

HOME CARE

Effective Date: January 1, 2019

Review Dates: 1/93, 12/99, 12/01, 11/02, 11/03,
11/04, 5/05, 4/06, 4/07, 7/07, 4/08, 4/09, 6/09, 6/10,
6/11, 6/12, 6/13, 5/14, 5/15, 5/16, 5/17, 2/18, 11/18

Date Of Origin: June 30, 1988

Status: Current

Summary of Changes

Clarifications:

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Deletions:

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Additions:

- Pg. 1, Section I, A, 1, added language that plan of care established and periodically reviewed by physician.
- Pg. 6, Section II, added language addressing that home care visits are to be authorized for all products with exception that Commercial and Individual do not require authorization for first 30 home health skilled nursing visits per plan year.

I. POLICY/CRITERIA

A. Covered Services

1. Home Health Care — Intermittent skilled services approved in advance by us (please see Section II. Medical Necessity Review below for additional information) and furnished in the home by a home health care agency or by a registered nurse, licensed practical nurse, physical therapist, occupational therapist, respiratory therapist or speech therapist under a plan of care established and periodically reviewed by a Physician. Custodial care is not covered, even if you receive home health care services along with custodial care. (Additional coverage limitations and indications below in C1 and C2).
2. Home Physician Services — Intermittent, non-urgent physician services approved in advance by us and furnished in the home by a physician or home physician agency. Prior authorization is not required for home physician services provided by the member's PCP or for Priority Medicare members. All other home physician services require prior authorization. (See specific Medicaid coverage below in B3)

B. Exclusions

1. Custodial and Maintenance Care — any care you receive (if, in our opinion) when you have reached the maximum level of mental and/or physical function and you will not improve significantly more.

2. Services provided to Members who are not home bound unless those services are determined by Priority Health to be more cost effective or more practical when provided in a home setting.
3. Home physician services by home physicians agencies for Medicaid/Healthy Michigan Plan members. For Medicaid/Healthy Michigan Plan members, home physician services are covered only if provided by the PCP.
4. Services or supplies not specified in the home care plan.
5. Services of a person who ordinarily resides in the patient's home or is a member of the patient's family.
6. Homemaker services.]
7. For Medicaid/Health Michigan Plan members Medical Social Worker are not covered.
8. Home care for chronic conditions requiring long periods of care or observation which can be safely provided in the member's home by a person without medical training.
9. A person expected to need *full-time* skilled nursing care over an extended period of time would not qualify for home care benefits.
10. Services that can be safely and more cost effectively provided in an alternative setting, such as an office, clinic or infusion center.

C. Limits/Indications

1. The following conditions apply to all home care patients:
 - a. Prior hospitalization for the same or related condition is not required.
 - b. Services may be required to be provided in a setting other than the home (e.g. outpatient) if the patient is not homebound.
 - c. Intermittent care is limited to 2-4 hours of medically necessary skilled care administered in a 24-hour period. Extended services must be recommended by the physician and approved by the Health Plan when, because of unusual circumstances, neither the alternative part-time care nor institutionalization is feasible.
 - d. A service is not considered a skilled nursing service merely because it was performed by or under the direct supervision of a nurse. Where a service can be safely and effectively performed (or self-administered) by the average nonmedical person, without the direct supervision of a nurse, the service cannot be regarded as a skilled nursing service.
 - e. Medical supplies (e.g. dressings) are provided under the DME/Supplies benefit separate from the Home Care benefit. Supplies must be prescribed by a physician and obtained from a DME provider.
 - f. Hospice services and palliative care services (see *Hospice Care #91520* and *Palliative Care #91558 policies*) as well as telemonitoring services (see *Telemedicine #91604*).
2. The following services may be covered when ordered for skilled or rehabilitative care:

