NO. 91023

HOME CARE

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Instructions for use: This document is for informational purposes only. Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable. Eligibility and benefit coverage are determined in accordance with the terms of the member's plan in effect as of the date services are rendered. It is not an authorization, certification, explanation of benefits, or contract. Receipt of benefits is subject to satisfaction of all terms and conditions of coverage. Priority Health's medical policies are developed with the assistance of medical professionals and are based upon a review of published and unpublished information including, but not limited to, current medical literature, guidelines published by public health and health research agencies, and community medical practices in the treatment and diagnosis of disease. Because medical practice, information, and technology are constantly changing, Priority Health reserves the right to review and update its medical policies at its discretion. Priority Health's medical policies are intended to serve as a resource to the plan. They are not intended to limit the plan's ability to interpret plan language as deemed appropriate. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment they choose to provide.

Policy scope: This policy outlines general considerations for home care services, including intermittent skilled nursing, rehabilitative therapies and other medically necessary services provided in the home setting.

Related policies:

- Rehabilitative Medicine Services No. 91318
- Speech Therapy No. 91336
- Surgical Dressings and Wound Care Supplies No. 91650
- Telemonitoring / Remote Monitoring No. 91604
- Infusion Services and Equipment No. 91414

I. MEDICAL NECESSITY CRITERIA

A. Home Health Care

1. Intermittent Skilled Services

Inclusions:

Intermittent skilled services may be considered medically necessary as home health services when **all** of the following criteria are met:

- **a.** Services are furnished in the home by a certified home health care agency; and
- **b.** The services are provided by a registered nurse (RN), physical therapist (PT), occupational therapist (OT), respiratory therapist (RT), or speech language pathologist (SLP); and
- **c.** Services are provided according to members established plan of care that is periodically reviewed by one of the following: Physician, Physician assistant (PA), Nurse practitioner (NP), or Clinical nurse specialist (CNS); and
- **d.** Services are provided on an intermittent basis.

Limitations:

- **a.** Intermittent care is limited to 2-4 hours of medically necessary skilled care administered in a 24-hour period.
- **b.** Extended services must be recommended by the physician and approved Priority Health when, because of unusual circumstances, neither the alternative part-time care nor institutionalization is feasible.

Exclusions:

The following are not medically necessary as home health services:

- **a.** Custodial and Maintenance Care:
  - **i.** Any care a member receives (if, in Priority Health's opinion) when the member has reached the maximum level of mental and/or physical function and the member will not improve significantly more.
  - **ii.** Custodial care, even if the member receives home health care services along with custodial care.
- **b.** 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.
- **c.** Homemaker services.
- **d.** 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.
- **e.** Services that can be safely and more cost effectively provided in an alternative setting, such as an office, clinic, or infusion center.
- **f.** Services or supplies not specified in the home care plan.

g. Services of a person who ordinarily resides in the patient's home or is a member of the patient's family.
h. A member expected to need full-time skilled nursing care over an extended period of time would not qualify for home care benefits.

2. Wound Care

Inclusions:

Home wound care services may be considered medically necessary for:
a. Wound care evaluation and treatment (e.g., debridement, dressing selection)
b. Non-healing wounds, when supported by:
i. Evaluation at a wound clinic or consultation with a certified wound care nurse; and
ii. Documentation of treatment changes in the wound regime.

B. Home Physician Services

1. Home Physician Services

Inclusions:

Home physician services may be considered medically necessary for the following:
a. Intermittent, non-urgent physician services; **and**
b. Services are furnished in the home by a physician or home physician agency.

C. Skilled or Rehabilitative Care

1. Intermittent Skilled Nursing

Inclusions:

Intermittent skilled nursing care may be considered medically necessary when **all** of the following are met:
a. The services are performed by a registered nurse (RN)
b. The service requires clinical judgment and cannot be safely performed by a non-medical individual.
i. Examples include:
1) Assessment and monitoring of unstable conditions
2) Intravenous therapy or injections

3) Complex wound care
4) Skilled teaching and training

ii. 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 non-medical person, without the direct supervision of a nurse, the service cannot be regarded as a skilled nursing service.

