Subject: Home Health Care for Commercial and Medicare

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Disclaimer

Refer to the member's specific benefit plan and Schedule of Benefits to determine coverage. This may not be a benefit on all plans or the plan may have broader or more limited benefits than those listed in this Medical Policy.

Description

BACKGROUND

The Patient Protection and Affordable Care Act (ACA) provides new tools to enhance CMS's efforts to prevent and detect fraud in its programs. For example, the ACA requires certain categories of providers with an increased risk for fraud, such as home health agencies (HHAs), to comply with enhanced fraud-prevention provisions. Among other steps, the ACA requires that physicians (or certain practitioners working with them) who certify beneficiaries as eligible for Medicare home health services document—as a condition of payment for home health services—that face-to-face encounters with those beneficiaries occurred.

Medicare Requirements for Home Health Services

Medicare beneficiaries who are generally confined to their homes may be eligible to receive certain medical services at home.[1] These home health services include part-time or intermittent skilled nursing care, physical and/or occupational therapy, speech-language pathology, medical social services, and part-time or intermittent home health aide (HHA) services.[2] To qualify for home health services, Medicare beneficiaries must (1) be homebound; (2) need intermittent skilled nursing care, physical therapy or speech therapy, or continuing occupational therapy; (3) be under the care of a physician; and (4) be under a plan of care that has been established and periodically reviewed by a physician. For each 60-day episode of care that a beneficiary receives from an HHA, Medicare makes a standardized payment. For the HHA to receive that payment, a physician must certify the beneficiary's initial need for home health services and homebound status and must recertify the need at least every 60 days.[1]

Intermittent Skilled Nursing and/or Therapy Services

The Social Security Act defines "part-time or intermittent services" as "skilled nursing care that is either provided or needed on fewer than 7 days each week or less than 8 hours of each day for periods of 21 days or less."[1] The skilled nursing care must be provided by a registered nurse or licensed practical (vocational) nurse under the supervision of a registered nurse.[4] Home health aide services may include personal care, such as bathing and dressing; feeding; and simple dressing changes that do not require the skills of a licensed nurse.[1]

Therapy services must be performed by a qualified therapist or therapy assistant under the supervision of a qualified therapist.[1]

Requirement To Be Under the Care of a Physician

Medicare requires that to be eligible for home health services, beneficiaries be under the care of a Doctor of Medicine, osteopathy, or podiatric medicine. As of April 1, 2011, CMS began requiring full compliance with the requirement that the certifying physician or clinician have a face-to-face encounter with the beneficiary as a condition of payment for home health care.

Established Plan of Care

Medicare pays for home health services only if they are provided under a plan of care that a physician establishes and periodically reviews.[1] The physician must review, sign, and date the plan at least once every 60 days.[1] If a beneficiary does not receive at least one covered skilled nursing visit, physical therapy visit, speech-language pathology service visit, or occupational therapy visit within the 60-day episode, CMS considers the plan to be terminated.

Face-to-Face Requirement

For the initial home health episode of care only, the certifying physician must document a face-to-face encounter with the patient.[1] The HHA must obtain documentation that the face-to-face encounter with the patient occurred and that the encounter was related to the primary reason the beneficiary needs home health care. If the certifying physician does not complete the documentation correctly, CMS can deny the HHA payment because the face-to-face requirement is a Medicare condition of payment.[1] CMS holds the HHA financially accountable for ensuring that the documentation from the physician meets the applicable criteria.

Footnotes:

[1] Social Security Act, § 1814(a)(2)(C).
[2] Social Security Act, § 1861 Home Health Services (m); or CMS, Pub. No. 100-02, CH. 7, § 40.
[3] 42 CFR § 424.22-Requirements for home health services
[4] Medicare Benefit Policy Manual, ch. 7, § 10.3
[5] Medicare Benefit Policy Manual, ch. 7, § 40.1.1
[6] Medicare Benefit Policy Manual, ch. 7, § 50.2
[7] Medicare Benefit Policy Manual, ch. 7, §§ 40.2–40.2.4.3
[8] Medicare Benefit Policy Manual, ch. 7, § 30.2 thru 30.2.10
[9] Medicare Benefit Policy Manual, ch. 7, § 30.5.1.1

Coverage Determination

Certification:

Timing and signature. The certification of need for home health services must be obtained at the time the plan of care is established or as soon thereafter as possible and must be signed and dated by the physician or allowed practitioner who establishes the plan. It is not acceptable for Home Health Agencies to wait until the end of a 60-day episode of care to obtain a completed certification, also verbal orders are not allowed during Certification/Recertification phase.

