Subject: Medicaid Home Health Services

Medical Policy #: 13.6

Original Effective Date: 02-22-2012

Status: Reviewed

Last Review Date: 08-27-2025

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

The New Mexico Medicaid program (Medicaid) pays for medically necessary health services furnished to eligible recipients, including home health services.

Prior Approval:

All home health services beyond initial visits for evaluation purposes require prior approval from MAD or its designee.

Services for which prior approval was obtained remain subject to utilization review at any point in the payment process. Prior approval does not guarantee payment, if upon utilization review after payment has occurred, recipients are determined to be ineligible or medical necessity is not found.

Background:

The New Mexico Medicaid program (Medicaid) pays for medically necessary health services furnished to eligible recipients, including home health services, as indicated in Code of Federal Regulations related to home health service, (see Title 42-Public Health, Volume 4-5, Chapter IV, Part 441.15; Part 484.1 – 484.375; and Part 440, Subpart A §440.70). This section describes eligible providers, covered services, service limitations, and the general reimbursement methodology.

Eligible Recipients:

Recipients must have a medical need to receive care at home to be eligible for home health agency services and must be certified as such by their attending physicians. A medical need to receive care at home means that the recipient has a condition caused by illness or injury which renders him/her unable to leave the home to obtain necessary medical care and treatment (i.e., is essentially homebound) or that the medical need for care at home is more appropriate and cost-effective and will prevent or delay institutionalization. Recipients do not need to be bedridden to be considered as having a medical need to receive care at home.

Recipients may be considered eligible to receive care at home if they meet 1 or more of the following criteria:

1. Recipients who cannot leave their residences without the use of wheelchairs, crutches, walkers or assistance from another individual.
2. Recipients who because of severe physical or mental illness or injury must comply with doctor's orders and avoid all stressful physical activity.
3. Recipients who cannot leave their residences because of danger caused by a mental condition.
4. Recipients who have just returned to their residence after hospital stays for severe illness or surgical procedures and whose activities are restricted by their physicians because of pain, suffering, medical limitation or danger of infection.
5. Recipients who are at high risk during pregnancy, infancy or childhood and for whom home health care is more appropriate to their needs.

Recipients are not eligible to receive care at home just because they

1. Cannot drive,
2. Have multiple medical problems or
3. Live in an isolated area.

Recipients can leave their residences occasionally for medical treatment or personal errands and be eligible to receive home health care.

Coverage Determination

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

PHP follows New Mexico Health Care Authority, Provider Policies, Specialty Services, Home Health Services NMAC 8.325.9 for MAD 768 and Rehabilitation Service Providers NMAC 8.325.8 Medicaid Care Managed Care Policy Manual and we also follow MCG for determination of frequency and intensity of services.

Medicaid covers those home health services which are skilled, intermittent, and medically necessary. The focus of home health services shall be on the curative, restorative or preventive aspects of care. The goal of these services shall be to assist the recipient to return to an optimum level of functioning and to facilitate the timely discharge of the recipient to self-care or to care by his/her family, guardian or significant other. Services must be ordered by the recipient's attending physician and included in the plan of care established by the recipient's attending physician in consultation with home health agency staff. The plan of care must be reviewed, signed and dated by the attending physician.

The attending physician certifies that the recipient has a medical need to receive care at home at the initial certification, and as part of the plan of care review at recertification.

The attending physician certifies that the recipient requires the skilled services of a nurse, physical therapist, occupational therapist or speech therapist. If the recipient requires home health aide services or medical social work services, the physician shall certify the need for these services. The evaluation visit is covered whether or not the recipient is admitted to home health care.

Covered services include the following:

- NMAC 8.325.8 Rehabilitation Services Providers
    1. (8.325.8.12 COVERED SERVICES AND SERVICE LIMITATIONS)
- NMAC 8.325.9, (MAD 768) Provider Policies Specialty Services Home Health Services.
    1. **MAD 768.4 Covered Services**
    2. **MAD 768.41 Skilled Nursing Services**; Medicaid covers skilled, intermittent and medically necessary skilled nursing services.
    3. **MAD 768.42 Therapy Services**: Medicaid covers the therapy services furnished through the home health agency by licensed physical therapists, occupational therapists, or speech language pathologists.
    4. **MAD 768.43 Home Health Aide Services;** See condition listing in its entirety by accessing below link. See requirement of training, duties of the home health aide; and/or requirement a registered nurses or other appropriate professional staff members to make a supervisory visit to the recipient's residence at least every two (2) weeks to observe and decide whether goals are being met.
    5. **MAD 768.44 Durable Medical Equipment and Medical Supplies**: Medicaid covers medically necessary DME and medical supplies which are specified in the plan of care, (see NMAC 8.324.5.9).
    6. **MAD 768.45 Maternal/child services**: Medicaid covers perinatal and pediatric home health services such as treat a high-risk pregnancy, at-risk infant, illness, injury and to prevent infection when it meets reasonable and medically necessary.
- Medicaid Care, Managed Care Policy Manual
    1. Section 8: Agency Based Community Benefit (ABCB)
        a. 8.4. ABCB Covered Services
        b. 8.12. Home Health Aide (HH Aide)
        c. 8.18 – 8.21. Skilled Maintenance Therapies: Skilled maintenance therapies include Occupational Therapy (OT), Physical Therapy (PT) for Adults and Speech and Language Therapy (SLT) for individuals 21 years and older.
    2. Section 9: Self-Directed Community Benefit (SDCB)
        a. 9.10. SDCB Covered Services
        b. 9.11. SDCB- non-covered services

