# Medical Necessity Guideline

| Medical Necessity Guideline (MNG) Title: Home Health Services | | |
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| **MNG #: 099** | **☐SCO ☐One Care**<br>**☒ MA Medicare Preferred**<br>**☒ MA Medicare Value**<br>**☒ RI Medicare Preferred**<br>**☒ RI Medicare Value**<br>**☒ RI Medicare Maximum** | **Prior Authorization Needed?**<br>**☒ Yes (always required)**<br>**☐ Yes (only in certain situations. See this MNG for details)**<br>**☐ No** |
| **Clinical: ☒** | **Operational: ☒** | **Informational: ☐** |
| **Benefit Type:**<br>**☒ Medicare**<br>**☐ Medicaid** | **Approval Date:**<br>2/3/2022; | **Effective Date:**<br>5/07/2022; |
| **Last Revised Date:** | **Next Annual Review Date:**<br>2/3/2023; | **Retire Date:** |

**OVERVIEW:** Commonwealth Care Alliance Medicare Advantage Prescription plan considers part-time intermittent home health care services (described below) as reasonable and medically necessary when documentation confirms specific criteria are met.

- Members must be homebound, and services must be ordered under a plan of care established and reviewed regularly by the attending physician caring for the member.

Covered services must be:

- Reasonable and medically necessary based on the member's condition, complexity of requested service(s), and accepted standards of clinical practice.
- An essential part of active treatment of the member's medical or behavioral health condition; AND
- Provided by a home health agency that is accredited/certified by an appropriate accrediting organization.
- Member must be homebound i.e., leaving the home is medically contraindicated or member is confined to home due to an illness, injury or disability that restricts his/her ability to leave home without a considerable and taxing effort.

**DEFINITIONS:**

**CCA – Commonwealth Care Alliance**
**HHA – Home Health Aide**
**MAPD – Medicare Advantage Prescription Plan**
**SW – Social Worker**
**RN – Registered Nurse**
**LPN - Licensed Practical Nurse**

**DECISION GUIDELINES:**

**Clinical Coverage Criteria:**

Commonwealth Care Alliance Medicare Advantage prescription plan considers an episode of care, including part-time/intermittent services (i.e., less than eight hours of combined skilled nursing and home health aide [HHA] services per day, up to 35 hours per week), as reasonable and medically necessary when documentation confirms

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ALL the following:

- The member is homebound (i.e., leaving the home is medically contraindicated or the member is confined to home due to an illness, injury or disability that restricts his/her ability to leave home without a considerable and taxing effort). Exceptions to this criterion may be made only in limited situations where Commonwealth Care Medicare Advantage (in collaboration with the attending provider) determines that:
  - ✓ The member's medical condition prohibits safe travel to a treatment site where medically appropriate care can be furnished, OR
  - ✓ The member's residence is the most clinically appropriate setting for the member to receive needed care or maximize independence.

**NOTE**: In some situations, a service cannot be provided at the residence of a homebound patient because required equipment is not available. If the services required by an individual involve the use of such equipment, the member may receive needed services on an outpatient basis at a hospital, skilled nursing facility or a rehabilitation center, and still be considered homebound if he/she requires the use of supportive devices, special transportation, or the assistance of another person to travel to the appropriate facility.

- Requested services are reasonable and necessary based on the member's condition and an essential part of the active treatment plan developed by the attending physician.
- Skilled services are medically necessary to achieve defined medical goals and expected to improve the patient's condition in a reasonable (and generally predictable) period of time. Documentation of the medical goals of the current home health care plan (e.g., improved mobility, patient/family independence in care), estimated duration of need for the requested services, and member's progress towards established goals (short and long-term) is required.

Commonwealth Care Alliance Medicare Advantage considers skilled nursing services that exceed part-time intermittent services as reasonable and medically necessary for the following:

- **Intravenous, intramuscular, or subcutaneous injections and infusions, and hypodermoclysis or intravenous feedings** require the skills of a licensed nurse to be performed (or taught) safely and effectively.

If a member or caregiver is unable to administer the injection, daily nursing visits (seven days a week) may be considered for up to six months if reasonable and medically necessary. Documentation supporting the need for the extended course of treatment is required.

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**Service-Specific Criteria:**

| Service | Criteria | Additional Information |
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| **Skilled Nursing Services** | Services must require the skills of a registered nurse, or a licensed practical (vocational) nurse working under the supervision of a registered nurse. | Management and evaluation of a member care plan in the home health setting is considered a reasonable and medically necessary skilled service when underlying conditions or complications are such that only a registered nurse can ensure that essential non-skilled care is achieving its purpose; involvement of licensed nurses is required to promote the individual's recover and medical safety in view of the complexity of medically necessary unskilled services and member's overall condition. |
| **Skilled Rehabilitative Services:**<br>• **Physical Therapy (PT) Services**<br>• **Occupational Therapy (OT) Services**<br>• **Speech Therapy (ST), Speech Language Pathology (SLP) Services** | • Services must be of such a level of complexity or the member's condition must require services that can only be safely and effectively performed by a qualified therapist; and<br>• Services must be directly related to a treatment regimen established by the physician and designed to treat the beneficiary's illness or injury. | The amount, frequency and duration of the services must be reasonable and appropriate, and the members' condition must be expected to improve in a reasonable and generally-predictable period of time. |