2. **Physical, Occupational, and Speech Therapy Services**

Inclusions:

Physical, occupational, and speech therapy services provided in the home may be considered medically necessary when **all** of the following are met:

a. The services are provided by a certified Home Health Agency; and
b. The member meets the medical necessity criteria under the applicable therapy policy.
   i. See medical policies:
      1) Speech Therapy No. 91336
      2) Rehabilitative and Habilitative Medicine Services No. 91318

Limitations:

a. Subject to the applicable therapy policy and member benefit limitations.
b. Each physical, occupational or speech therapist visit will be considered one visit when determining contract limits or member copayments.

3. **Medical Social Services**:

Inclusions:

Medical social services provided in the home may be considered medically necessary when **all** of the following are met:

a. The member has in home medical social services coverage benefits; and
b. Services are provided by a qualified medical social worker, under the supervision of a registered nurse (RN), physical therapist (PT),

occupational therapist (OT), or speech language pathologist (SLP); and

c. 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.

Exclusions:

a. For Medicaid/Healthy Michigan Plan members, home health medical social worker services are not eligible under benefit design.

4. **Home Health Aides**:

Inclusions:

Home health aide services may be considered medically necessary as home health services when **all** of the following are met:

a. The member has home health aide services coverage benefits; and

b. Services are provided by a trained home health aide, under the supervision of a registered nurse (RN), physical therapist (PT), occupational therapist (OT), respiratory therapist (RT), or speech language pathologist (SLP); and

c. Services are provided on a short-term, intermittent basis; and

d. Services are necessary for the treatment of the member's illness or injury; and

e. The services provided are needed to maintain the member's health or to facilitate treatment of the member's illness or injury.

i. Medically necessary services when the above conditions are met may include:

1) Simple dressing changes

2) Assistance with medications which ordinarily are self-administered

3) 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

4) Routine care of prosthetic and orthotic devices

Note: Home health aide services may be appropriate when they support safe management of the member's condition in the home and are reasonably expected to reduce avoidable utilization of higher levels

of care, such as inpatient hospitalization or repeated emergency department visits.

Exclusions:

The following home health aide services are considered not medically necessary:

a. Custodial care services

5. **Registered Dietician**:

Inclusions:

Registered dietician services provided may be considered medically necessary as home health services when:

a. The member has **home** care registered dietician services coverage benefits; and
b. Services are provided by a registered dietician, under the supervision of a registered nurse (RN); and
c. Services are needed to furnish dietetic or nutritional services; and
d. Services are needed on an intermittent basis; and
e. Services are necessary for the treatment of the member's illness or injury; and
f. The services provided are needed to maintain the member's health or to facilitate treatment of the member's illness or injury.

Exclusions:

a. For Medicaid/Healthy Michigan Plan members, registered dietitian home health services are not eligible under benefit design.

D. Medical Supplies

Limitations:

1. Medical supplies (e.g., dressings) are provided under the DME/Supplies benefit separate from the Home Care benefit.
2. Supplies must be prescribed by a physician and obtained from a DME provider.

E. Hospice Services

1. **Refer to** *Hospice Care Billing Policy No. 085*

F. Telemonitoring Services

1. **Refer to** *Telemonitoring / Remote Monitoring Medical Policy* No. 91604

G. General Policy Provisions

1. Prior hospitalization for the same or related condition is not required.
2. Services may be required to be provided in a setting other than the home (e.g., outpatient) if the patient is not homebound.
3. Case management should be provided to specify limits and initiate ongoing review of patient's status

II. CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) COVERAGE DETERMINATION

Any applicable federal or state mandates will take precedence over this medical coverage policy.

Medicare: Refer to the CMS Online Manual System (IOMs) and Transmittals.
For the most current applicable CMS National Coverage Determination (NCD)/Local Coverage Determination (LCD)/Local Coverage Article (LCA) refer to CMS Medicare Coverage Database.