Documentation of Medical Need to Receive Care at Home: The home health agency is responsible for documenting on the written plan of care evidence of the recipient's medical need for home health care.

Plan of Care:

See Section 768.10 of NMAC 8.325.9, (MAD 768) Provider Policies Specialty Services Home Health Services.

The plan of care, established by the physician in consultation with the home health agency staff, and the request for prior approval must be received or postmarked within five (5) working days of the proposed start of services or recertification period by MAD or its designee. Plans of care must be signed and dated by the physician or verbal order signed by Registered Nurse, and prior approval must be received from MAD or its designee before claims are submitted to the MAD claims processing contractor. The plan of care must include the following:

1. All principle diagnoses, surgical procedures, and other pertinent diagnoses;
2. Medications and dosages;
3. Types of services, equipment and non-routine supplies required;
4. Frequency of visits;
5. Safety measures to protect against injury;
6. Nutritional/fluid balance requirements;
7. Allergies;
8. Functional limitations, activities permitted, and documentation of homebound status;

9. Mental status;
10. Prognosis;
11. Goals and measurable objectives, including rehabilitation potential, long range projection of likely changes in the recipient's condition and plans for timely discharge to self-care or to care by family, guardian or significant other; and
12. Clinical findings and updates.

The plan of care for home health services is certified by MAD or its designee for specific time periods, not to exceed sixty-two (62) working days.

The attending physician and home health agency professional personnel must review the total plan of care prior to a request for recertification and submit the revised plan, including a report on the patient's response to care provided under the previous plan of care and specifying changes in services required.

Exclusions – Non-Covered Services

Home health services are subject to the limitations and coverage restrictions of other Medicaid services. See NMAC (8.325.9), (See Section 768.5-Noncovered Services):

1. Services beyond the initial evaluation which are furnished without prior approval;
2. Home health services which are not skilled, intermittent or not medically necessary;
3. Services furnished to recipients who do not meet the eligibility criteria for home health services;
4. Services furnished to recipients in places other than their place of residence;
5. Services furnished to recipients who reside in intermediate care facilities for the mentally retarded or nursing facility (NF) residents who require a high NF level of service; Physical, occupational, and speech therapy can be furnished to residents of nursing facilities who require a low level of service.
6. Skilled nursing services which are not supervised by registered nurses; and
7. Services not included in written plans of care established by physicians in consultation with the home health agency staff.

NMAC 8.325.8.13 NONCOVERED SERVICES: Rehabilitation services are subject to the limitations and coverage restrictions of other Medicaid services. See 8.301.3 NMAC, General Noncovered Services. Medicaid does not cover the following rehabilitation services:

A. services furnished by providers who are not licensed and/or certified to furnish services;
B. educational programs or vocational training not part of an active treatment plan for residents in an intermediate care facility for the mentally retarded or for recipients under the age of twenty-one (21) receiving inpatient psychiatric services [42 CFR Section 441.13 (b)];
C. services billed separately by home health agencies, independent physical therapists, independent occupational therapists, or outpatient rehabilitation centers to recipients in high nursing facilities or inpatient hospitals;
D. transportation, for recipients in low level nursing facilities or other Medicaid recipients, to travel to outpatient hospital facilities unless there are no home health agencies, independent physical therapists or independent occupational therapists available in the area to provide the therapy at the recipient's residence; and
E. services solely for maintenance of the recipient's general condition; these services include repetitive services needed to maintain a recipient's functional level that do not involve complex and sophisticated therapy procedures requiring the judgement and skill of a therapist; services related to activities for the general good and welfare of recipients, such as general exercises to promote overall fitness and flexibility and activities to provide general motivation, are not considered physical or occupational therapy for Medicaid reimbursement purposes. [2/1/1995; 8.325.8.13 NMAC - Rn, 8 NMAC 4.MAD.767.4, 3/1/2012]