In accordance to CFR § 424.22(a)(1)-Requirements for home health services and the 30.5.1 Physician or Allowed Practitioner Certification, a certification (versus recertification) is considered to be anytime that a Start of Care (SOC) OASIS is completed to initiate care. In such instances, a physician or allowed practitioner must certify (attest) that:

1. The home health services are or were needed because the patient is or was **confined to the home** as defined in §30.1.1; Telehealth can be performed to determine that a member cannot leave home due to medical contraindication and needs skilled services, he or she will be considered homebound and qualify for the Medicare Home Health Benefit.
2. The **patient needs or needed skilled nursing services** on an intermittent basis or physical therapy, or speech-language pathology services. Where a patient's sole skilled service need is for skilled oversight of unskilled services (management and evaluation of the care plan as defined in §40.1.2.2), the physician or allowed practitioner must include a brief narrative describing the clinical justification of this need as part of the certification, or as a signed addendum to the certification;
3. A **plan of care has been established and is periodically reviewed by a physician or allowed practitioner**;
4. The services are or were furnished while the patient is or was **under the care of a physician or allowed practitioner**;
5. **Face-to-Face patient encounter**:
    - occurred no more than 90 days prior to the home health Start of Care (SOC) date **or** within 30 days of the start of the home health care,
    - was related to the primary reason the patient requires home health services, and
    - must be performed by the certifying physician or allowed practitioner himself or herself, a physician or allowed practitioner that cared for the patient in the acute or post-acute care facility (with privileges who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health) or a certified nurse midwife or physician assistant under the supervision of the certifying physician or the acute/post-acute care physician.

    In situations when a physician or allowed practitioner orders home health care for the patient based on a new condition that was not evident during a visit within the 90 days prior to Start of Care (SOC), the physician or an allowed NPP must see the patient again within 30 days after admission. Specifically, if a patient saw the physician or NPP within the 90 days prior to Start of Care (SOC), another encounter would be needed if the patient's condition had changed to the extent that standards of practice would indicate that the physician or a non-physician practitioner should examine the patient in order to establish an effective treatment plan.

    Telehealth: The face-to-face encounter can be performed via a telehealth service, in an approved originating site. An originating site is considered to be the location of an eligible member at the time the service being furnished via a telecommunications system occurs. Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site located in a rural health professional shortage area or in a county outside of a Metropolitan Statistical Area. Telehealth cannot be the members home as an originating site.

Recertification:

In accordance to CFR § 424.22(a)(1)-Requirements for home health services and 30.5.2 Physician or Allowed Practitioner Recertification, Timing and signature of recertification. Recertification is required at least every 60 days when there is a need for continuous home health care after an initial 60-day episode. Recertification should occur at the time the plan of care is reviewed and **must be signed and dated by the physician or allowed practitioner who reviews the plan of care**. Recertification is required at least every 60 days unless there is a:

- A beneficiary transfer to another HHA; **or**
- Discharge with goals met and/or no expectation of a return to home health care.

For recertification of home health services, the physician or allowed practitioner must certify (attest) that:

1. The home health services are or were needed because the patient is or was confined to the home as defined in §30.1;
2. The patient needs or needed skilled nursing services on an intermittent basis (other than solely venipuncture for the purposes of obtaining a blood sample), or physical therapy, or speech-language pathology services; or continues to need occupational therapy after the need for skilled nursing care, physical therapy, or speech-language pathology services ceased. Where a patient's sole skilled service need is for skilled oversight of unskilled services (management and evaluation of the care plan as defined in §40.1.2.2), the physician or allowed practitioner must include a brief narrative describing the clinical justification of this need as part of the recertification, or as a signed addendum to the recertification.
3. A plan of care has been established and is periodically reviewed by a physician or allowed practitioner; and
4. The services are or were furnished while the patient is or was under the care of a physician or allowed practitioner.

Medicare does not limit the number of continuous 60-day recertifications for beneficiaries who continue to be eligible for the home health benefit. The certification may cover a period less than but not greater than 60 days. Because the updated home health plan of care must include the frequency and duration of visits to be made, the physician or allowed practitioner does not have to estimate how much longer skilled services will be needed for the recertification.

Homebound Status:
Per §1814(a) and §1835(a) of the Act, an individual shall be considered "confined to the home" for a patient to be eligible to receive covered home health services under both Part A and Part B, the law requires that a physician or allowed practitioner to certify in all cases that the patient is confined to his/her home. For purposes of the statute, an individual shall be considered "confined to the home" (homebound) when "**Criterion One**" and "**Criterion Two**" outlined in Medicare Benefit Policy Manual, Chapter 7 for Home Health Services, Section 30.1.1 - Patient Confined to the Home are met.

All home health services beyond initial visits for evaluation purposes, require prior approval. Logon to Pres Online to submit a request: https://ds.phs.org/preslogin/index.jsp

I. Home Health Agency (HHA) Initial Assessment Visit 42 CFR §484.55(a)(1-2) Condition of participation: Comprehensive assessment of patients.

Initial assessment visit does not require Prior Authorization.

1. **Orders**: As stated in Medicare Policy Manual, Ch 7, section 30.2.3 the specificity of orders on the plan of care must indicate the type of services to be provided to the patient, both with respect to the professional who will provide them and the nature of the individual services, as well as the frequency of the services. 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. Allowed practitioners in addition to physicians, can certify and recertify beneficiaries for eligibility, order home health services, and establish and review the care plan, as stated in Medicare Policy Manual chapter 7 section 30.2.1 – Definition of an Allowed Practitioner; allowed practitioners are defined at § 484.2 as a physician assistant, nurse practitioner, or clinical nurse specialist 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.

