refer to the CMS website at http://www.cms.gov for additional information.

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PURPOSE

The purpose of this policy is to establish the clinical review criteria that support the determination of medical necessity of home health services.

POLICY

Clinical Criteria

Home care services from an in-network provider require only network validation review for the following home health visits:

1. Initial assessment visit.
2. Initial six (6) combined visits for any of the following services:
   - Skilled nursing visits
   - Physical therapy

- Occupational therapy
- Speech therapy
- Respiratory therapy
- Medical social worker
- Registered dietitian
- Home Health Aide Services

Prior authorization and medical necessity clinical review is required for the following:

1. Any home care services beyond the initial six (6) combined services previously approved.
2. Extended hours skilled nursing home care (more than 2 hours per day)
3. Private duty nursing (if this benefit is covered as part of the member's policy).
4. Any home health service request from a non-network provider.

Required Documentation:

Providers must document all evaluations, services provided, member progress and discharge plans. The record of therapy services must contain the following:

1. The date, type, length and scope of each service provided,
2. The name and title of the person(s) providing each service,
3. A statement, every 30 days, by the therapists providing or supervising the services that certify the nature, scope, duration and intensity of the therapy are appropriate to the medical condition of the member.

Criteria for Home Care - Skilled Services:

ALL of the following criteria must be met to support approval for home care services:

1. The member must meet **at least one** of the following:
    a. The member is homebound or is physically unable to access the services within the community:
        i. A member is deemed to be homebound when:

- It is medically contraindicated for the member to leave the home
- Leaving the home is likely to directly and negatively impact the member's physical health.
- Leaving the home requires considerable effort and the member not normally able to leave the home

Note: Members do not have to be bedridden to be considered homebound.

b. The member needs extended IV medications

c. The member needs skilled wound care.

2. The services meet the ALL of the following criteria:

a. The services are ordered by the member's treating provider.

i. Provider orders must be part of the written plan of care (see #4 below).

ii. Recertification must be obtained at least every two months to document and verify the continued medical necessity of the services provided.

b. The following items must be documented:

- An estimated length of treatment.
- Frequency and duration of the services.
- Description of the skilled service(s) to be received.
- The services must be consistent with medical and community standard of care determined by health care providers.
- The proposed services should are intended to:
  - Help restore or maintain the member's health to prevent deterioration of the member's condition
  - Prevent an onset of other health or medical conditions that would adversely impact the member

c. Timeframe:

i. The services are required on an intermittent basis (a maximum of 56 hours per week)

- This includes a combination of all disciplines (e.g.,14 hours per discipline per week);

- A visit is considered up to 2 hours of care.

ii. The services are needed for a limited period of time.

d. The services are performed by or under the direction of a licensed RN, physical therapist, speech therapist or occupational therapist.

i. Services are not considered to be custodial care.

e. Care is reasonable and necessary for the treatment of illness or injury.

f. The service is provided at a frequency that is considered to be community or industry standard.

3. An assessment visit is completed prior to development of a treatment plan

An assessment visit is a personal contact visit made to the member's home by a home care agency's provider (for example, registered nurse, physical therapist, occupational therapist, etc.) . The purpose of the assessment visit is to identify the problems, needs, and capabilities of the member and determine the support the member's family or support system can provide.

Examples of issues commonly addressed during an assessment visit are:

a. Member's diagnosis and clinical condition.

b. Functional limitations to activities of daily living.

c. Provider's orders (medications, treatment plan, etc.).

d. Psycho-social history.

e. Physical evaluation.

f. Availability and skills of family and/or support system caregivers.

g. Evaluation of home environment including equipment needs, safety concerns, etc.

4. A Written Plan of Care is Submitted

A plan of care is developed to address the individual needs of the member and to stabilize and/or improve the member's health status. An established treatment plan must be submitted as part of the authorization request and include the following:

a. Verification of the member's homebound status or need for home-based care.

b. Determination of need for skilled nursing care, physical therapy, occupational therapy, or speech therapy.

c. Provider's order for the treatment and care.

d. Written and measurable goals of care.

e. Summary of progress towards goals achieved and summary of goals yet to be attained.

5. **Services must be performed in the member's place of residence**

   This may be the member's own dwelling, an apartment, a relative's home, an apartment complex which provides assisted living services or another type of facility.