Reviewed by / Approval Signatures

Population Health & Clinical Quality Committee: Clinton White MD
Senior Medical Director: Jim Romero MD
Medical Director: Kresta Antillon
Date Approved: 08/27/2025

References

1. New Mexico Human Services Department, Chapter NMAC 8.325.9 (MAD 768) Home Health Service, Provider Policies, Specialty Services, MAD:97-12. Effective: 08-01-97. Accessed 07/31/2025
2. New Mexico Human Services Department, Chapter NMAC 8.325.8, Rehabilitation Services, Providers, Effective date March 1, 2012, [Cited 07/31/2025]
3. New Mexico Human Services Department, Chapter Managed Care Policy Manual, Turquoise Care Managed Care Policy Manual Effective July 01, 2024 [Cited 07/31/2025]
    a. Section 08 - Agency Based Community Benefits, Effective dates: July 1, 2024
    b. Section 09 – Self Directed Community Benefits, Effective dates: July 1, 2024
4. New Mexico Human Services Department, Chapter 8.324.5-Vision Appliances, Hearing Appliances, Durable Medical

Equipment, Oxygen, Medical Supplies, Prosthetic, and Orthotics, effective date January1, 2014. [Note: NMAC "*MAD.754*" is no longer mentioned in the NMAC 8.324.5 after the Repealed effective 2/1/95], [Cited 07/31/2025]

5. New Mexico Human Services Department, Archived Program Rules, Chapter 8.301.3-Medicaid General Non-Covered Services, Effective 03-01-06. [1-1-95; 8.301.3.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3-1-06; A, 5-14-10]. [Cited 07/31/2025]
6. New Mexico Human Services Department, Chapter 8.325.9, MAD 768, Home Health Services, effective 08-01-1997. [Cited 07/31/2025]
7. Electronic Code of Federal Regulations, CFR, Title 42: Public Health, Chapter IV, Subchapter G Standards and Certification:
   - **a.** Part 441.15 – Home health services, [43 FR 45229, Sept. 29, 1978, as amended at 45 FR 24889, Apr. 11, 1980; 63 FR 310, Jan. 5, 1998]. [Cited 07/31/2025]
   - **b.** Part §484.1 – 484.375 - Home Health Services. [Cited 09-16-2024]
   - c. Part 440.70 – Home health services, [85 FR 27626, May 8, 2020]. [Cited 07/31/2025]

Publication History

02-22-12	Original Effective Date 02-22-2012
05-25-16	Annual Review.
09-27-17	Annual Review. Accessed HSD and CFR Regs. No change.
07-31-19	Annual Review. Accessed NMAC and Code of Federal Regulations (CFR). Updated policy links. Changes to add additional coverage information such as maternal/child services, DME, documentation requirements and exclusion. Updated links.
11-18-20	Annual review. Reviewed by PHP Medical Policy Committee on 10-30-20. No change. Continue to follow NMAC 8.325.9. Updated the policy with all applicable Home Health LCD policy links and updated the links to CFR to the most updated revision. Continue with Prior Authorization.
09-22-21	Annual review. Reviewed by PHP Medical Policy Committee on 09-10-2021. No criteria change. Updated NMAC weblinks in the covered service section and added additional non-covered criteria. Weblinks were updated throughout the policy. Note: *MAD.754* is no longer mentioned in the NMAC 8.324.5, it was repealed effective 2/1/95; also, MAD 602 is now located in NMAC 8.301.3.9.
09-28-22	Annual review. Reviewed by PHP Medical Policy Committee on 08-17-2022. No change. NMAC 8.325.; 8.324.5, 8 and Manage Care Manual are on same revision as last review.
09-27-23	Annual review. Reviewed by PHP Medical Policy Committee on 08/16/2023. Removed duplication in two areas: 1) "Access MAD: 97-12 for further description on condition and service requirements for each of the covered services mentioned above" under covered section; and 2) "and 8.301.3.9, GENERAL NONCOVERED SERVICES. Medicaid does not cover the following home health agency services" under non-covered section. Added citation under the Plan of Care section to see Section 768.10 of NMAC 8.325.9. The overall policy had no change.
10-23-24	Annual review. Reviewed by PHP Medical Policy Committee on 09-20-2024. No change to policy just grammatical updates.
08-27-25	Annual review. Reviewed by PHP Medical Policy Committee on 08/01/2025. No change to the relevant sources.

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.