Clinical Policy: Home Health Services

Reference Number: WNC.CP.207 Coding Implications
Last Review Date: Revision Log

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description[1]

Home Health Services include medically necessary skilled nursing services, specialized therapies (physical therapy, speech-language pathology, and occupational therapy), home health aide services, and medical supplies provided to beneficiaries in any setting in which normal life activities take place, other than a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities; except for home health services in an intermediate care facility for Individuals with Intellectual Disabilities that are not required to be provided by the facility under subpart I of part 483 or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. Home health services cannot be limited to services furnished to beneficiaries who are homebound in accordance with 42 CFR 440.70.

Policy/Criteria[1]

I. WellCare of North Carolina® **shall cover** the following Home Health Services:

A. All Home Health Visits

1. Nursing, home health aide, and specialized therapy services are provided on a per-visit basis. Services provided are deemed appropriate when the service can be more effectively provided through Home Health Services due to either the frequency of the service or the member's condition. The medical records must include documentation supporting one or more of the following reasons that the services must be provided through Home Health Services instead of in the physician's office, clinic, or other outpatient setting.
   a. the member requires assistance, such as with opening doors and other routine activities, due to a physical impairment or a medical condition, making it difficult getting to and from the physician's office, clinic, or other outpatient setting.
   b. the member is non-ambulatory or wheelchair bound.
   c. the member would require ambulance transportation.
   d. the member is medically fragile or unstable:
      i. infants up to 6 weeks of age who have acute needs, who are at medical risk, or both.
      ii. post-surgery beneficiaries who are restricted from activity except for short periods of time.
      iii. travel is ill-advised due to:
         a) exacerbation of the condition;
         b) being detrimental to the member's health;

c) shortness of breath becoming exacerbated.

iv. beneficiaries who are experiencing severe pain.
v. beneficiaries who, because of their medical condition, must be protected from exposure to infections.
vi. beneficiaries who have just had major surgery.

e. leaving the home health service location would interfere with the effectiveness of the services:
   i. beneficiaries, especially young children, with an extreme fear of the hospital or physician's office.
   ii. beneficiaries living in an area where travel time to outpatient services would require 1 hour or more of driving time.
   iii. beneficiaries who need a service repeated at frequencies that would be difficult to accommodate in the physician's office, clinic, or other outpatient setting.
   iv. beneficiaries requiring regular and PRN (as needed) catheter changes.
   v. beneficiaries who have:
      a) demonstrated a failure to comply with medical appointments at a physician's office, clinic, or other outpatient facility due to a medical condition or cognitive impairment **and**
      b) suffered adverse consequences as a result.
   vi. beneficiaries requiring complex wound care, such as irrigation and packing, twice a day or more often.
f. the member requires training for the use of assistive devices specifically customized for his or her environment (such as bath chairs and shower grab bars).

B. Skilled Nursing Services

1. A member qualifies for skilled nursing services when he or she meets the Home Health Visit criteria and **all** the following requirements are met:
   a. the services are ordered by the member's attending physician and provided according to an approved plan of care (POC).
   b. the member requires medically necessary skilled nursing care that can be provided only by an RN or LPN.
   c. the member requires repeated skilled nursing assessments and ongoing monitoring that can be provided on an intermittent or part-time basis.

C. Specialized Therapy Services

1. A member qualifies for specialized therapy (physical therapy, occupational therapy, and speech-language therapy) assessment, evaluation, and treatment services when the Home Health Visit criteria is met and the specialized therapy service is determined to be medically necessary.

D. Home Health Aide Services

1. Home health aide services are ordered by the member's attending physician and delivered according to a POC that is established by the RN or licensed therapist and authorized by the attending physician. Home Health Aide services can be provided without other skilled services being ordered but will require skilled nursing supervision.

An eligible Medicaid member qualifies for home health aide services when he or she meets the Home Health Visit criteria and **all** of the following requirements apply:

a. the member requires help with personal care, ADLs, or other non-skilled health care as designated in the POC.
b. the service is provided under the professional supervision of an RN or licensed therapist in accordance with 21 NCAC 36.0401 and 42 CFR 484.80.
c. the tasks performed by the home health aide are those specified in the POC. The tasks must be within the scope of home care licensure rules as set forth by 10A NCAC 13J.

E. **Medical Supplies - Covered when they are:**

1. Ordered by a physician, physician assistant, or nurse practitioner;
2. Documented in the member's POC;
3. Medically necessary as part of the member's home health services, and reasonable for treatment of a member's illness or injury;
4. For a therapeutic or diagnostic purpose for a specific member and are not convenience or comfort items which are defined as items often used by persons who are not ill or injured, such as soaps, shampoos, lotions and skin conditioners, and pantiliners or pads;
5. Specifically ordered by the physician and included in the POC. The physician's order in itself does not make an item "medically necessary" for the purposes of coverage. The order authorizes the agency to provide the item, but the agency should bill for the item only if it meets criteria;
6. Not items routinely furnished as part of member care (minor medical and surgical supplies routinely used in member care, such as alcohol wipes, applicators, lubricants, lemon-glycerin mouth swabs, thermometers, nonsterile gloves, and thermometer covers). These items are considered part of an agency's overhead costs and cannot be billed and reimbursed as separate items;
7. Items that WellCare of North Carolina® considers to be a home health medical supply item. Items such as drugs and biologicals, medical equipment (i.e., Blood pressure cuffs, glucometers, etc.), orthotics and prosthetics, and nutritional supplements are examples of items not considered home health medical supplies;
8. Assessed for need and appropriateness every **60** calendar days. When incontinence supplies are being provided and the only service being rendered is physical or occupational therapy, the assessment for incontinence supplies may be conducted by the therapist;
9. Items needed in the provision of physical therapy, occupational therapy, speech language therapy, skilled nursing, or home health aide services are covered under the home health policy. Medical supplies not needed in the provision of these other home health services, are available for consideration under Medical Equipment Clinical Coverage Policies; **and**
10. Documented by the agency and the documentation supports the medical necessity and quantity of supplies for the member's need.