   A facility may not be considered a member's residence if it meets the definition of a hospital or skilled nursing facility in accordance with the member's contract or reasonable community definition.

Criteria for specific services:

1. **Injections and/or Infusions**

   Intravenous, intramuscular, or subcutaneous injections and infusions and hypodermoclysis or intravenous feedings require the skills of a licensed nurse to be performed safely and effectively. . For these services to be reasonable and necessary:

   - The medication being administered must be accepted as a safe and effective treatment of the member's illness or injury
   - There must be a medical reason that the medication cannot be taken orally.
   - The frequency and duration of the administration of the medication must be within accepted standards of medical practice, or there must be a valid explanation regarding the extenuating circumstances to justify the need for the additional injections.

2. **Wound care:**

   Home care services to address the situations below may be authorized:

   - Open wounds that:
     - Are draining purulent or colored exudate
     - Have a foul odor present
     - Require antibiotic therapy.
   - Wounds with a drain or T-tube that require shortening or movement of the drains.

- Wounds that require irrigation or instillation of a sterile cleansing or medicated solution into several layers of tissue and skin and/or packing with sterile gauze.
- Recently debrided ulcers
- Pressure sores (decubitus ulcers) with the following characteristics:
  - Partial tissue loss with signs of infection such as foul odor or purulent drainage; or
  - Full thickness tissue loss that involves exposure of fat or invasion of other tissue such as muscle or bone.
- Teaching wound care where the complexity of the wound, the overall condition of the member, or the ability of the caregiver makes teaching necessary.

Special Circumstances to Waive Prior Authorization Requirements:

Brand New Day/Central Health Medicare Plan Clinical Leadership may choose to waive the authorization and medical necessity review requirements outlined above for to out-of-network or non-contracted providers in certain circumstances and situations (for example, COVID-19 high incidence area, State of Emergency Declarations in service markets, etc). This exception will be communicated to providers via the Brand New Day/Central Health Medicare Plan website or upon submission of an authorization service request.

Providers must submit a notification of admission to the Brand New Day/Central Health Medicare Plan Utilization Management team to assist in facilitating any additional benefit and/or service needs.

BACKGROUND

Home care therapies are provided in the home to improve or maintain a member's functioning. Home care therapies include physical, occupational, speech-language pathology and respiratory care, etc. Home care therapies are classified as one of the following:

1. **Restorative therapy:**
   Health service ordered by a provider, specified in the member's care plan, and designed to **restore** the member's functional status to a level consistent with the member's underlying physical or mental limitations.

2. **Specialized maintenance therapy:**
   Health service ordered by a provider, specified in the member's care plan, and

necessary for **maintaining** a member's functional status at a level consistent with the member's underlying physical or mental limitations.

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Brand New Day/Central Health Medicare Plan will determine if coverage is available by reviewing both the skilled nature of the service and the need for Provider-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.
Services may be limited to a certain number of visits per calendar year and require pre-authorization.

DEFINITIONS

Skilled services: Nursing or rehabilitation services requiring the skills of technical or professional clinical staff to develop a care plan, provide required care and assess the member's current condition. Skilled services must be provided by an RN, an LPN under the supervision of an RN, or a physical/occupational/speech therapist. Personal Care Assistants (PCAs) cannot provide skilled services.

Home health services include skilled care, therapies (physical, occupational, speech, respiratory and inhalation), social work services, medical supplies furnished during visits, nutrition counseling by a nutritionist or dietician, home health aide services that are supervised by a registered nurse or licensed therapist.

Skilled treatments include:

- Administering medications that cannot be self-administered.
- Wound care.
- Rehabilitation services.
- Catheter insertion.
- Teaching and training related to the administration of injectable medications or medication regimens, training in wound care, etc. Teaching and training are not appropriate if (after a reasonable amount of time) the member is unable to follow through with self-care for whatever reason.

Skilled Care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following apply:

- Care is ordered by a qualified provider.
- Care is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing, or transferring from a bed to a chair.
- Care requires clinical training in order to be delivered safely and effectively
- The care provided is not Custodial Care.
- Care is delivered or supervised by a licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.