The information below is current as of the review date for this policy. However, the coverage issues and policies maintained by CMS are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. MAC jurisdiction for purposes of local coverage determinations is governed by the geographic service area where the Medicare Advantage plan is contracted to provide the service. Please refer to the Medicare Coverage Database website for the most current applicable NCD, LCD, LCA, and CMS Online Manual System/Transmittals.

National Coverage Determinations (NCDs)	
None Identified	
Local Coverage Determinations (LCDs)	
CGS Administrators, LLC	LCD - Physical Therapy - Home Health (L33942)
First Coast Service Options, Inc.	None Identified
Wellpoint Federal (formerly National Government Services, Inc.)	None Identified
Noridian Healthcare Solutions	None Identified
Novitas Solutions, Inc.	None Identified
Palmetto GBA	LCD - Home Health Physical Therapy (L34564) LCD - Home Health Occupational Therapy (L34560)

	LCD - Home Health Speech-Language Pathology (L34563)
WPS Insurance Corporation	None Identified

III. BACKGROUND

Home Health Care

Home health care services are health care services furnished in the member's place of residence for the treatment of an illness or injury when the member requires medically necessary, part-time or intermittent skilled care and the services are included in an established plan of care. Home health services may include skilled nursing, physical therapy, occupational therapy, speech-language pathology services, medical social services, and part-time or intermittent home health aide services when criteria are met. Medicare describes home health services as services provided for an illness or injury to help a member improve, maintain function, or slow the rate of decline when applicable home health eligibility requirements are met (Centers for Medicare & Medicaid Services [CMS], 2023; Medicare.gov, n.d.).

Home health care is generally intended to provide skilled, medically necessary services in the home when the member's clinical condition, functional status, and plan of care support the need for home-based care. Services should be individualized, goal-directed, periodically reviewed, and furnished by qualified professionals practicing within their scope of practice. Ongoing services should continue only while skilled care remains medically necessary and should be transitioned to self-care, caregiver-assisted care, outpatient services, or another appropriate setting when the member's condition can be safely and effectively managed without skilled home health services (CMS, 2023; Medicare.gov, n.d.).

A member receiving home health services generally must require skilled care on an intermittent basis and, when applicable by benefit design, meet homebound requirements. A member does not need to be bedridden to be considered homebound; however, leaving the home must require a considerable and taxing effort due to illness, injury, need for assistive devices, special transportation, assistance of another person, or because leaving the home is medically contraindicated. Occasional absences from the home for medical treatment or short, infrequent non-medical reasons do not necessarily preclude homebound status (CMS, 2023; Medicare.gov, n.d.).

Home health services are commonly delivered through an interdisciplinary model of care that evaluates medical, functional, psychosocial, environmental, and caregiver-related factors that may affect a member's health and ability to safely remain in the home. Comprehensive home-based assessments may facilitate identification of unmet healthcare and social needs, support care coordination, and reduce avoidable utilization of higher-acuity services (Better Medicare Alliance, 2024; CMS, 2017).

Intermittent Skilled Services
Skilled care refers to services that require the clinical knowledge, judgment, and skill of a licensed health care professional and cannot be safely or effectively performed by the member, caregiver, or an average non-medical person. The determination of whether a service is skilled considers both the inherent complexity of the service and the member's clinical condition. A service is not considered skilled solely because it is performed by, or under the supervision of, a licensed professional (CMS, 2023).

Intermittent skilled services may include skilled nursing, physical therapy, occupational therapy, respiratory therapy, speech-language pathology services, or other skilled services furnished under an established plan of care. These services are generally short-term and treatment-focused, with the goal of improving, maintaining, or preventing deterioration in the member's functional or clinical condition when such services require skilled professional involvement (CMS, 2023; Medicare.gov, n.d.).

