Medical Policy

Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

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BCN Policy Effective Date: 7/13/23
(See policy history boxes for previous effective dates)

Title: Home Health Care

Description/Background

A coordinated home health care program may be used as an extension of hospital or approved convalescent care services. Services are provided in the home setting as an alternative to hospitalization or convalescent care or as a transition from an inpatient setting to the home setting. Its purpose is to allow individuals who meet certain criteria to remain in the home while receiving skilled care who would otherwise have to be hospitalized or be in a long-term care facility.

Home health care may be provided for those who meet the following conditions:

- The individual must be in need of intermittent skilled nursing care, physical therapy, speech therapy or occupational therapy.
- The patient is under the care of a physician who determines the need for home care, sets up the plan of care and periodically reviews the plan.
- The home health agency serving the patient is approved for payment by Blue Care Network.

Medical Policy Statement

The safety and effectiveness of home health services have been established. They are useful therapeutic options for patients who meet the specific criteria listed in this policy and it is within the limits of the member's certificate.

Inclusionary and Exclusionary Guidelines

Inclusions:

Conditions of Coverage

1. **Typically*,** the member should either be:
   - Discharged from a hospital or skilled nursing facility directly to the home care program, be essentially homebound and be discharged earlier than would be possible without home care services, or
   - Essentially homebound for medical reasons and must be physically unable to obtain needed medical services on an outpatient basis.

   ***Please note that the homebound requirement is not mandatory.**
2. The home health care agency must obtain pre-authorization from Care Management when required by the plan.
3. The services requested by a home health care provider must meet the established InterQual® criteria for home health care.
4. The home health care program must represent a cost-effective alternative to covered services that the member would otherwise have to receive in a hospital or other more costly setting.
5. The member must be medically in need of skilled nursing care or skilled rehabilitation therapy and the rehabilitation services must be expected to result in significant improvement of the member's condition within 60 days or meet the definition of terminally ill, not ready for traditional hospice services.
6. The member must be willing to accept home care and have a suitable support system available. The member's primary care physician or plan medical director must refer the member for home health care services.
7. Medical-social services to help the patient with emotional concerns related to the illness (if ongoing counseling is required, behavioral health should be recommended).

BCN will cover the following services if all of the qualifying criteria are met:

- Skilled nursing care on a part-time or intermittent basis.
  Skilled nursing care includes services and care that can only be performed safely and correctly by a licensed nurse. The term "part-time or intermittent" for purposes of coverage means skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) **less than 8 hours each day and 28 or fewer hours** each week (**or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week)**. For any home health services to be covered, the patient must meet the qualifying criteria, including having a need for skilled nursing care on an intermittent basis, physical therapy, speech-language pathology services, or a continuing need for occupational therapy as defined in this section.
- The home aide benefit is covered only when the services of a nurse or a skilled rehabilitation provider are needed.
- Be in need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology; or have a continuing need for occupational therapy
- Medical-social services to help the patient with emotional concerns related to the illness
- Certain medical supplies, such as wound dressings.
- Durable medical equipment such as a wheelchair or walker. Covered under the DME benefit. Appropriate DME copays will apply.

Plan of Care: Home health care services are ordered pursuant to a written plan of care approved by the member's primary care physician, coordinated by a BCN clinical team member when necessary and provided by BCN affiliated providers. The plan of care must:

- Meet the BCN home health care conditions of coverage listed above.
- Be reviewed and signed by the primary care physician not less frequently than every two months (60 days).
- Be submitted to the health plan in accord with required authorization guidelines.

Care of the Terminally Ill: With BCN clinical team member discretion and plan medical director approval, palliative home care, under the intermittent skilled nursing services is a covered benefit for the terminally ill member. This is reserved for members who do not wish to choose traditional hospice care, yet require home care support despite the fact their condition will not improve and skilled needs may be minimal.

Covered Services and Supplies: Home health care services and supplies may be covered for an eligible member. The member must have a documented medical need for the services or supplies for the condition under treatment and the services must be in accordance with the member's prescribed and approved plan of care.

