Priority Health

MEDICAL POLICY
No. 91023-R14

HOME CARE

Effective Date: September 1, 2025	**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, 11/19, 11/20, 8/21, 8/22, 8/23, 8/24, 8/25**
Date Of Origin: June 30, 1988	**Status: Current**

Related policies:

- *Palliative Care #91558*
- *Rehabilitative Medicine Services #91318*
- *Speech Therapy #91336*
- *Telemedicine/Virtual Services #91604*

Summary of Changes

- Change:
  - Removed prior authorization requirement for services provided by home health care agencies.
  - Removed Medicaid exclusion for home physician services.

I. POLICY/CRITERIA

A. Covered Services

1. Home Health Care

a. **Intermittent skilled services** furnished in the home by a home health care agency when services are provided by a registered nurse, physical therapist, occupational therapist, respiratory therapist, or speech therapist under a plan of care established and periodically reviewed by a Physician, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS).

i. 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 Priority Health when, because of unusual circumstances, neither the alternative part-time care nor institutionalization is feasible.

b. **Wound Care:**

i. Evaluation and treatment (e.g., debridement, dressing) for wound care.

ii. For non-healing wounds:

1. Visit to wound clinic or consultation with a certified wound care nurse.
2. Documentation of change in the wound regime.

2. Home Physician Services

a. Intermittent, non-urgent physician services approved in advance by Priority Health and furnished in the home by a physician or home physician agency.
    i. Prior authorization is not required for home physician services provided by the member's PCP or for Priority Medicare members.
    ii. All other home physician services require prior authorization.

3. Skilled or rehabilitative care:
The following services may be covered when ordered for skilled or rehabilitative care:

a. **Intermittent nursing** care by a registered nurse (RN). 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.
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. Each visit by a physical, occupational or speech therapist will be considered one visit when determining contract limits or member copayments.
c. **Medical social services**: Only covered if specified in the member's coverage documents. When covered, are provided by a qualified medical social worker, under the supervision of an RN, PT, OT, or ST 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**:
    i. 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 RN, PT, OT, or ST 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.
    ii. 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.

iii. 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 and 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.

4. **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.
5. **Hospice services and palliative care services:** See *Hospice Care #91520* and *Palliative Care #91558* policies.
6. **Telemonitoring services**: See *Telemedicine/Virtual Services #91604*.
7. Prior hospitalization for the same or related condition is not required.
8. Services may be required to be provided in a setting other than the home (e.g., outpatient) if the patient is not homebound.

B. Non covered services

1. Custodial and Maintenance Care:
   a. 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.
   b. Custodial care is not covered, even if the member receives home health care services along with custodial care.
2. 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.
3. Homemaker services.
4. 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.

5. Services that can be safely and more cost effectively provided in an alternative setting, such as an office, clinic, or infusion center.
6. Services or supplies not specified in the home care plan.
7. Services of a person who ordinarily resides in the patient's home or is a member of the patient's family.
8. For Medicaid/Health Michigan Plan members: Medical Social Worker and Registered Dietician are not covered.
9. A member expected to need full-time skilled nursing care over an extended period of time would not qualify for home care benefits.

Special Notes:

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

II. MEDICAL NECESSITY REVIEW

Prior authorization for certain drug, 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, please refer to the Priority Health Provider Manual.

Authorization for services provided by in-network home health agencies is not required.

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) and/or the Evidence of Coverage (EOC); 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

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 careis defined as care received by a member whenthe 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 for treatment of medical diagnoses if due to:

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

Short-term rehabilitative therapy services::

- Can be received as an outpatient or in the home, ***and***
- It can reasonably be expected to improve the member's condition within 90 days of the start date of therapy, as determined by Priority Health in consultation with the member's 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 when there is a treatment plan with expected restoration of function when necessary for diagnosis and treatment of speech and language disorders which result in communication disabilities .

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 because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence or have a condition such that leaving his or her home is medically contraindicated. Additionally, there must exist a normal inability to leave home and leaving home must require a considerable and taxing effort.

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.

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 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.

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

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 *(not covered for Medicaid)*
0570 – 0571	Certified Home Health *Aide (not covered for commercial plans)*
0589	Dietician *(not covered for Medicaid)*

Early Maternity Discharge Program	
552	Skilled Nursing - Hourly Charge
993	Patient Convenience Items – Telephone

IV. REFERENCES

1. Centers for Medicare and Medicaid. Medicare Benefit Policy Manual. Chapter 7. Home Health Services. Rev. 11447, 06-06-22.