Custodial and maintenance care is distinct from skilled care. Custodial care generally refers to services primarily intended to assist with activities of daily living, supervision, companionship, homemaker tasks, or long-term care needs when skilled clinical judgment is not required. Examples may include routine bathing, dressing, feeding, toileting, meal preparation, medication reminders for medications that can be self-administered, housekeeping, or general supervision when these services are not part of a medically necessary skilled plan of care. Medicare does not pay for homemaker services unrelated to the care plan or custodial/personal care when that is the only care needed (CMS, 2023; Medicare.gov, n.d.).

Wound Care
Home wound care services may be medically necessary when the wound requires skilled assessment, treatment planning, dressing selection, debridement, monitoring for complications, or modification of the treatment plan based on the member's clinical response. Examples may include pressure injuries, surgical wounds, diabetic ulcers, venous or arterial ulcers, traumatic wounds, or other wounds requiring skilled intervention. CMS identifies wound care as a skilled nursing service when the complexity of the wound, treatment, or member's condition requires skilled nursing involvement (CMS, 2023; Medicare.gov, n.d.).

Routine or maintenance wound care that can be safely performed by the member or caregiver generally does not require skilled home health care. The need for skilled wound care should be supported by documentation of the wound's clinical status, treatment plan, response to treatment, and any need for ongoing skilled assessment or modification of care (CMS, 2023).

Home Physician Services
Home physician services may include intermittent, non-urgent physician services furnished in the member's home when clinically appropriate. These services may be

used when the member's condition, functional status, or care needs support evaluation or management in the home setting. Home physician services should be distinct from emergent care and should be furnished in accordance with the member's clinical needs and applicable benefit requirements.

Skilled or Rehabilitative Care

Rehabilitative care refers to skilled services directed toward improving, restoring, maintaining, or preventing decline in physical, cognitive, communication, swallowing, or functional abilities that have been impaired due to illness, injury, surgery, neurologic condition, congenital condition, or other medical diagnosis. Rehabilitative services may include physical therapy, occupational therapy, and speech-language pathology services when there is a treatment plan, measurable goals, and the services require the skills of a qualified professional. Medicare recognizes that home health services may be used to help a member improve, maintain function, or slow decline when home health eligibility requirements are met (CMS, 2023; Medicare.gov, n.d.).

Intermittent Skilled Nursing

Skilled nursing services in the home may include assessment and monitoring of an unstable condition, observation and evaluation when a significant change in condition is expected, management and evaluation of a care plan, teaching and training activities, medication administration, intravenous therapy, catheter care, complex wound care, ostomy care, tube feeding, respiratory care, and other services requiring nursing judgment. Home health nursing is generally intended to be treatment-focused, with transition to self-care, caregiver-assisted care, outpatient care, or another appropriate setting when the member's condition permits (CMS, 2023).

The American Nurses Association identifies nursing scope and standards as the framework for safe, competent nursing practice, including assessment, planning, implementation, evaluation, care coordination, education, advocacy, and quality improvement. These professional standards support the role of registered nurses in evaluating clinical status, coordinating care, educating members and caregivers, and providing skilled interventions when the member's condition requires nursing judgment (American Nurses Association [ANA], 2014; CMS, 2023).

Home health nurses also play an important role in medication management, medication reconciliation, care transitions, patient and caregiver education, and coordination of services among multiple providers. Medication reconciliation is recognized as an important patient safety activity that helps identify medication discrepancies, reduce adverse drug events, and improve continuity of care during transitions between care settings (American Physical Therapy Association Academy of Home Health [APTA] Home Health, 2023b; CMS, 2023).

Physical Therapy

Physical therapy services in the home are directed toward improving or restoring mobility, strength, balance, endurance, transfers, gait, functional movement, safety, and the member's ability to participate in daily activities. Physical therapy may be appropriate after injury, illness, surgery, hospitalization, neurologic impairment, musculoskeletal impairment, cardiovascular disease, pulmonary disease, or functional decline when the member requires skilled assessment and treatment in the home setting. The American Physical Therapy Association's (APTA) Guide to Physical Therapist Practice identifies physical therapists as movement experts who evaluate impairments, functional limitations, participation restrictions, and environmental factors to develop individualized treatment plans designed to improve function and safety (APTA, 2023a).