Intermittent Skilled Nursing Care includes, but is not limited to:

1. Observation and assessment of the member's condition requiring the special skills of a trained professional when the likelihood of change in a member's condition requires skilled nursing or skilled rehabilitation services to identify and evaluate the member's need for possible modification of treatment. Initiation of additional medical procedures until the member's treatment regimen is essentially stabilized.
2. Provision of direct care:
    - Application of dressings involving prescription medications and aseptic technique
    - Treatment of decubitus ulcers, with a severity rating of Grade 3 or worse, or a widespread skin disorder
    - IV, IM or SQ injections or hypodermoclysis or IV feedings. Although giving an insulin injection is a skilled service, it is customary to teach the member to self-administer an injection. If self-injection cannot be learned, however, the insulin injection is a skilled service
    - Nasogastric tube, gastrostomy and jejunostomy feedings
    - Nasopharyngeal and tracheotomy aspirations
    - Insertion, sterile irrigation and replacement of catheters, care of a suprapubic catheter and, in selected members, urethral catheter. (The mere presence of a urethral catheter, particularly for convenience or control of incontinence, does not justify the need for skilled nursing services. However, the insertion and maintenance of a urethral catheter as an adjunct to the active treatment of disease of the urinary tract may justify a need for skilled nursing care.)
3. Instruction of the member, family members and other caregivers on the aspects of the member's care:
    - Self-administration of injectable medications or a complex medication regime
    - Administration of insulin to a newly diagnosed diabetic
    - Self-administration of medical gases (oxygen) to a member
    - Care for a recent ostomy (colostomy, ileostomy or urostomy)
    - Self-catheterization
    - Gastrostomy feedings

- Use and care of braces, splints, orthotics and any associated skin care
- Care of specialized dressings or skin treatments
- Care and maintenance of central venous lines, such as Hickman catheters

4. Coordination and management of the member's care through communication with other members of the home health care team and the member's primary care physician

Home Health Aide Services: These services are covered **only when provided in conjunction with skilled nursing care or skilled rehabilitation therapy**: The care must be part-time and for the purpose of providing hands on personal care to the member or to maintain the member's health or to facilitate treatment of the member's illness or injury, including the following:

- Personal care – bathing, dressing, grooming, foot care, etc.
- Simple dressing changes
- Assistance with medications that are ordinarily self-administered and do not require the skills of a licensed nurse
- Routine care of prosthetics and orthotics

Prescription Drugs:

- Oral medications are not covered under the BCN Home Health Care program. Coverage may be available under a drug rider (including Medicare Part D.)
- IV administered prescription medications, injectable medications and prescription parenteral solutions and enteral suspensions are covered under the BCN Home Health Care program to treat the condition for which the member is in the Home Health Care program, but not an unrelated condition.
- There is no coverage for IV therapy under BCN-65 unless the member had an applicable exact fill rider.

Exclusions

- 24-hour-a-day care at home (at any level).
- More than eight hours per day or more than **28 hours** each week of combined skilled nursing or health aid care (see **exception** in the inclusions section).
- Housekeeping, homemaker, laundry and chore services in the absence of the need for skilled nursing services.
- Food, food supplements and home delivered meals
- Long-term care and custodial maintenance, including, but not limited to private duty nursing or home health aide services.
- Maintenance rehabilitation therapy including maintenance physical therapy, occupational therapy or speech therapy.
- Replacement of family or personal support systems or community services in caring for an individual.
- Services not in compliance with the medical criteria of the program or in excess of the specific limits.
- Services for conditions of a normal pregnancy.
- Physician services (covered under separate benefit).
- Permanent or temporary equipment or appliances such as wheelchairs, hospital beds, oxygen equipment, walkers, etc. Coverage may be available under the durable medical, transportation and ambulance services benefits.
- Services addressing the needs of family members of the member and not needs of the member, e.g., counseling for the spouse of the member.

- Personal care comfort and hygiene items such as sheepskin, lotions, pillows, elastic stockings (except under BCN 1, see durable medical equipment).

CPT/HCPCS Level II Codes *(Note: The inclusion of a code in this list is not a guarantee of coverage. Please refer to the medical policy statement to determine the status of a given procedure)*

Established Revenue Codes:

0421	0431	0441	0551	0552	0561
0562	0571	0572	0581	0582	0583

Rationale

Medicare has established the medical necessity of home health care for patients who meet specific criteria. It has been found to be a useful alternative when the services may be safely rendered in the home setting.

Government Regulations
National:

Medicare Benefit Policy Manual, Chapter 7, Home Health Services.
Revision 10438, Issued: 11/06/20, Effective: 03/01/20, Implementation: 01/11/21.

Section 30 Conditions Patient Must Meet to Qualify for Coverage of Home Health Services

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

- Be confined to the home
- Under the care of a physician or allowed practitioner
- Receiving services under a plan of care established and periodically reviewed by a physician or allowed practitioner
- Be in need of skilled nursing care on an intermittent basis, or physical therapy, or speech-language pathology; or
- Have a continuing need for occupational therapy

Medicare Manual: Section 30.1.1 - Patient Confined to the Home
(Rev. 10438 Issued: 11/06/20, Effective: 03-01-20, Implementation: 01/11/21)
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 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) if the following two criteria are met:

1. Criteria-One:
   The patient must either:
   - Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence, OR
   - Have a condition such that leaving his or her home is medically contraindicated.