- a. Intermittent nursing care by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) who is supervised by an R.N.
- b. Physical therapy, occupational therapy, and speech therapy (see *Speech Therapy #91336* and *Rehabilitative Medicine Services #91318* policies) provided by a certified Home Health Agency.
- c. Medical social services provided by a qualified medical social worker, under the supervision of an RN, may be covered as home health services when it is necessary to resolve social or emotional problems that are or are expected to impede the effective treatment of a member's medical condition or rate of recovery.
- d. Home Health Aides – Only covered if specified in the member's coverage document. When covered, home health aide services are covered when they are provided by a trained home health aide, under the supervision of a R.N., on an intermittent basis and are necessary to the treatment of the member's illness or injury. The care provided must be needed to maintain the member's health or to facilitate treatment of the member's illness or injury. Covered services when the above conditions are met may include, simple dressing changes, assistance with medications which ordinarily are self-administered, assistance with activities which are directly supportive of skilled therapy services but do not require the skill of a therapist to be safely and effectively performed, and routine care of prosthetic and orthotic devices. Home health aides are not a covered benefit to provide custodial care services. They are to be utilized for short-term care on an intermittent basis, provided that the condition is not long-term or chronic, if the home health aide service can predictably avoid over utilization of services at a higher level of care, such as inpatient admission or repeated emergency department visits.
- e. Registered Dietician - Only if covered if specified in the member's coverage document. When covered, registered dietician services to furnish dietetic or nutritional services to patients in their homes, under the supervision of R.N., on an intermittent basis and are necessary to the treatment of the member's illness or injury. The care provided must be needed to maintain the member's health or to facilitate treatment of the member's illness or injury.

Special Notes:

Case management should be provided to specify limits and initiate ongoing review of patient's status.

Each visit by a physical, occupational or speech therapist will be considered one visit when determining contract limits or member copayments.

Definitions:

Skilled care — defined as medical services which must be available 24 hours a day and be performed by or under the direct supervision of a registered nurse to assure the safety of the patient and to achieve the medically desired results. The services must be included in a treatment plan, must be required on an intermittent basis and must be reasonable and necessary to the treatment of an illness or injury. Home skilled nursing services are meant to be short term in nature until care can be transitioned to an outpatient setting, other than the home. Consideration must be given to both the inherent complexity of the service and the condition of the patient. If the service can be safely and effectively performed by the average nonmedical person without the direct supervision of a licensed nurse, then the service is not regarded as skilled.

Examples of skilled care include:

- Observation or evaluation where the physician expects a significant change in the patient's condition requiring skilled services.
- Teaching and training activities that require the skills or knowledge of a nurse.
- Therapeutic exercises.
- Insertion and sterile irrigation of a catheter.
- Administration of intravenous medication.
- Skin care (not including routine prophylactic and palliative skin care).

Custodial and maintenance care — is defined as care received by a member when, in our opinion, the member has reached the maximum level of mental and/or physical function and will not improve significantly more. The purpose of custodial care is to assist an individual in the activities of daily living such as assistance in walking, getting in/out of bed, bathing, dressing feeding, toileting, preparation of special diets, supervision of medication that can be self or family or caregiver administered. Custodial and maintenance care includes room and board, therapies, nursing care, home health aides and personal care designed to help the member in the activities of daily living, and home care and adult day care provided, or that could be provided, by members of the family.

Rehabilitative care — is defined as services that are directed toward and supportive of restoring physical function and abilities which have been lost due to recent medical conditions and where there is a reasonable expectation of partial or complete restoration of physical function.

Physical therapy, cardiac rehabilitation, pulmonary therapy, occupational therapy, biofeedback and speech therapy are covered for treatment of medical diagnoses if due to:

- an injury
- an illness, *or*
- a congenital defect for which you have received corrective surgery

Short-term rehabilitative therapy services are covered if:

- you receive them as an outpatient or in the home, *and*
- they can reasonably be expected to improve your condition within 90 days of the date you start therapy, as determined by us in consultation with your physician.

Examples of rehabilitative care include:

1. Physical therapy, except services related to activities for the general good and welfare of the patient, e.g., general exercises to promote overall fitness, flexibility or general motivation. If no further restoration is expected, the physical therapy services would not be covered.
2. Gait training for a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality and whose ability to walk would be expected to improve significantly by such gait training.
3. Range of motion testing.
4. Occupational therapy to improve that patient's ability to perform those tasks required for independent functioning. The services of an occupational therapist in designing a maintenance program would be covered, but professional services provided to carry out a maintenance program are not covered.
5. Speech therapy necessary for diagnosis and treatment of speech and language disorders which result in communication disabilities are covered when there is a treatment plan with expected restoration of function.