Home-based physical therapy may also include fall prevention, medication reconciliation, caregiver education, chronic disease self-management, and care coordination activities. APTA Home Health additionally recognizes physical therapy as an important component of home-based management for individuals with heart failure through exercise prescription, symptom monitoring, mobility training, and self-management education (APTA Home Health, 2023b; DeLorm et al., 2022).

Occupational Therapy

Occupational therapy services in the home focus on improving or maintaining a member's ability to safely and independently perform activities of daily living, instrumental activities of daily living, functional mobility, health management activities, community participation, and other meaningful life roles. Occupational therapy may be appropriate when illness, injury, disability, cognitive impairment, sensory impairment, vestibular dysfunction, neurologic disease, or functional limitations interfere with participation in daily activities or the ability to function safely within the home environment (American Occupational Therapy Association [AOTA], n.d.; Standards of Practice for Occupational Therapy, 2021).

Occupational therapists evaluate physical, cognitive, psychosocial, sensory, environmental, and occupational performance factors that affect a member's ability to function safely and independently. Interventions may include therapeutic activities, adaptive techniques, upper-extremity rehabilitation, cognitive rehabilitation, caregiver training, fall prevention strategies, home safety evaluations, environmental modifications, and recommendations for assistive technologies and durable medical equipment to improve safety and participation in daily activities (Standards of Practice for Occupational Therapy, 2021; Inclusive Environments, 2022).

The American Occupational Therapy Association publishes evidence-based practice guidelines and professional standards supporting occupational therapy services for individuals with stroke, Parkinson disease, multiple sclerosis, vestibular disorders, chronic pain, traumatic brain injury, and other conditions that may affect function, mobility, safety, and quality of life (Cunningham et al., 2022; Hildebrand et al., 2023; Wood et al., 2022). Occupational therapists may also assist individuals with chronic pain

through activity modification, self-management strategies, environmental adaptation, and functional participation interventions (Role of Occupational Therapy in Pain Management, 2021).

The American Occupational Therapy Association (AOTA) recognizes occupational therapy as an important component of vestibular rehabilitation and management of balance, dizziness, visual-vestibular dysfunction, fall risk, and community participation limitations. Occupational therapists also play an important role in helping members adapt to functional limitations, optimize performance within the home environment, and promote participation in meaningful occupations and routines across the lifespan (American Occupational Therapy Association [AOTA], 2025; Standards of Practice for Occupational Therapy, 2021).

Speech-Language Pathology Services

Speech-language pathology services in the home may address communication, cognition, voice, motor speech, swallowing, feeding, and other speech-language or related functional impairments caused by illness, injury, neurologic disease, surgery, developmental conditions, or other medical conditions. Speech-language pathology services may be appropriate when skilled assessment, treatment, compensatory strategy training, caregiver education, or swallowing safety intervention is required in the home setting (American Speech-Language-Hearing Association (ASHA), n.d. -a; American Speech-Language-Hearing Association, n.d.-b).

American Speech-Language-Hearing Association (ASHA) identifies speech-language pathologists as preferred providers for dysphagia services and integral members of the interprofessional team for diagnosis and management of oral and pharyngeal dysphagia. Dysphagia intervention may include swallowing exercises, compensatory strategies, posture modifications, diet or bolus consistency modification, and patient or caregiver education (ASHA, n.d.-a). Rehabilitative speech-language pathology services are intended to improve, restore, maintain, or prevent decline in communication, cognitive-communication, feeding, and swallowing abilities that affect safety, independence, and daily functioning (ASHA, n.d.-c).

American Speech-Language-Hearing Association (ASHA) also supports provision of home-based speech-language pathology services when communication, cognitive-communication, speech, language, feeding, or swallowing impairments affect health, safety, independence, or participation and when the home environment is an appropriate setting for intervention, caregiver training, and functional skill development (ASHA, 2022; ASHA, n.d.-b).