2. **Comprehensive assessment of patients**. Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment. For Medicare beneficiaries, the Home Health Agency must verify the patient'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-c)
   a. A registered nurse must conduct an **initial assessment visit** to determine the immediate care and support needs of the patient; and, for Medicare patients, to 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 patient's return home, or on the physician or allowed practitioner-ordered Start of Care (SOC) date. The **completion of the comprehensive assessment** must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the Start of Care (SOC).
   b. When rehabilitation therapy service (speech language pathology, physical therapy, or occupational therapy) is the **only** service ordered by the physician who is responsible for the home health plan of care, and if the need for that service establishes program eligibility, the **initial assessment visit** may be made by the appropriate rehabilitation skilled professional. A physical therapist, speech-language pathologist or occupational therapist may **complete the comprehensive assessment**, and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status. The occupational therapist may complete the comprehensive assessment if the need for occupational therapy establishes program eligibility.
   c. **Content of comprehensive assessment**: The comprehensive assessment must accurately reflect the patient's status. See 42 CFR §484.55(c) for complete description.

   NOTE: As indicated in CMS manual 100-02, Ch.7. 70.2. When personnel of the agency make such an initial evaluation visit, the cost of the visit is considered an administrative cost of the agency and is not chargeable as a visit since at this point the patient has not been accepted for care. If, however, during the course of this initial evaluation visit, the patient is determined suitable for home health care by the agency and is also furnished the first skilled service as ordered under the physician or allowed practitioner's plan of care, the visit would become the first billable visit in the 30-day period.

3. **Documentation Requirements**: Medicare Benefit Policy Manual, Ch7, Home Health Services, Physician or Allowed Practitioner Certification and Recertification of Patient Eligibility for Medicare Home Health Services, see 30.5.1.2 Supporting Documentation Requirements, (Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01-11-21).

   The certifying physician or allowed practitioner and/or the acute/post-acute care facility medical record (if the patient was directly admitted to home health) for the patient must contain information that justifies the referral for Medicare home health services. This includes documentation that substantiates the patient's:

   a) Need for the skilled services; and
   b) Homebound status;

   Must contain the actual clinical note for the face-to-face encounter visit that demonstrates that the encounter:

   c) Occurred within the required timeframe,
   d) Was related to the primary reason the patient requires home health services; and
   e) Was performed by an allowed provider type.

   This information can be found most often in clinical and progress notes and discharge summaries. While the face-to-

face encounter must be related to the primary reason for home health services, the patient's skilled need and homebound status can be substantiated through an examination of all submitted medical record documentation from the certifying physician or allowed practitioner, acute/post-acute care facility, and/or HHA (see below). The synthesis of progress notes, diagnostic findings, medications, nursing notes, etc., help to create a longitudinal clinical picture of the patient's health status.

The Content of the Plan of Care, 30.2.2, Medicare Benefit Policy Manual, Ch 7: For HHA services to be covered, the individualized plan of care must specify the services necessary to meet the patient-specific needs identified in the comprehensive assessment. In addition, the plan of care must include the identification of the responsible discipline(s) and the frequency and duration of all visits as well as those items listed in 42 CFR 484.60(a) that establish the need for such services. All care provided must be in accordance with the **plan of care**.

See also regulations at 42 CFR 424.22(c), which supports 30.5.1.2 – Supporting Documentation Requirements as mentioned above. The documentation from the certifying physicians or allowed practitioner's medical record or the acute/post-acute care facility's medical records (if the patient was directly admitted to home health) or both must be used as the basis for certification of the patient's eligibility for home health as described in paragraphs (a)(1) and (b) of this section. Documentation from the HHA may also be used to support the basis for certification of home health eligibility, but only if the following requirements are met:

Information from the HHA must be corroborated by other medical record entries and align with the time period in which services were rendered.

- Must review and sign off on anything incorporated into the patient's medical record that is used to support the certification of patient eligibility (that is, agree with the material by signing and dating the entry).
- Information from the HHA, such as the plan of care required per 42 CFR §409.43 and the initial and/or comprehensive assessment of the patient required per 42 CFR §484.55, can be incorporated into the certifying physician or allowed practitioner's medical record for the patient and used to support the patient's homebound status and need for skilled care.

The documentation must be provided upon request to review entities or CMS or both. If the documentation used as the basis for the certification of eligibility is not sufficient to demonstrate that the patient is or was eligible to receive services under the Medicare home health benefit, payment is not rendered for home health services provided.