Home Bound — An individual does not have to be bedridden to be considered as confined to the home. However, the condition of these members should be such that there exists an inability to leave home and, consequently, leaving their home would require a considerable and taxing effort. The member may be considered homebound if the absences from the home are infrequent or for periods of relatively short duration. Any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. In addition, any absence attributable to the need to receive health care treatment shall not disqualify an individual from being considered homebound.

The person who does not often travel from home because of frailness brought on by advanced age would not be considered confined to the home for purposes of receiving home health services unless they meet one of the above conditions for covered services.

II. MEDICAL NECESSITY REVIEW

Required*

Not Required

Not Applicable

*Medicare and Medicaid require authorization for all home health visits

*Commercial and Individual plans - No prior authorization is required for the first 30 home health skilled nursing visits per plan year.

*Authorization for home health services reviewed utilizing InterQual criteria and Medicare manual or Medicaid manual or member policy.

Please verify benefits by contacting the Provider Helpline at 800.942.4765, option 2.

III. APPLICATION TO PRODUCTS

Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable.

- ❖ **HMO/EPO:** *This policy applies to insured HMO/EPO plans.*
- ❖ **POS:** *This policy applies to insured POS plans.*
- ❖ **PPO:** *This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.*
- ❖ **ASO:** *For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.*
- ❖ **INDIVIDUAL:** *For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.*
- ❖ **MEDICARE:** *Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, this policy applies.*
- ❖ **MEDICAID/HEALTHY MICHIGAN PLAN:** *For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html, the Michigan Medicaid Provider Manual will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.*

IV. DESCRIPTION

Home care may be covered for Priority Health members as defined above.

V. CODING INFORMATION

ICD-10 Diagnosis Codes:

Various – report condition that best supports skilled service.

CPT/HCPCS Codes:

Report for physician services - (HCFA 1500 claim form)

- 99341 Home visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.
- 99342 Home visit for the evaluation and management... new patient . . .expanded problem focused history; . . .examination; and Medical decision making of low complexity. . . .Physicians typically spend 30 minutes face-to-face with the patient and/or family.
- 99343 Home visit for the evaluation and management . . . new patient, detailed history; . . .examination; and Medical decision making of moderate complexity. . . . Physicians typically spend 45 minutes face-to-face with the patient and/or family.
- 99344 Home visit for the evaluation and management . . . new patient, . . . comprehensive history; . . . examination; and Medical decision making of moderate complexity. . . . Physicians typically spend 60 minutes face-to-face with the patient and/or family.
- 99345 Home visit for the evaluation and management . . . new patient, . . . A comprehensive history; . . . examination; and Medical decision making of high complexity. . . . Physicians typically spend 75 minutes face-to-face with the patient and/or family.
- 99347 Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
- 99348 Home visit for the evaluation and management . . . established patient, . . . expanded problem focused interval history;. . . examination; Medical decision making of low complexity. . . .Physicians typically spend 25 minutes face-to-face with the patient and/or family.
- 99349 Home visit for the evaluation and management . . . established patient, . . . detailed interval history; . . .examination; Medical decision making of moderate complexity. . . . Physicians typically spend 40 minutes face-to-face with the patient and/or family.

99350 Home visit for the evaluation and management . . . established patient, . . . comprehensive interval history; . . . examination; Medical decision making of moderate to high complexity. . . . Physicians typically spend 60 minutes face-to-face with the patient and/or family.

Not Covered for commercial and Medicaid members:

- G0179 Physician re-certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per re-certification period
- G0180 Physician certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per certification period

Revenue Codes (UB-04 claim form):

Revenue codes should be reported with the appropriate CPT or HCPCS codes for information and when required. Home Health Agencies must bill using UB-04 claim form.

(Contracted billing codes may vary by product.)

<u>Skilled Home Care</u>	
551 – 559	Skilled Nursing
421 - 429	Physical Therapy
431 - 439	Occupational Therapy
441 - 449	Speech-Language Pathology
<u>0589</u>	Dietician (not covered for Medicaid)
<u>0560 – 0569</u>	Social Worker <i>(not covered for Medicaid)</i>
<u>0570 – 0571</u>	Certified Home Health Aide <i>(not covered for commercial plans)</i>
<u>0270</u>	DME/Supplies – <i>not payable to HH agency – use DME provider</i>
<u>Early Maternity Discharge Program</u>	
552	Skilled Nursing - Hourly Charge
993	Patient Convenience Items – Telephone

VI. REFERENCES

AMA CPT Copyright Statement:

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