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Home Health Aides provide hands-on personal care in conjunction with medical services that are needed to maintain the member's health or to facilitate treatment of the member's illness or injury. A home health aide is a provider who assists a member with non-skilled care to meet activities of daily living in order to allow the member to remain in their home setting. Services from a Home Health Aide require prior authorization. The services of a home health aide are rendered in conjunction with intermittent skilled home health care services provided by an RN, an LPN under the supervision of an RN, or a physical/occupational/speech therapist AND the services delivered by the home health aide directly support skilled home health care services.

These may include:

- Assisting with a prescribed exercise regimen,
- Assisting with activities of daily living,
- Changing non-sterile dressings that do not require the skills of a licensed nurse,
- Routine care of prosthetic and orthotic devices,
- Supervising the individual's adherence to prescribed, self-administered medication and/or special meals or food,
- Performing blood pressure checks and other health monitoring activities.

Treating Provider: The provider who is directing, ordering or overseeing the need for and/or delivery of Home Care Services and may include (for example) a Hospitalist or SNF Provider.

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CODING

The following list(s) of procedure is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply 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. Other Policies and Guidelines may apply.

CPT® codes:

99500	Home visit for prenatal monitoring and assessment to include fetal heart rate, nonstress test, uterine monitoring, and gestational diabetes monitoring
99501	Home visit for postnatal assessment and follow-up care
99502	Home visit for newborn care and assessment
99503	Home visit for respiratory therapy care (e.g., bronchodilator, oxygen therapy, respiratory assessment, apnea evaluation)
99504	Home visit for mechanical ventilation care
99505	Home visit for stoma care and maintenance including colostomy and cystostomy
99506	Home visit for intramuscular injections
99507	Home visit for care and maintenance of catheter(s) (e.g., urinary, drainage, and enteral)
99511	Home visit for fecal impaction management and enema administration
99512	Home visit for hemodialysis
99601	Home infusion/specialty drug administration, per visit (up to 2 hours);
99602	Home infusion/specialty drug administration, per visit (up to 2 hours);each additional hour (List separately in addition to code for primary procedure)

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HCPCS Codes

Brand New Day/Central Health Medicare Plan follows CMS billing guidelines for Individual and Family Plan (IFP) and Small Group (SG) plan members. S codes are not payable under CMS billing guidelines and are non- reimbursable services by Brand New Day/Central Health Medicare Plan.

G0068	Professional services for the administration of anti-infective, pain management, chelation, pulmonary hypertension, and/or inotropic infusion drug(s) for each infusion drug administration calendar day in the individual's home, each 15 minutes
G0069	Professional services for the administration of subcutaneous immunotherapy for each infusion drug administration calendar day in the individual's home, each 15 minutes
G0070	Professional services for the administration of chemotherapy for each infusion drug administration calendar day in the individual's home, each 15 minutes
G0151	Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes G0155 Services of clinical social worker in home health or hospice settings, each 15 minutes
G0156	Services of home health/hospice aide in home health or hospice settings, each 15 minutes
G0157	Services performed by a qualified physical therapist assistant in the home health or hospice setting, each 15 minutes
G0158	Services performed by a qualified occupational therapist assistant in the home health or hospice setting, each 15 minutes
G0159	Services performed by a qualified physical therapist, in the home health setting, in the establishment or delivery of a safe and effective physical therapy maintenance program, each 15 minutes
G0160	Services performed by a qualified occupational therapist, in the home health setting, in the establishment or delivery of a safe and effective occupational therapy maintenance program, each 15 minutes
G0161	Services performed by a qualified speech-language pathologist, in the home health setting, in the establishment or delivery of a safe and effective speech-language pathology maintenance program, each 15 minutes
G0162	Skilled services by a registered nurse (RN) for management and evaluation of the plan of care; each 15 minutes (the member's underlying condition or complication requires an RN to ensure that essential non-skilled care achieves its purpose in the home health or hospice setting)