II. Home Health Agency (HHA) Initial Service Request

Prior Authorization is required upon completion of certification. Logon to Pres Online to submit a request: https://ds.phs.org/preslogin/index.jsp

1. **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 HHC is needed from physician. Medicare Policy Manual chapter 7 section 30.2.1 – Definition of an Allowed Practitioner; allowed practitioners are defined at § 484.2 as a physician assistant, nurse practitioner, or clinical nurse specialist 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.
   a. 42 CFR §484.55(a)(1-2) Comprehensive assessment of patients, initial assessment visit.
2. **Home Bound:** Attending provider signed home bound status per CMS 2 criteria in 30.1.1
   a. Medicare Benefit Policy Manual, Chapter 7 for Home Health Services
   b. Per §1814(a) and §1835(a) of the Act, an individual shall be considered "confined to the home" for a patient to be eligible to receive covered home health services
   c. The patient 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 (e.g. funeral, graduation, trip to the barber).
3. **Care Plan Certification:** Attending provider signed or Voice order counter signed by accepting Home Health RN and submitted to PHP for medical necessity review.
   a. CFR 484.60 Condition of participation: Care planning, coordination of services, and quality of care. *Standard Plan of care:* Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-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.
   b. **Recertification for Home Health Services** – initial certification period lasts 60 days or 9 weeks, (see above under the section for Recertification, for details or see Ch 7, 30.5.2)
4. **Therapeutic services: For rehabilitative services provided by physical therapy (PT), speech therapy (ST) and occupational therapy (OT).** See section (VIII) below to review Local Coverage Determinations (LCD) and related Local Coverage Articles (LCA) for ICD-10 Codes that Support Medical Necessity.
5. **Verbal orders:** Policy Manual Chapter 7, 30.2.6 - Use of Oral (Verbal) Orders (Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)
   When services are furnished based on a physician or allowed practitioner's oral order, the orders may be accepted and put in writing by personnel authorized to do so by applicable State and Federal laws and regulations as well as by the HHA's internal policies. The orders must be signed and dated with the date of receipt by the registered nurse or qualified therapist (i.e., physical therapist, speech-language pathologist, occupational therapist, or medical social

worker) responsible for furnishing or supervising the ordered services. The orders may be signed by the supervising registered nurse or qualified therapist after the services have been rendered, as long as HHA personnel who receive the oral orders notify that nurse or therapist before the service is rendered. Thus, the rendering of a service that is based on an oral order would not be delayed pending signature of the supervising nurse or therapist. Oral orders must be countersigned and dated by the physician or allowed practitioner before the HHA bills for the care in the same way as the plan of Care

Services which are provided from the beginning of the initial 60-day certification period and before the physician or allowed practitioner signs the plan of care are considered to be provided under a plan of care established and approved by the physician or allowed practitioner where there is a verbal order for the care prior to rendering the services which is documented in the medical record and where the services are included in a signed plan of care.

Services that are provided following the initial 60-day certification period are considered provided under the plan of care of the recertification 60-day episode where there is a verbal order before the services provided in the subsequent period are furnished and the order is reflected in the medical record. However, services that are provided after the expiration of the plan of care, but before the acquisition of a verbal order or a signed plan of care are not considered provided under a plan of care.

6. **Nursing**: Review Local Coverage Determinations and Medicare Benefit Policy Manual, Chapter 7 for Home Health Services
    a. 40.1 - Skilled Nursing Care (Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14) A3-3118.1, HHA-205.1
    b. Local Coverage Determination (LCD) L35125- Wound Care, the related article LCA (A53001).
7. **Home Health Aide:** Review Medicare Benefit Policy Manual, Chapter 7 for Home Health Services. 50.2 - Home Health Aide Services (Rev. 1, 10-01-03) A3-3119.2, HHA-206.2
8. **Documentation Requirements:** (Please see section (I.3) above)

III. Home Health Agency (HHA) Extension (Recertification) Request

Prior Authorization is required upon completion of recertification. Logon to Pres Online to submit a request: https://ds.phs.org/preslogin/index.jsp

1. **Care plan recertification**: 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 HHC is needed from physician. Medicare Policy Manual chapter 7 section 30.2.1 – Definition of an Allowed Practitioner; allowed practitioners are defined at § 484.2 as a physician assistant, nurse practitioner, or clinical nurse specialist 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.
    a. See Recertification section above or see 30.5.2 Physician or Allowed Practitioner Recertification, for guidelines on recertification when nearing the end of the initial 60-day certification.
2. **Update of the comprehensive assessment**: In accordance to 42 CFR §484.55(d) the comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than –
        1. The last 5 days of every 60 days beginning with the Start of Care (SOC) date, unless there is a -
            a. Beneficiary elected transfer;
            b. Significant change in condition; or
            c. Discharge and return to the same HHA during the 60-day episode.
        2. Within 48 hours of the patient'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. At discharge.
3. **Home Bound**: Attending provider signed homebound status per CMS 2 criteria
    a. Medicare Benefit Policy Manual, Chapter 7 for Home Health Services: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf
    b. Home Health Services Section 30.1.1 - Patient Confined to the Home -Homebound.
4. **Care Plan**: Attending provider signed or Voice order counter signed by accepting Home Health RN and submitted to PHP for medical necessity review.
    a. CFR 484.60 Condition of participation: Care planning, coordination of services, and quality of care. *Standard Plan of care:* Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-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.
    b. Benefit Policy Manual Chapter 7, 30.2.6 - Use of Oral (Verbal) Orders (Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)
    c. Benefit Policy Manual Chapter 7, 30.5
5. **Therapeutic services: For rehabilitative services provided by physical therapy (PT), speech therapy (ST) and occupational therapy (OT).** See section (VIII) below to review Local Coverage Determinations (LCD) and related Local Coverage Articles (LCA) for ICD-10 Codes that Support Medical Necessity.
6. **Verbal orders:** Benefit Policy Manual Chapter 7, 30.2.6 - Use of Oral (Verbal) Orders (Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

a. Verbal orders are accepted with verbal order read back from the ordering provider, signed by a registered nurse, Occupational Therapist, speech therapist or Physical therapist

