'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona

WellCare (Alabama, Arizona, Arkansas, California, Connecticut, Florida, Georgia, Illinois, Indiana, Louisiana, Maine, Michigan, Mississippi, Missouri, New Hampshire, New Jersey, New York, North Carolina, Ohio, South Carolina, Tennessee, Texas, Washington)

WellCare Prescription Insurance

WellCare TexanPlus (Medicare – Dallas & Houston markets)

Home Health Services (Medicare)

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APPLICATION STATEMENT

The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

DISCLAIMER

The Clinical Coverage Guideline (CCG) is intended to supplement certain standard WellCare benefit plans and aid in administering benefits. Federal and state law, contract language, etc. take precedence over the CCG (e.g., Centers for Medicare and Medicaid Services [CMS] National Coverage Determinations [NCDs], Local Coverage Determinations [LCDs] or other published documents). The terms of a member's particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member's benefit plan may contain specific exclusions related to the topic addressed in this CCG. Additionally, CCGs relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for the treatment and recommendations provided to the member. The application of the CCG is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations, and any state-specific Medicaid mandates. Links are current at time of approval by the Medical Policy Committee (MPC) and are subject to change. Lines of business are also subject to change without notice and are noted on www.wellcare.com. Guidelines are also available on the site by selecting the Provider tab, then "Tools" and "Clinical Guidelines".

BACKGROUND

Social Security describes home health as a service furnished to an individual, by a home health agency, with a plan of care established and periodically reviewed by a physician, on a visiting basis in the individual's place of residence. Services consist of nursing care, physical, occupational, or speech therapy, medical social services, home health aide services, medical supplies, medical services provided by an intern or resident with agencies affiliated with hospitals, and outpatient services in situations where needed equipment is not available in the individuals place of residence.[1]

There are many benefits to receiving home health. Home health is typically less expensive than hospital or nursing home care and just as effective. It allows for healing in the home setting and helps the recipient regain as much independence as possible. The home health agency responsible for caring for the individual is responsible for meeting their medical, nursing, rehabilitative, social, and discharge planning needs, as noted in their home health plan of care. Home health agencies are required to perform comprehensive assessments of each care need and communicate those needs to the doctor responsible for the plan of care upon admission. After that, home health agencies are required to routinely assess needs.[2]

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Skilled Nursing Care – Skilled nursing services are provided by either a registered nurse (RN) or a licensed practical nurse (LPN). The nurse teaches and manages the care as well as observing progress and evaluating the effectiveness. Examples of skilled nursing care include: giving IV drugs, shots, or tube feedings; changing dressings; and teaching about prescription drugs or diabetes care. Any service that could be done safely by a non-medical person without the supervision of a nurse is not considered skilled nursing care. To qualify for skilled nursing services an individual must have an order from their physician for care relating to a specific condition. There must also be documentation that the individual receiving services is homebound.[2,3]

Physical, Occupational, and Speech-Language Therapy Services – Medicare uses the following criteria to determine if therapy services are reasonable and necessary in the home setting:

1. The therapy services must be a specific, safe, and effective treatment for the condition.
2. The therapy services must be complex such that the condition requires services that can only be safely and effectively performed by, or under the supervision of, qualified therapists.
3. The condition must require one of these:
   a. Therapy that's reasonable and necessary to restore function affected by the illness or injury.
   b. A skilled therapist to safely and effectively establish a program and perform therapy to maintain the current condition or to prevent the condition from worsening.
4. The amount, frequency, and duration of the services must be reasonable.[2]

Medical Social Services – Medicare covers medical social services when an order is provided under the direction of a physician to help with social and emotional concerns that may interfere with treatment or recovery. These services may include counseling or assistance in obtaining community resources. [2,3]

Home Health Aide Services – Services may be covered when given on a part-time or intermittent basis if needed as support services for skilled care. Home health aide services must be part of the care for the applicable illness or injury. Home health aide services are not covered when not used in conjunction with skilled care like nursing services or physical, occupational, or speech-language therapy services from the HH agency.[2,3]

Medical Supplies – Supplies, such as wound dressings, are covered when ordered by the physician as part of the plan of care. Durable medical equipment is paid separately from home health services.[2]

POSITION STATEMENT

Applicable To:

☑ Medicare – All Markets (excluding KY)

Exclusions

The following are not covered services:

- 24 hour a-day home care.
- Home meal delivery.
- Homemaker services (shopping, cleaning, laundry, cooking, etc.)
- Home health aide services (bathing, dressing, toileting, etc.) in the absence of any skilled services.

Coverage

Ongoing (following completed 60 day certification period for same indications) home health services are considered medically necessary when:

1. Member has MD order for home health services; **AND**
2. Continuation of insulin injections is required for a member who is unable to administer insulin themselves and has no willing or able caregiver; **OR,**

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3. Continued need for ongoing services following 60 day certification period
   a. If member has previously finished a 60 day certification period for same indications, request must be sent for secondary review

Initial home health is considered medically necessary when:

1. Member has MD order for home health services; **AND**

2. Member has had a change in health status or health care needs:
   a. Illness/Exacerbation/Injury/Surgery in last 30 days; **OR,**
   b. Discharged from inpatient facility within 5 days; **OR,**
   c. Member requires insulin injections and is unable to administer insulin themselves and has no willing or able caregiver

   AND

3. Member requires skilled intervention:
   a. Adjustments in treatment/care regimen; **OR,**
   b. Adherence assessment; **OR,**
   c. Management and evaluation of current health status; **OR,**
   d. New diagnosis/symptoms

   AND

4. Member/Caregiver is unable to manage care due to:
   a. Cognitive deficit; **OR,**
   b. Knowledge deficit; **OR,**
   c. Physical deficit

   AND

5. Member is homebound due to:
   a. Illness or injury; **OR,**
   b. Need for the aid of supportive devices (cane, crutches, wheelchair, walker, etc.); **OR,**
   c. Need for special transportation; **OR,**
   d. Need for assistance of another person in order to leave their residence; **OR,**
   e. A condition making it contraindicated for them to leave their home.