Note: Nonsterile gloves for agency staff use are considered an overhead cost to the agency and cannot be billed for Medicaid reimbursement. Gloves for use by the

member or caregiver can be billed but must meet medical necessity criteria to be covered. There must be a need for immediate contact with the member's bodily fluids or infectious waste to meet this criterion. Incontinence supplies for children under age 3 are considered age appropriate and not medically necessary and are, therefore, not covered.

II. WellCare of North Carolina® **shall not** cover the following Home Health Services:

A. Any services that were not ordered by a physician and included on the authorized POC or verbal order.
B. Medical supply items routinely furnished as part of member care, such as alcohol wipes, applicators, lubricants, mouth swabs, nonsterile gloves, or thermometers.
C. Medical supplies considered convenience or comfort items which are defined as items often used by persons who are not ill or injured, such as soaps, shampoos, lotions and skin conditioners, and pantiliners or pantiliners.
D. Any services when there is no evidence that the Home Health services are the most appropriate.
E. Provision of any service without documentation (in clinical or progress notes) to support that the service was provided in accordance with policy guidelines. All documentation must be signed and dated in accordance with accepted professional standards. The service provision must be supported by the POC.
F. Any services related to the terminal illness when the member has elected Medicare or Medicaid hospice benefits (home health services may be provided when they are unrelated to the terminal illness).

Background[1]

A. Medical Supply Items Not Listed on the Fee Schedule

1. In compliance with the CMS Home Health Final Rule Title 42, §440.70, items not listed on the home health fee schedule may be considered for coverage if requested by a provider, or a member through a provider, and submitted for prior authorization (PA) review of medical necessity. Non-listed items may be requested in accordance with the circumstances detailed below. When considering the use of the miscellaneous supply procedure code, do the following:
   a. determine whether the item is classified as a home health medical supply. Medical supplies are defined as consumable nondurable supplies that:
      i. are usually disposable in nature;
      ii. cannot withstand repeated use by more than one member;
      iii. are primarily and customarily used to serve a medical purpose;
      iv. are not useful to a member in the absence of illness or injury; **or**
      v. are ordered or prescribed by a physician.
   b. determine whether the item meets medical necessity criteria.
   c. document the medical reason for using this item instead of one listed on the fee schedule; retain this information in the member's medical records.

2. Items not listed on the fee schedule may be requested by the provider or member via their service provider using the process outlined for the following circumstances:
   a. Prior approval is required for miscellaneous supply billing, greater than $500. Prior approval must be submitted to WellCare of North Carolina for a review. Any prior approval request by a provider for a supply or DME item will be reviewed for medical necessity, regardless of fee schedule amount.
   b. A request for a HCPCS Code may be submitted to WellCare of North Carolina® by the provider or the member via their service provider, if the medical supply item would be used continuously but is not listed on the fee schedule.

Note: The Home Health Services Fee Schedule is a list of national HCPCS codes, as mandated under the Health Insurance Portability and Accountability Act (HIPAA) that can be found on NC Medicaid's website at https://medicaid.ncdhhs.gov/. Periodic updates are made to the fee schedule to accommodate coding changes made by CMS.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2023, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS ®* Codes	Description
T1999	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in "Remarks"

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original approval date	04/21	05/21
Reviewed HCPCS code.	08/21	11/21
Annual Review. HCPCS code reviewed	08/22	08/22
Annual Review. NCHC verbiage removed from NC Guidance Verbiage.	05/23	05/23
Annual Review. HCPCS code reviewed. Removed ICD-10-CMS and CPT code boxes.		

References

1. State of North Carolina Medicaid. Medicaid and Health Choice Clinical Coverage Policy No: 3A Home Health Services. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published April 1, 2023. Accessed January 3, 2024.

North Carolina Guidance

Eligibility Requirements

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as

long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:
   NCTracks Provider Claims and Billing Assistance Guide:
   https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
   EPSDT provider page: https://medicaid.ncdhhs.gov/

Provider(s) Eligible to Bill for the Procedure, Product, or Service
To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Compliance
Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Claims-Related Information
Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

a. Claim Type - as applicable to the service provided:
   Professional (CMS-1500/837P transaction)
   Institutional (UB-04/837I transaction)
   Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

b. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.
c. Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
   Unlisted Procedure or Service
   CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.
   HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service
d. Modifiers - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
   For Medicaid refer to Medicaid State Plan:
   https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.