7. **Nursing**: Review Local Coverage Determinations and Medicare Benefit Policy Manual, Chapter 7 for Home Health Services
   a. 40.1 - Skilled Nursing Care (Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14) A3-3118.1, HHA-205.1
   b. Local Coverage Determination (LCD) L35125- Wound Care, the related article LCA (A53001).
8. **Home Health Aide:** Review Medicare Benefit Policy Manual, Chapter 7 for Home Health Services. 50.2 - Home Health Aide Services (Rev. 1, 10-01-03) A3-3119.2, HHA-206.2
9. **Documentation Requirements:** (Please see section (I.3) above)

IV. Full PHP Dual Eligible Special Needs Plans (D-SNP):

Prior Authorization is not required. Logon to Pres Online to submit a request:
https://ds.phs.org/preslogin/index.jsp

1. Home Health Agency (HHA) Initial Assessment Visit, (see above (I).
   a. Home Health Agency (HHA) Initial Service Request, (see above (II).
   b. Home Health Agency (HHA) Extension Request, (see above III).

V. PHP Medicare only Dual Eligible Special Needs Plans (D-SNP):

Prior Authorization is not required. Logon to Pres Online to submit a request:
https://ds.phs.org/preslogin/index.jsp

1. Home Health Agency (HHA) Initial Assessment Visit, (see above (I).
   a. Home Health Agency (HHA) Initial Service Request, (see above (II).
   b. Home Health Agency (HHA) Extension Request, (see above III).

VI. PHP NM Medicaid only Dual Eligible Special Needs Plans (D-SNP):

1. Medicare servicing insurance requirement for NM Medicaid review.
   a. Medicare denial. PHP needs a decision letter from Medicare servicing insurance to process request for possible NM Medicaid coverage under PHP Medical Policy Medicaid Home Health Services, MPM 13.6
   b. Medicare partial denial. PHP needs a decision letter from Medicare servicing insurance to process request for possible NM Medicaid coverage PHP Medical Policy Medicaid Home Health Services, MPM 13.6
   c. Medicare approval. PHP needs a decision letter from Medicare servicing insurance to process request for NM Medicaid coverage

Note: Documentation of an approved or denied services from Primary Medicare (not Presbyterian) insurance company is required.

VII. PHP NM Medicaid only Dual Eligible Special Needs Plans (D-SNP) Extensions:

1. Medicare servicing insurance requirement for NM Medicaid review.
   a. Medicare denial. PHP needs a decision letter from Medicare servicing insurance to process request for possible NM Medicaid coverage under PHP Medical Policy Medicaid Home Health Services, MPM 13.6
   b. Medicare partial denial. PHP needs a decision letter from Medicare servicing insurance to process request for possible NM Medicaid coverage PHP Medical Policy Medicaid Home Health Services, MPM 13.6
   c. Medicare approval. PHP needs a decision letter from Medicare servicing insurance to process request for NM Medicaid coverage

Note: Documentation of an approved or denied services from Primary Medicare (not Presbyterian) insurance company is required.

VIII. For therapeutic rehabilitative services provided by physical therapy (PT), speech therapy (ST) and occupational therapy (OT):

Coverage of skilled rehabilitation services is contingent upon the member's need for skilled care. Please access MCG Website to review the applicable rehabilitative service Local Coverage Determinations and related Local Coverage Articles listed below for ICD-10 Codes that Support Medical Necessity.

Initial Assessment: When rehabilitation therapy service (speech language pathology, physical therapy, or occupational therapy) is the only service ordered by the physician who is responsible for the home health plan of care, and if the need for that service establishes program eligibility, the initial assessment visit may be made by the appropriate rehabilitation skilled professional.

Completion of comprehensive assessment: When physical therapy, speech-language pathology, or occupational therapy is the only service ordered by the physician or allowed practitioner, a physical therapist, speech-language pathologist or occupational therapist may complete the comprehensive assessment, and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status. The occupational therapist may complete the comprehensive assessment if the need for occupational therapy establishes program eligibility.

