naviHealth	MEDICAL POLICY MPC.01.004 – Home Health Coverage Guidelines		
	Original Issue Date: 08/29/2023	Most Current Revision Date: 08/29/2023	# of Pages: 5

I. Purpose:

To provide clinical coverage guidelines for continued care in a home health setting. Coverage guidelines are to be used with the member's eligibility and benefits as established by the health plan.

II. Definitions

Allowed Practitioner – Allowed practitioners are defined at § 484.2 as a physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) as defined at this part. NPs, CNSs, and PAs are required to practice in accordance with state law in the state in which the individual performs such services. (Medicare Benefit Policy Manual Chapter 7 Section 30.2.1)

Care Plan Certification - Attending provider signed or verbal order counter signed by accepting Home Health SOC clinician and submitted to naviHealth for medical necessity review.

- CFR 484.60 Condition of participation: Care planning, coordination of services, and quality of care. *Standard Plan of care:* Each beneficiary must receive the home health services that are written in an individualized plan of care that identifies beneficiary-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a Doctor of Medicine, osteopathy, or podiatry or Allowed Practitioner acting within the scope of his or her state license, certification, or registration.

Homebound Status (Medicare Benefit Policy Manual Chapter 7 - Home Health Services)

- Per §1814(a) and §1835(a) of the Act, an individual shall be considered "confined to the home" for a beneficiary to be eligible to receive covered home health services
- The beneficiary may be considered homebound if absences from the home are, infrequent; for periods of relatively short duration; for the need to receive health care treatment; for religious services; to attend adult daycare programs; or for other unique or infrequent events (i.e., funeral, graduation, trip to the barber).

III. Applicable lines of Business

Medicare

IV. Coverage Criteria

To qualify for the Medicare home health benefit, under §§1814(a)(2)(C) and 1835(a)(2)(A) of the Act, a Medicare beneficiary must meet all the following requirements:

- Be homebound under the care of a physician or Allowed Practitioner;

- Need skilled nursing care on an intermittent basis or physical therapy or speech-language pathology; or have a continuing need for occupational therapy (Medicare Benefit Policy Manual Chapter 7 - Home Health Services)
- Receiving services under a plan of care established and periodically reviewed by a physician or Allowed Practitioner**.**

V. Covered Services

Eligibility and health plan benefits and requirements also apply, which may supersede clinical medical necessity determination.

In addition to the CMS policies, National Coverage Determinations (NCD) and Local Coverage Determinations/Articles (LCD/LCA), identified through the Medicare Coverage Database, provide coverage guidelines, as applicable by the service request or location.

- **Skilled Nursing Care** (Medicare Benefit Policy Manual Chapter 7 Section 40.1)
  - Local Coverage Determinations as applicable to the member's location
  - Intermittent services provided by a registered nurse or a licensed practical nurse, under the supervision of a registered nurse, that are reasonable and necessary to treat an illness or injury.
  - Intermittent Nursing care is delivered less than 7 days each week or less than 8 hours per day for 21 days or less.
- **Skilled Therapy Services** (Medicare Benefit Policy Manual Chapter 7 Section 40.2)
  - Review Local Coverage Determinations as applicable to the member's location
  - Intermittent Physical, Speech, and Occupational Therapy services provided by a qualified therapist or therapy assistant, under the supervision of a qualified therapist, that are reasonable and necessary to treat an illness or injury.
- **Medical Social Services** (Medicare Benefit Policy Manual Chapter 7 Section 50.3)
  - Review Medicare Benefit Policy Manual, Chapter 7 for Home Health Services Section 50.3
  - Services provided by a medical social worker or a social work assistant under the supervision of a qualified medical social worker, with a qualifying skilled service, to resolve social or emotion problems that are expected to impede treatment or rate of recovery.
- **Home Health Aide** (Medicare Benefit Policy Manual Chapter 7 Section 50.2)
  - Intermittent personal care services, with a qualifying skilled service, that are reasonable and necessary for the treatment of an illness or injury.

VI. Coverage Determination

A. Overview: naviHealth performs review of medical necessity for authorization requests for home health visits. The request must comply with the required documentation, including OASIS events, 485 Plan of Care, homebound status, and clinical visit notes to support skilled need. If the Medical Necessity criteria are met, naviHealth will authorize visits within the limits of the beneficiary's plan of care.

B. Initial Authorization Request/Start of Care (SOC) and Resumption of Care (ROC):

1. Prior authorization is not required to initiate services, but the home health agency is required to complete the SOC or ROC visit prior to submission for authorization.

2. The agency must attest that the beneficiary meets all necessary CMS coverage criteria.
3. The provider receives initial approval for service amounts designated by the health plan without an initial medical necessity review.

C. Request for Additional Services

1. The provider must submit required clinical documentation to initiate the clinical review process.
2. Services are authorized contingent upon the beneficiary's need for skilled care as outlined in Medicare Benefit Policy Manual Chapter 7 - Home Health Services.
    a. naviHealth will use Medicare Benefit Policy Manual Chapter 7 Section 40 for covered services under a qualifying home health plan of care.
    b. In some cases, naviHealth will utilize InterQual® in addition to the Medicare Benefit Policy Manual, as directed by the health plan.