Medical Social Services

Medical social services may be appropriate when social, emotional, behavioral, environmental, financial, or caregiver-related factors are expected to interfere with the

member’s treatment plan, recovery, safety, or ability to remain in the home setting. Medical social workers may assist with psychosocial assessment, care coordination, counseling, resource identification, discharge planning, caregiver support, and addressing barriers to adherence with the plan of care. The National Association of Social Workers publishes practice standards and guidelines, including standards for social work practice in health care settings and case management, which describe benchmarks for social work services and expected professional practice (National Association of Social Workers [NASW], n.d.-a; NASW, n.d.-b).

Registered Dietitian Services

Registered dietitian services may be appropriate in the home setting when nutrition assessment, medical nutrition therapy, disease-specific nutrition counseling, nutrition support monitoring, diet modification, or caregiver education is necessary for treatment of the member's illness or injury. Registered dietitians may support care for members with malnutrition, heart failure, diabetes, chronic kidney disease, gastrointestinal disorders, pulmonary disease, enteral or parenteral nutrition needs, wounds, frailty, and other conditions where nutrition directly affects clinical outcomes. The Academy of Nutrition and Dietetics develops evidence-based nutrition practice guidelines and professional resources that support nutrition assessment, intervention, monitoring, and evaluation across a broad range of medical conditions (Academy of Nutrition and Dietetics, n.d.; Commission on Dietetic Registration, 2024).

Home Health Aide Services

Home health aide services provide short-term, intermittent support services under the supervision of an appropriate skilled professional, such as an RN, PT, OT, or SLP, when the services are necessary to support treatment of the member’s illness or injury and are included in the plan of care.

Home health aide services are intended to support safe management of a member's condition in the home setting and may help reduce avoidable utilization of higher levels of care, such as inpatient hospitalization or repeated emergency department visits.Home health aide services may include assistance with personal care or activities that support skilled services, such as simple dressing changes, assistance with ordinarily self-administered medications, assistance with activities directly supportive of skilled therapy, and routine care of prosthetic or orthotic devices (Medicare.gov, n.d.; 42 C.F.R. § 484.80, 2026).

Federal home health aide requirements include training and competency standards and require aides to be able to observe, report, and document patient status and the care furnished. Home health aide services are distinct from homemaker, companion, or custodial services when the aide services are tied to the treatment of the member’s illness or injury, provided under supervision, and included in the plan of care (42 C.F.R. § 484.80, 2026; Medicare.gov, n.d.).

IV. GUIDELINES / POSITION STATEMENTS

Medical/Professional Society	Guideline
American Nurses Association	Nursing Scope and Standards of Practice | ANA (2014)
American Physical Therapy Association APTA Home Health, an Academy of the American Physical Therapy Association	THE GUIDE TO PROVIDING PHYSICAL THERAPY IN THE HOME (2023) Medication Reconciliation in Home Health Physical Therapy (2023) PAIN MANAGEMENT IN HOME HEALTH PRACTICE (2018) Physical Therapy Management of the Patient with Heart Failure in the Home Setting (2022)
American Occupational Therapy Association	Vestibular Rehabilitation and the Role of Occupational Therapy (2025) Inclusive Environments: Home, Work, Public Spaces, Technology, and Specialty Environments within Occupational Therapy Practice (2022) Occupational Therapy Practice Guidelines for Adults with Stroke (2023) Occupational Therapy Practice Guidelines for People with Parkinson's Disease (2022) Occupational Therapy Practice Guidelines for Adults with Multiple Sclerosis (2022)
American Speech-Language-Hearing Association	Adult Dysphagia (n.d.) Rehabilitative Habilitative Services Devices (2015) Guidelines for Referring to SLP Services: Adult Home Health Care (n.d.) Speech-Language Pathology Services in the Home (Early Intervention) (2022)

National Association of Social Workers	NASW LTSS standards public comment draft June 2026
Electronic Code of Federal Regulations	484.80 Condition of participation: Home health aide services (2026) Medicare and Medicaid Program: Conditions of Participation for Home Health Agencies (2017)
Academy of Nutrition and Dietetics	Evidence-Based Nutrition Practice Guidelines (n.d.)
Commission on Dietetic Registration	Revised 2024 Scope and Standards of Practice for the Registered Dietitian Nutritionist

V. REGULATORY (US FOOD AND DRUG ADMINISTRATION)

See U.S. Food & Drug Administration (FDA) Medical Device Databases for the most current information.