1. LCD L34564, Home Health Physical Therapy, related article LCA A53058 Billing and coding: Home Health Physical Therapy and the listed ICD-10 codes that Support Medical Necessity.
    a. Review the LCD for PT Evaluation and PT Re-evaluation, documentation requirements and other requirements.
    b. Services are to be furnished according to a written plan of treatment determined by the physician.
    c. Review Diagnosis specific CGMs for guidance for 50% visit numbers
2. LCD L34560, Home Health Occupational Therapy, related article LCA A53057 Billing and Coding: Home Health Occupational Therapy and the listed ICD-10 codes that Support Medical Necessity.
    a. Review the LCD for OT Evaluation and OT Re-evaluation, documentation requirements and other requirements.
    b. Services are to be furnished according to a written plan of treatment determined by the physician.
    c. Review Diagnosis specific CGMs for guidance for 50% visit numbers
3. LCD L34563, Home Health Speech-Language Pathology, related article LCA A53052 Billing and Coding: Home Health Speech-Language Pathology (SLP) and the listed ICD-10 codes that Support Medical Necessity
    a. Review the LCD for SLP Evaluation and SLP Re-evaluation, documentation requirements and other requirements.
    b. Services are to be furnished according to a written plan of treatment determined by the physician.
    c. Review Diagnosis specific CGMs for guidance for 50% visit numbers

Services not covered by Home Health:

Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 7 §80)
In addition to the general exclusions from coverage in the *Medicare Benefit Policy Manual*, (Pub. 100-02, Ch. 16), the following are also excluded from coverage as home health services:

- Drugs and biological (except where noted differently)
- The transportation of a patient
- Services that would not be covered if furnished as inpatient hospital
- Housekeeping services for which the sole purpose is to enable the patient 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* (Pub. 100-02, Ch. 7, § 50.4.1.1), states that medical supplies including catheters, catheter supplies, ostomy bags and supplies related to ostomy care furnished by an HHA are specifically excluded from the term "orthotics and prosthetics". These items are bundled while a patient is under a home health plan of care, and an HHA must furnish them to the patient, even if the HHA is not treating a condition/illness requiring these supplies
- Respiratory services

Dietary or nutrition services (If the HHA is performing a complete consult, these services can be included on the Medicare cost report as an administrative cost.)

Coding

The coding listed in this medical policy is for reference only. Covered and non-covered codes are within this list.

CPT Codes	Care plan oversight | Training | Report of Location
G0162	Skilled services by a registered nurse (RN) 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 nonskilled care achieves its purpose in the home health or hospice setting)
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)
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
Q5001	Hospice or home health care provided in patient's home/residence

CPT Codes	General skilled nursing
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.
T1001	Nursing assessment/evaluation
T1002	RN services, up to 15 minutes
T1003	LPN/LVN services, up to 15 minutes

CPT Codes	Home Health Certification/Recertification
G0179	Physician or allowed practitioner 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 and allowed practitioners to affirm the initial implementation of the plan of care
G0180	Physician or allowed practitioner 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 or allowed practitioners to affirm the initial implementation of the plan of care

CPT Codes	**Home Health Physical Therapy** LCD L34564,
97010	Application of a modality to 1 or more areas; hot or cold packs
90712	Application of a modality to 1 or more areas; traction, mechanica
97022	Application of a modality to 1 or more areas; whirlpool
97024	Application of a modality to 1 or more areas; diathermy (eg, microwave)
97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)
97161	Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family
97162	Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97163	Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.
97164	Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome Typically, 20 minutes are spent face-to-face with the patient and/or family.
97545	Work hardening/conditioning; initial 2 hours
97546	Work hardening/conditioning; each additional hour (List separately in addition

CPT Codes	**Home Health Physical Therapy** LCD L34564,
	to code for primary procedure)
G0151	Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes
G0157	Services performed by a qualified physical therapist assistant in the home health or hospice setting, each 15 minutes
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 minutes
G2168	Services performed by a physical therapist assistant in the home health setting in the delivery of a safe and effective physical therapy maintenance program, each 15 minutes
For a list of ICD-10 that support the listed codes above see Home Health Physical Therapy **(A53058)**	

CPT Codes	**Home Health Occupational Therapy (L34560)**
90901	Biofeedback train any meth
92526	Oral function therapy
92610	Evaluate swallowing function
95851	Range of motion measurements
95852	Range of motion measurements
96125	Cognitive test by hc pro
97016	Vasopneumatic device therapy
97018	Paraffin bath therapy
97026	Infrared therapy
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes
97033	Electric current therapy
97034	Application of a modality to 1 or more areas; contrast baths, each 15 minutes
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes
97037	Application of a modality to 1 or more areas; low-level laser therapy (ie, nonthermal and non-ablative) for post-operative pain reduction
97110	Therapeutic exercises
97112	Neuromuscular reeducation
97124	Massage therapy
97140	Manual therapy 1/> regions
97165	Ot eval low complex 30 min
97166	Ot eval mod complex 45 min
97167	Ot eval high complex 60 min
97168	Ot re-eval est plan care
97530	Therapeutic activities
97533	Sensory integration
97535	Self care mngment training
97537	Community/work reintegration
97542	Wheelchair mngment training
97550	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; initial 30 minute
97551	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; each additional 15 minutes (List separately in addition to code for primary service)
97750	Physical performance test
97755	Assistive technology assess
97760	Orthotic mgmt&traing 1st enc
97761	Prosthetic traing 1st enc
97763	Orthc/prostc mgmt sbsq enc
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes