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| | Services may also be covered when the specialized skills, knowledge and judgment of a qualified therapistare needed to design or establish a safe and effective maintenance program related to a member's unique clinical condition.<br><br>Services may also be considered when the member's clinical condition is so complex that an effective maintenance program must be delivered by the therapist (not an assistant) to ensure the individual's safety. | |
| **Home Health Aide (HHA) Services** | Services are considered only when:<br>• The member requires skilled home health services; and<br>• CCA determines HHA services are essential and directly related to authorized skilled plan of care.<br>• HHA must provide hands on assistance with ADLs i.e., bathing, dressing, following established plan of care | |
| **Medical Social Services** | Services are considered (as appropriate) only when:<br>• The member requires skilled home health services; and<br>• CCA determines medical social services are essential and directly related to authorized skilled plan of care. | |

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| **Nutritional Counseling** | Services are considered (as appropriate) only when:<br>• The member requires skilled home health services; and<br>• CCA determines nutritional counseling services are essential and directly related to authorized skilled plan of care. | |

**LIMITATIONS/EXCLUSIONS:**

Commonwealth Care Alliance Medicare Advantage Prescription Plan does not cover:

- CCA does not pay for home health services provided in a hospital, nursing facility, intermediate care facility for persons with intellectual disabilities, or any other institutional facility setting providing medical, nursing, rehabilitative, or related care.
- Services must be provided in the member's residence. This is wherever the member makes their home. This may be the member's own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution, this also includes a homeless shelter.
- Services may not be provided in Adult Day Health centers, Day Habilitation Centers, dialysis or in combination with any other service or setting that includes any nursing, physical therapy, occupational therapy, speech language pathology, home health aide or medical social worker services Exceptions to this criterion may be made only in limited situations where Commonwealth Care Medicare Advantage (in collaboration with the attending provider) determines that:
  - ✓ The member's medical condition prohibits safe travel to a treatment site where medically appropriate care can be furnished, OR
  - ✓ The member's residence is the most clinically appropriate setting for the member to receive needed care or maximize independence.
- Home health aides (HHA) or homemaking services that are not an essential part of an active, goal-oriented, skilled home health care program
- Homemaking services only
- Custodial care (i.e., services furnished for companionship, maintenance therapy, supervision or primarily to assist a member with personal care)
- Private duty nursing or block nursing services
- When a family member or other caregiver is providing services, including nursing/HHA services, that adequately meet the member's needs, it is not medically necessary for the Home Health Agency to provide such services CCA will not cover medical social services if the member's needs can be met by one of the disciplines of the ICT

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**AUTHORIZATION:**

**Codes are listed below for informational purposes only, and do not guarantee member coverage or provider reimbursement. The list may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible.**

| HCPCS Code | Description |
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| **G0299** | Services provided by a qualified RN in the home health or hospice setting, each 15 minutes |
| **G0151** | Services performed by a qualified physical therapist in the home health or hospice setting, each15 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 |
| **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 |
| **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, each15minutes |
| **99601, 99602 G0088-G0090** | Home Infusion Therapy |

**REGULATORY NOTES / RELATED REFERENCES:**

1. Code of Federal Regulations: Title 42 - Public Health Chapter IV - Centers for Medicare & Medicaid Services – Department of Health and Human Services, subchapter b – Medicare program part 409 - Supplementary medical insurance benefits, Subpart E - Home Health Services Under Hospital Insurance.
2. 42 CFR Part 484 Home Health Services
3. CMS: National Coverage Determination (NCD) for HOME HEALTH Visits to a Blind Diabetic (290.1). Accessed January 12, 2021.
4. CMS: National Coverage Determination (NCD) for HOME HEALTH Nurses' Visits to Patients Requiring Heparin Injection (290.2). Accessed January 12, 2021.
5. CMS NCD) for Institutional and HOME Care Patient Education Programs (170.1). Accessed January 12, 2021.
6. Medicare Benefit Policy Manual; Chapter 7- Home Health Services (Rev. 10738, 05-07-21)
7. Medicare Claims Processing Manual; Chapter 10- Home Health Agency Billing (Rev. 10919, 08-06-21)

**ATTACHMENTS:**

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| **EXHIBIT A:** | |
| **EXHIBIT B** | |

# Medical Necessity Guideline

**REVISION LOG:**

| REVISION DATE | DESCRIPTION |
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**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.

**APPROVALS:**

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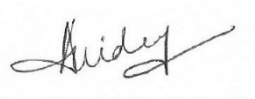
|---|---|
| Avideep Chawla | Director, Utilization Management |
| **CCA Senior Clinical Lead [Print]** | **Title [Print]** |
|  | 2/3/2022 |
| **Signature** | **Date** |
| Doug Hsu, MD | Vice President, Medical Policy & Utilization Review |
| **CCA Senior Operational Lead [Print]** | **Title [Print]** |
|  | 2/3/2022 |
| **Signature** | **Date** |
| Lori Tishler, MD | Senior Vice President, Medical Services |
| **CCA CMO or Designee [Print]** | **Title [Print]** |
|  | 2/3/2022 |

**Signature** **Date**