   AND

6. **Both** of the following must apply:
   a. There must exist a normal inability to leave the home; **AND,**
   b. Leaving the home requires considerable and taxing effort.

   *NOTE – A member can still be considered "homebound" if they are absent from the home infrequently, for short periods of time, or to receive medical treatments not available in the home. Examples include, but are not limited to: attendance at adult day care centers, renal dialysis, outpatient chemo or radiation, or attendance at a religious event. Occasional trips to the barber shop, attendance at a family funeral, graduation, or reunion are examples of infrequent, unique events that do not exclude the member from homebound status.

   AND

7. Member and/or caregiver agree and are able to participate in home based care.

   AND

8. Request is for one of the following:
   a. Episode of Care (EOC)

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b. Non-Episode of Care services, select appropriate disciplines below for review.

When all above criteria are met, review for individual disciplines below, all must be reviewed separately based on request and all applicable criteria must be met for each discipline.

- Skilled Nursing
- Medical Social Worker
- Speech Therapy
- Physical Therapy
- Occupational Therapy
- Home Health Aide

Skilled Nursing is considered medically necessary when the following is needed:

1. Treatments ordered by MD requiring advanced medical skills (i.e. wound care, blood pressure monitoring, insulin injections, catheter change); **OR,**
2. Teaching; **OR,**
3. Assessment

Medical Social Worker is medically necessary when a member needs one of the following:

1. Assessment of home environment, financial or community resources; **OR,**
2. Assistance with obtaining community services; **OR,**
3. Long term planning.

Speech therapy is considered medically necessary when:

1. Treatments ordered by MD requiring advanced medical skills; **OR,**
2. Teaching (i.e. swallowing techniques, expressive language techniques); **OR,**
3. Assessment

Physical and Occupational Therapy is considered medically necessary when:

1. Treatments ordered by MD requiring advanced medical skills; **OR,**
2. Teaching (i.e. safe transfers); **OR,**
3. Assessment

Home Health Aide is considered medically necessary when:

1. Member is receiving skilled nursing, physical therapy, occupational therapy, or speech therapy; **AND,**
2. Member requires assistance with ADLs and/or IADLs

CODING

Covered CPT®* Codes *This list may not be all inclusive.*

Physical Therapy (revenue code 042x)

G0151 Services performed by a qualified physical therapist in the home health or hospice setting, each 15 mins
G0157 Services performed by a qualified PT assistant in the home health or hospice setting, each 15 mins
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 mins

Occupational Therapy (revenue code 043x)

G0152 Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 mins
G0158 Services performed by a qualified OT assistant in the home health or hospice setting, each 15 mins
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 mins

Speech-Language Pathology (revenue code 044x)

G0153 Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 mins

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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 mins

Note that modifiers indicating services delivered under a therapy plan of care (modifiers GN, GO or GP) are not required on HH PPS claims.

Skilled Nursing (revenue code 055x)

General skilled nursing:
For dates of service before January 1, 2016:
G0154 Direct skilled services of a licensed nurse (LPN or RN) in the home health or hospice setting, each 15 mins

For dates of service on or after January 1, 2016. Visits previously reported with G0154 are reported with one of the following codes:
G0299 Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting
G0300 Direct skilled nursing of a licensed practical nurse (LPN) in the home health or hospice setting.

Care plan oversight:
For dates of service before January 1, 2017:
G0162 Skilled services by a licensed nurse (RN only) for management and evaluation of the plan of care, each 15 minutes (the patient'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).
G0163 Skilled services of a licensed nurse (LPN or RN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting).

For dates of service on or after January 1, 2017, HHAs report visits previously reported with G0163 with one of the following codes:
G0493 Skilled services of a registered nurse (RN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient'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 patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting).

Training:
For dates of service before January 1, 2017:
G0164 Skilled services of a licensed nurse (LPN or RN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes.

For dates of service on or after January 1, 2017, HHAs report visits previously reported with G0164 with one of the following codes:
G0495 Skilled services of a registered nurse (RN), in the training and/or education of a patient 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.

Medical Social Services (revenue code 056x)
G0155 Services of a clinical social worker under a home health plan of care, each 15 minutes.

Home Health Aide (revenue code 057x)
G0156 Services of a home health aide under a home health plan of care, each 15 minutes.

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

REFERENCES

1. Compilation of the Social Security laws: part E (miscellaneous provisions. Social Security Web Site. https://www.ssa.gov/OP_Home/ssact/title18/1861.htm. Accessed April 2, 2019.
2. Department of Health and Human Services. Medicare and home health care. Revised March 2017. Available from https://www.medicare.gov/Pubs/pdf/10969-Medicare-and-Home-Health-Care.pdf. Accessed April 2, 2019.
3. Medicare benefit policy manual: chapter 7 (home health services. Centers for Medicare and Medicaid Services Web site. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c07.pdf. Published November 5, 2015. Accessed April 10, 2018.
4. Medicare Claims Processing Manual Chapter 10 - Home Health Agency Billing. Centers for Medicare and Medicaid Services Web site. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf. Accessed April 2, 2019.

MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

Date	Action
4/4/2019, 5/3/2018	• Approved by MPC. No changes.
6/28/2017	• Approved by MPC. New.