CPT Codes	Home Health Occupational Therapy (L34560)
G0158	Services performed by a qualified occupational therapist assistant in the home health or hospice setting, each 15 minutes
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 minutes
G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care
G2169	Services performed by an occupational therapist assistant in the home health setting in the delivery of a safe and effective occupational therapy maintenance program, each 15 minutes
For a list of ICD-10 that support the listed codes above see **Home Health Occupational Therapy (A53057)**	

CPT Codes	Home Health Speech Language Pathology
92507	Speech/hearing therapy
92517	Vemp test i&r cervical
92518	Vemp test i&r ocular
92519	Vemp tst i&r cervical&ocular
92521	Evaluation of speech fluency
92522	Evaluate speech production
92523	Speech sound lang comprehen
92524	Behavral qualit analys voice
92526	Oral function therapy
92597	Oral speech device eval
92607	Ex for speech device rx 1hr
92608	Ex for speech device rx addl
92609	Use of speech device service
92610	Evaluate swallowing function
92626	Eval aud funcj 1st hour
92627	Eval aud funcj ea addl 15
92630	Aud rehab pre-ling hear loss
92633	Aud rehab postling hear loss
92650	Aep scr auditory potential
92651	Aep hearing status deter i&r
92652	Aep thrshld est mlt freq i&r
92653	Aep neurodiagnostic i&r
96105	Assessment of aphasia
96112	Devel tst phys/qhp 1st hr
96113	Devel tst phys/qhp ea addl
96116	Nubhvl xm phys/qhp 1st hr
96121	Nubhvl xm phy/qhp ea addl hr
96125	Cognitive test by hc pro
97110	Therapeutic exercises
97129	Ther ivntj 1st 15 min
97130	Ther ivntj ea addl 15 min
97530	Therapeutic activities
97533	Sensory integration
97535	Self care mngment training
G0153	Hhcp-svs of s/l path,ea 15mn
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 minutes
For a list of ICD-10 that support the listed codes above see Home Health Physical Therapy **(A53052)**	

Reviewed by / Approval Signatures

Population Health & Clinical Quality Committee: Clinton White MD
Senior Medicaid Medical Director: Jimmy Romero MD
Date Approved: 03-26-2025

References

1. Code of Federal Regulations, Title 42 CFR § 424.22-Requirements for home health services, up to date as of 02/04/2025, Last Amended 01/23/2025 [cited 01/30/2025]
2. Medicare Benefit Policy Manual, Pub 100-02, Home Health Services, Ch 7 Refer to the Medicare Benefit Policy Manual, Chapter 7, §30.1 (Rev. 12382; Issued: 11-28-23), (Rev. 12425 Issued: 12-21-23) [Cited 01/30/2025]
1. CMS, 100-02, Medicare Benefit Policy Manual, Chapter 15, Covered Medical and Other Health Service, (Rev. 11447, 06-06-22) [Cited 01/30/2025]
2. CMS, Manual (Publication 100-04), Chapter 10 Home Health Agency Billing, of the Medicare Claims Processing, (Rev. 11966, 04-21-23) [Cited 01/30/2025]
3. CMS Manual (Publication 100-08), Chapter 6 - Medicare Contractor Medical Review Guidelines for Specific Services of the Medicare Program Integrity, (Rev. 10365, 10-02-20). (See 6.2 Medical Review of Home Health Services- Form 485/Plan of Care) (Rev. 10184; Issued: 06-19-2020; Effective: 07-21-2020; Implementation: 07-21-2020). [Cited 01/30/2025]
4. CMS, Official government booklet by Medicare & Home Health Care, this is not a legal document. The information in this booklet describes the Medicare Program at the time this booklet was printed. Changes may occur after printing. Visit Medicare.gov or call 1-800-MEDICARE (1-800-633-4227) to get the most current information. TTY users can call 1-877-486-2048. [Cited 01/30/2025]
5. CMS, Home Health Plan of Care/Certification, Clinical benefit templates Page Last Modified: 09/06/2023. [Cited 01/30/2025]
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9. Respiratory Therapy Services: CMS, Medicare Benefit Policy Manual, Chapter 12, Comprehensive Outpatient Rehabilitations Facility (CORF) Coverage, (Rev. 255, 01-25-19) or CMS Medicare Claims Processing Manual, Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services (Rev. 11129, 11-22-21) [Cited 01/30/2025]
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11. Code of Federal Regulations (CFR), Title 42, Chapter IV, Subchapter G, Part 484 – Home Health Services, [86 FR 62422, Nov. 9, 2021, as amended at 88 FR 77879, Nov. 13, 2023] [Cited 01/30/2025]
12. CMS, Quality, Safety & Oversight – Guidance to Laws & Regulations, Home Health Agencies, Page Last Modified: 09/10/2024 06:04 PM. State Operations Manual, Appendix B of the State Operations Manual (PDF), (Rev. 219; Issues: 04-12-24). [Cited 01/30/2025]
13. Novitas, Provider Specialty: Home Health, Resources, MLN, Certifying Patients for the Medicare Home Health Benefit, Effective as of January 1, 2015. [Cited 01/30/2025]
14. CMS, Home Infusion Therapy Services Benefit Beginning January 2021, Frequently Asked Questions, Last updated June 2022. [Cited 01/30/2025]

Publication History

01-26-2022 New policy specifically for Medicare and Commercial Home Health. Reviewed by PHP Medical Policy Committee on 01/14/2022.