If the patient meets one of the Criteria-One conditions, then the patient must ALSO meet two additional requirements defined in Criteria-Two below.

2. Criteria-Two:
   - There must exist a normal inability to leave home; **AND**
   - Leaving home must require a considerable and taxing effort.

If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive health care treatment. Absences attributable to the need to receive health care treatment include, but are not limited to:

- Attendance at adult day centers to receive medical care;
- Ongoing receipt of outpatient kidney dialysis; or
- The receipt of outpatient chemotherapy or radiation therapy.

[See the remaining chapter information for examples of homebound patients; definition of place of residence, definition of allowed practitioner, plan of care, supporting documentation requirements, etc.]

Section 40 Covered Services Under a Qualifying Home Health Plan of Care (Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01-11-21)

Section 1861(m) describes home health services as

- Part-time or intermittent skilled nursing care (other than solely venipuncture for the purposes of obtaining a blood sample);
- Part-time or intermittent home health aide services;
- Physical therapy;
- Speech-language pathology;
- Occupational therapy;
- Medical social services;
- Medical supplies (including catheters, catheter supplies, ostomy bags, supplies related to ostomy care, and a covered osteoporosis drug (as defined in §1861(kk of the Act), but excluding other drugs and biologicals);
- Durable medical equipment while under the plan of care established by physician or allowed practitioner;
- Medical services provided by an intern or resident-in-training under an approved teaching program of the hospital in the case of an HHA which is affiliated or under common control with a hospital; and
- Services at hospitals, skilled nursing facilities, or rehabilitation centers when they involve equipment too cumbersome to bring to the home.

The term "part-time or intermittent" for purposes of coverage under §1861(m) of the Act means skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week). See §50.7.

For any home health services to be covered by Medicare, the patient must meet the qualifying criteria as specified in §30, including having a need for skilled nursing care on

an intermittent basis, physical therapy, speech-language pathology services, or a continuing need for occupational therapy as defined in this section.

Local: NA

(The above Medicare information is current as of the review date for this policy. However, the coverage issues and policies maintained by the Centers for Medicare & Medicare Services [CMS, formerly HCFA] are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. For the most current information, the reader should contact an official Medicare source.)

Related Policies

Hospice Care

References

1. Medicare Benefit Policy Manual. Chapter 7, Home Health Services. Revision 11447, 06-22-22 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf Accessed June 1, 2023.

The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through June 1, 2023, the date the research was completed.

BCN Medical Policy History

Date	Rationale
6/30/99	Original BCN medical policy
5/30/01	Criteria and formatting updated
7/29/05	Routine maintenance
1/26/06	New criteria added
1/26/07	Addition added to exclusions
5/21/08	Routine maintenance
2/17/10	Routine maintenance
5/18/11	Routine maintenance; updated Medicare inclusions and exclusions
5/16/12	Routine maintenance; no change in policy status
5/15/13	Routine maintenance. Policy recommended for retirement as all services are on autopay.
11/19/14	Policy “unretired” to update definition of “homebound” status.
11/18/15	Routine maintenance, no change in policy status.
11/16/16	Routine policy maintenance. Updated references Michigan Medicaid name change. Removed Bluecaid reference.
11/15/17	Routine policy maintenance. Updated references.
11/14/18	Routine policy maintenance, removed Medicaid reference from the government section. No change in policy status.
09/24/19	Routine policy maintenance. No change in policy status.
7/9/20	Routine policy maintenance. No change in policy status.
7/15/21	Routine policy maintenance. No change in policy status.
7/7/22	Routine policy maintenance; no change in policy status.
7/13/23	Routine policy maintenance; no change in policy status. Vendor: N/A (ky)

Next review date: 3rd Qtr. 2024

MEDICAL POLICY TITLE: HOME HEALTH CARE
BCN BENEFIT ADMINISTRATION

I. Coverage Determination

Commercial HMO (includes Self-Funded groups unless otherwise specified)	Covered; criteria apply.
BCNA (Medicare Advantage)	See government section.
BCN65 (Medicare Complementary)	Coinsurance covered if primary Medicare covers the service.

II. Administrative Guidelines

- The member's contract must be active at the time the service is rendered.
- The service must be authorized by the member's PCP except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Services must be performed by a BCN-contracted provider, if available, except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Payment is based on BCN payment rules, individual certificate benefits and certificate riders.
- Appropriate copayments will apply. Refer to certificate and applicable riders for detailed information.
- CPT - HCPCS codes are used for descriptive purposes only and are not a guarantee of coverage.