VI. CODING

See also:
Priority Health Home Health- Billing Policy No. 066
Priority Health Hospice Care- Billing Policy No. 085
Priority Health Home Infusion- Billing Policy No. 042
Priority Health Telemedicine/Virtual Services- Billing Policy No. 170

ICD-10 Codes that may support medical necessity
Various – report condition that best supports skilled service.

CPT/HCPCS Codes
Report for physician services - (HCFA 1500 claim form)

99341	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
99342	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

99344	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
99345	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.
99347	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
99348	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99349	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
99350	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

CPT Codes applicable to Medicare Members only:

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
G0181	Physician or allowed practitioner supervision of a patient receiving Medicare-covered services provided by a participating home health

agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician or allowed practitioner development and/or revision of care plans

G0318 Prolonged home or residence evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to cpt codes 99345, 99350 for home or residence evaluation and management services). (do not report G0318 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 99417). (do not report G0318 for any time unit less than 15 minutes)

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

Skilled Home Care 0270	DME/ Supplies – *not payable to HH agency – use DME provider*
421 - 429	Physical Therapy
431 - 439	Occupational Therapy
441 - 449	Speech-Language Pathology
551 – 559	Skilled Nursing
0560 – 0569	Social Worker
0570 – 0571	Certified Home Health *Aide (Refer to plan documents for coverage)*
0589	Dietician

VII. MEDICAL NECESSITY REVIEW

Prior authorization for certain drugs, devices, services and procedures may or may not be required. In cases where prior authorization is required, providers will submit a request demonstrating that a drug, service or procedure is medically necessary. For more information, refer to the Priority Health Provider Manual.

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

Individual case review may allow coverage for care or treatment that is investigational yet promising for the conditions described. Requests for individual consideration require prior plan approval. All determinations of coverage for experimental, investigational, or unproven treatment will be made by a Priority Health medical director or clinical pharmacist. The exclusion of coverage for experimental, investigational, or unproven treatment may be reviewed for exception if the condition is either a terminal illness, or a chronic, life threatening, severely disabling disease that is causing serious clinical deterioration.

VIII. APPLICATION TO PRODUCTS

Coverage is subject to the 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. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual, the Michigan Medicaid Provider Manual will govern. If there is a discrepancy or lack of guidance in the Michigan Medicaid Provider Manual, the Priority Health contract with Michigan Medicaid will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.

IX. REFERENCES

Society and Professional Guidelines

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SUMMARY OF CHANGES

Deletions:

- Removed PA language in the medical necessity criteria for home physician services.
- Removed retired palliative care medical policy link.

Additions:

- Added examples of skilled nursing services, under "intermittent skilled nursing" section.

Changes:

- Converted policy to new template with relevant sections added.
- Updated format to relevant sections: inclusions, limitations, exclusions.
- Updated related medical policy names and links.
- Updated background and references.
- Relocated section "B" Non-covered services to appropriate sections in medical policy.

Clarifications:

- Language updated for clarity.

Past committee review dates: 01/1993, 12/1999, 12/2001, 11/2002, 11/2003, 11/2004, 05/2005, 04/2006, 04/2007, 07/2007, 04/2008, 04/2009, 06/2009, 06/2010, 06/2011, 06/2012, 06/2013, 05/2014, 05/2015, 05/2016, 05/2017, 02/18, 11/2018, 11/2019, 11/2020, 08/2021, 08/2022, 08/2023, 08/2024, 08/2025, 08/2026

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