The policy follows Home Health Code of Federal Registrations (CFR); Centers for Medicare & Medicaid Services program manuals; and Local Coverage Determination for related Physical Therapy, Occupational, Speech-Language Therapy. All home health services beyond initial visits for evaluation purposes, require prior approval.

Prior authorization determinations are as follow:

- Prior authorization is not required for initial assessment visit.
- Prior Authorization is required for Start of Care (SOC) or an extension service of certification and recertification. It is not acceptable for Home Health Agencies to wait until the end of a 60-day episode of care to obtain a completed certification, also verbal orders are not allowed during Certification/Recertification phase.
- Prior authorization is not required at the initial assessment for:
  - Full PHP Dual Eligible Special Needs Plans (D-SNP)
  - PHP Medicare only Dual Eligible Special Needs Plans (D-SNP) will require

01-25-2023 Annual review: Continue with no change. Added physical therapy codes: 97010, 90712, 97022, 97024, 97116, 97161, 97162, 97163, 97164, 97545, and 97546. Revised language to clarify the section under Documentation Requirements section (I.3) which included additional language from 42 CFR 424.22(c). There is no change to the criteria, the content in the language that was added is in support of Medicare Benefit Manual, 30.5.1.2. As a result the language to section (II.8) and (III.9) were removed and noted to see section (I.3).

02-07-2024 Annual review. Reviewed by PHP Medical Policy Committee on 01/03/2024.
The CMS manuals have no change relevant to timeframes of face-to-face encounter for certification and recertification. Certification should occur no more than 90 days prior to home health start of care or within 30 days of the start of the home health care. The recertification should occur at the end of the initial 60-day episode, a decision must be made as to whether or not to recertify the patient for a subsequent 60-day episode. Recertification is required at least every 60 days when there is a need for continuous home health care after an initial 60-day episode.
There are no changes to the LCDs referenced in this policy.
Also no change to the following:

- Continue to follow CMS guidance.
- PHP will not be responsible for enforcing to obtain Signatures, this is the responsibility of the HHA.
- PHP will not be responsible for enforcing Face-to-Face requirement, this is the responsibility of HHA.
- PHP primarily responsibility is to verify medical necessity and our UM staff will obtain orders related to the request and/or medical necessity.

03-26-2025 Annual review. Reviewed by PHP Medical Policy Committee on 01-31-2025. No change. Keep policy as is since there are no changes to the website links that impact the MPM. The only CMS manual noted to have a change is Medicare Benefit Policy Manual Chapter 7 - Home Health Services, updated on 2023 and 2024 for Negative Pressure Wound Therapy Using a Disposable Device which is not a part of our policy guidance. There are no changes to the LCDs/LCAs for Home Health (Physical, Occupational and Speech Language) Therapies.
Revised coding description for 97032, 97033, 97034, 97035.
Added codes 97037, 97550 and 97551.
Prior authorization determinations and language will continue without change:

- All home health services, beyond initial visits for evaluation purposes, require prior approval.
- Prior authorization is not required at the initial assessment visit
- Prior Authorization is required upon completion of certification
- Prior Authorization is required upon completion of recertification
  - Prior authorization is Not required at the initial assessment for:
    - Full PHP Dual Eligible Special Needs Plans (D-SNP)
    - PHP Medicare only Dual Eligible Special Needs Plans (D-SNP) will require

Removed management of LCDs/LCAs and affiliated codes for Alzheimer Disease (G0299, G0300), Psychiatric Care (G0152, G0155, G0156, G0299, G0300) and Monitoring Glucose Control in the Medicare Home Health environment, since it is not outlined within PHP policy as part of coverage indication.

This Medical Policy is intended to represent clinical guidelines describing medical appropriateness and is developed to assist Presbyterian Health Plan and Presbyterian Insurance Company, Inc. (Presbyterian) Health Services staff and Presbyterian medical directors in determination of coverage. The Medical Policy is not a treatment guide and should not be used as such. For those instances where a member does not meet the criteria described in these guidelines, additional information supporting medical necessity is welcome and may be utilized by the medical director in reviewing the case. Please note that all Presbyterian Medical Policies are available online at: ***Click here for Medical Policies***

Web links:
At any time during your visit to this policy and find the source material web links has been updated, retired or superseded, PHP is not responsible for the continued viability of websites listed in this policy.

When PHP follows a particular guideline such as LCDs, NCDs, MCG, NCCN etc., for the purposes of determining coverage; it is expected providers maintain or have access to appropriate documentation when requested to support coverage. See the References section to view the source materials used to develop this resource document.