D. Request for Recertification

1. The provider submits a request for recertification within 5 days of the end of the current certification (Medicare Benefit Policy Manual Chapter 7 Section 10.3 – Continuous 60-Day Recertifications).
2. Services are authorized contingent upon the beneficiary's need for skilled care as outlined in Medicare Benefit Policy Manual Chapter 7 - Home Health Services.
    a. naviHealth will use Medicare Benefit Policy Manual Chapter 7 Section 40 for covered services under a qualifying home health plan of care.
    b. In some cases, naviHealth will utilize InterQual® in addition to the Medicare Benefit Policy Manual, as directed by the health plan.

VII. Documentation – The following documentation is required from the provider by naviHealth pursuant to 42 CFR §484.55(a-d) and Medicare Benefit Policy Manual Chapter 7 Section 30.5.1.2 - Supporting Documentation Requirements

A. Initial Authorization Request/Start of Care (SOC) and Resumption of Care (ROC):

1. Attestation: Agency statement that beneficiary qualifies for home health services under Medicare Benefit Policy Manual Chapter 7.
2. Comprehensive Assessment: Each beneficiary must receive a beneficiary-specific, comprehensive assessment. For Medicare beneficiaries, the provider must verify the beneficiary's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. For the following see 42 CFR §484.55(a-d)
    a. A registered nurse must conduct an initial assessment visit to determine the beneficiary's immediate care and support needs and determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the beneficiary's return home, or on the physician or Allowed Practitioner ordered SOC date.
    b. When rehabilitation therapy service (speech language pathology, physical therapy, or occupational therapy) is the only service ordered, the initial assessment visit may be made by the appropriate rehabilitation skilled professional. The occupational therapist may complete the comprehensive assessment when either physical therapy or speech therapy are part of the plan of care.
    c. Content of comprehensive assessment: The comprehensive assessment must accurately reflect the beneficiary's status. See 42 CFR §484.55(c) for complete

description.

d. The comprehensive assessment must be completed timely, consistent with the beneficiary's immediate needs, but no later than 5 calendar days after the SOC.
e. In accordance with 42 CFR §484.55(d) the comprehensive assessment must be updated and revised within 48 hours of the beneficiary's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests, or on physician or Allowed Practitioner-ordered resumption date.

3. Orders: a physician or an Allowed Practitioner can order home health services. Section 1861(m) of the Social Security Act requires that the home health plan of care be established and maintained by a physician to initiate home health care services.
4. Homebound Status Documentation
5. Care Plan Certification

B. Request for Additional Services

1. Updated Orders (if applicable): a physician or an Allowed Practitioner can order home health services. Section 1861(m) of the Social Security Act requires that the home health plan of care be established and maintained by a physician to initiate home health care services.
2. Homebound Status Documentation
3. Clinical Support Documentation**:** A minimum of the two most recent notes per each discipline in the request. Documentation must demonstrate reasonable and necessary skill.

C. Request for Recertification

1. Update of the comprehensive assessment: In accordance with 42 CFR §484.55(d) the comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the beneficiary's condition warrants due to a major decline or improvement in the beneficiary's health status, but not less frequently than –
    a. The last 5 days of every 60 days beginning with the Start of Care (SOC) date, unless there is a –
        i. Beneficiary elected transfer;
        ii. Significant change in condition; or
        iii. Discharge and return to the same provider during the 60-day episode.
2. Homebound Status Documentation
3. Care Plan Recertification
4. Clinical Support Documentation: A minimum of the two most recent notes per each discipline in the request. Documentation must demonstrate reasonable and necessary skill.

VIII. Services Not Covered

Reference: Medicare Benefit Policy Manual Chapter 7 Section 80)

In addition to the general exclusions from coverage in the Medicare Benefit Policy Manual Chapter 16 – General Exclusions From Coverage), the following are also excluded from coverage as home health services:

- Drugs and biologicals
- The transportation of a beneficiary
- Services that would not be covered as inpatient services
- Housekeeping services for which the sole purpose is to enable the beneficiary to continue residing in their home (e.g., cooking, shopping, Meals on Wheels, cleaning, laundry)
- Services that are covered under the ESRD program
- Prosthetic items

    - **Note:** The Medicare Benefit Policy Manual Chapter 7 Section 50.4.1.1 states that medical supplies including catheters, catheter supplies, ostomy bags and supplies related to ostomy care furnished by the provider are specifically excluded from the term "orthotics and prosthetics". These items are bundled while a beneficiary is under a home health plan of care, and the provider must furnish them to the beneficiary, even if the provider is not treating a condition/illness requiring these supplies
- Respiratory services
- Dietary or nutrition services (If the provider is performing a complete consultation, these services can be included on the Medicare cost report as an administrative cost.)

IX. Responsibility

This policy will be reviewed annually by the Utilization Management Committee

X. References

- Medicare Benefit Policy Manual Chapter 7 - Home Health Services
- Medicare Benefit Policy Manual Chapter 16 – General Exclusions From Coverage
- Code of Federal Regulations Title 42 – Public Health, Part 484 – Home Health Services
- InterQual® Level of Care Home Care
- Medicare National Coverage Determinations and Local Coverage Determinations (CMS Medicare Coverage Database)

VII. Approval/Maintenance:

This policy is approved by the UM Committee. Maintenance of this policy is the responsibility of the UM Committee.

Documentation of Approval:

Utilization Management Committee, 08/29/2023