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G0299	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes
G0300	Direct skilled nursing services of a licensed practical nurse (LPN) in the home health or hospice setting, each 15 minutes
G0490	Face-to-face home health nursing visit by a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) in an area with a shortage of home health agencies (services limited to RN or LPN only)
G0493	Skilled services of a registered nurse (RN) for the observation and assessment of the member's condition, each 15 minutes (the change in the member's condition requires skilled nursing personnel to identify and evaluate the member's need for possible modification of treatment in the home health or hospice setting)
G0494	Skilled services of a licensed practical nurse (LPN) for the observation and assessment of the member's condition, each 15 minutes (the change in the member's condition requires skilled nursing personnel to identify and evaluate the member's need for possible modification of treatment in the home health or hospice setting)
G0495	Skilled services of a registered nurse (RN), in the training and/or education of a member or family member, in the home health or hospice setting, each 15 minutes
G0496	Skilled services of a licensed practical nurse (LPN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes
H1004	Prenatal care, at-risk enhanced service; follow-up home visit
T1001	Nursing assessment/evaluation
T1002	RN services, up to 15 minutes
T1003	LPN/LVN services, up to 15 minutes
T1004	Services of a qualified nursing aide, up to 15 minutes
T1021	Home health aide or certified nurse assistant, per visit
T1022	Contracted home health agency services, all services provided under contract, per day
T1028	Assessment of home, physical and family environment, to determine suitability to meet patient's medical needs
T1030	Nursing care, in the home, by registered nurse, per diem
T1031	Nursing care, in the home, by licensed practical nurse, per diem
T1502	Administration of oral, intramuscular and/or subcutaneous medication by health care agency/professional, per visit

Revenue Codes:

Home Health Care Visits:

0550	Skilled nursing-general
0551	Skilled nursing-visit charge
0552	Skilled nursing-hourly charge
0559	Skilled nursing-other skilled nursing
0570	Home health aide-general
0571	Home health aide-visit charge
0572	Home health aide-hourly charge
0579	Home health aide-other home health aide
0580	Home health-other visits-general
0581	Home health-other visits-visit charge
0582	Home health-other visits-hourly charge
0583	Home health-other visits-assessment
0589	Home health-other visits-other home health visits
0590	Home health-units of service-general
0600	Oxygen (home health)-general
0601	Oxygen (home health)-stat/equip/supply or contents
0602	Oxygen (home health)-stat/equip/supply/under 1 lpm
0603	Oxygen (home health)-stat/equip/supply/over 4 lpm
0604	Oxygen (home health)-portable add-on
0609	Oxygen (home health)-other
0640	Home IV therapy services –general
0641	Home IV therapy services - non-routine nursing, central line
0642	Home IV therapy services - IV site care, central line
0643	Home IV therapy services - IV start/change, peripheral line
0644	Home IV therapy services - non-routine nursing, peripheral line
0645	Home IV therapy services - training patient/caregiver, central line
0646	Home IV therapy services - training, disabled patient, central line
0647	Home IV therapy services - training, patient/caregiver, peripheral line
0648	Home IV therapy services - training, disabled patient, peripheral line
0649	Home IV therapy services - other IV therapy services Therapy by a Home Health Care Agency/Facility These apply to the Home Health Care Visit limit when the Bill Type is either: • 032x - Home Health - Home Health Services Under a Plan of Treatment • 034x - Home Health - Home Health Services Not Under a Plan of Treatment
0420	Physical therapy-general
0421	Physical therapy-visit charge

0422	Physical therapy-hourly charge
0423	Physical therapy-group rate
0424	Physical therapy-evaluation or reevaluation
0429	Physical therapy-other physical therapy
0430	Occupational therapy-general
0431	Occupational therapy-visit charge
0432	Occupational therapy-hourly charge
0433	Occupational therapy-group rate
0434	Occupational therapy-evaluation or reevaluation
0439	Occupational therapy-other occupational therapy
0440	Speech therapy-language pathology-general
0441	Speech therapy-language pathology-visit charge
0442	Speech therapy-language pathology-hourly charge
0443	Speech therapy-language pathology-group rate
0444	Speech therapy-language pathology-evaluation or reevaluation
0449	Speech therapy-language pathology-other speech-language pathology

EVIDENCE-BASED REFERENCES

N/A

POLICY HISTORY

Original Effective Date	February 11, 2020
Revised Date	December 20, 2020 – Small Group added as applicable product March 5, 2021 – Updated language regarding types of review needed and timing, COVID exception language, added language regarding billing/procedure codes used, and removed “S” HCPC codes from the policy due to being non-reimbursed codes for Bright Health April 29, 2022 – Annual review March 1, 2023 - Adopted by MA UM Committee (no policy revisions made) January 1, 2024 - Updated to Brand New Day/Central Health Medicare Plan (no policy revisions made)

Approved by the Utilization Management Committee 4/29/22