LA.CLI.047 Home Health

Effective Date:	February 19, 2024	Accountable Dept.:	Medicaid Clinical Delivery Experience 10585
Last Reviewed Date:	February 19, 2024		

Summary of Changes:

Policy updated due to changes in Home Health Provider Manual.

Scope:

This policy applies to all Humana Healthy Horizons® in Louisiana (Plan) associates who administer, review, or communicate covered physical and behavioral health benefits and services to eligible enrolled members.

The purpose of this policy is to define Home Health Services and the criteria for medical necessity for Humana Healthy Horizons® in Louisiana.

Procedures:

Home health services are reimbursable only when ordered by an authorized healthcare provider (AHP) who certifies that the member meets the medical necessity criteria (Refer to section 23.3) to receive services a residential setting on an intermittent basis. An AHP includes a physician, nurse practitioner, clinical nurse specialist, or physician assistant licensed, certified, registered, or otherwise authorized to order home healthcare services consistent with State law.

Services may be provided in the member's place of residence, which is defined as the place where normal life activities take place, but cannot include a hospital, intermediate care facility for individuals with intellectual disabilities or any setting in which payment is or could be made by Medicaid for inpatient services that include room and board. However, members in an ICF-IID may receive short-term home health care from registered nurse (RN) during an acute illness to avoid the member being transferred to a nursing home.

Covered Home Health Services

Covered home health services include the following:

- Skilled Nursing (Intermittent or part-time);
- Home Health Aide Services are provided in accordance with the POC as recommended by the attending physician;
- Extended Skilled Nursing Services (also referred to as Extended Home Health), as part of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, is extended nursing care by a an RN or a licensed practical nurse (LPN) and may be provided to members under age 21 who are considered "medically fragile";
- Rehabilitation Services are physical, occupational and speech therapies, including audiology services; and
- Medical Supplies, Equipment and Appliances as recommended by the physician,

required in the POC for the member and suitable for use in any setting in which normal life activities take place are covered under the Durable Medical Equipment (DME) program when approved by the Prior Authorization Unit (MCO).

General Member Criteria

Members do not have to be homebound in order to receive home health services. The member cannot receive services in a hospital, nursing home, or intermediate care facility for individuals with intellectual disabilities (ICF-IID) (with limited exceptions). The AHP must certify that the member meets the medical criteria to receive the service in their place of residence and is in need of the home health service on an intermittent basis. This certification and AHP plan of care must be maintained in the member's record and on file at the HHA. The AHP must review the plan of care (POC) every 60 days.

Exception: In accordance with 42 CFR Part 483, Subpart I, there are situations in which a member residing in an ICF-IID may receive home health services. For example, short-term home health services may be provided to a member in an ICF-IID during an acute illness to avoid a member's transfer to a nursing facility.

1. Skilled Nursing Services

   Nursing services provided on a part-time or intermittent basis by an RN or LPN that are necessary for the diagnosis and treatment of a member's illness or injury. Examples of skilled nursing services include but are not limited to the following:

   1.1 Frequently monitoring blood pressure, fluid status, or blood glucose;
   1.2 More rigorous assessment of symptoms, including pain, dyspnea, or constipation;
   1.3 Management of complex wounds;
   1.4 Patient education around therapy (e.g., home glucose monitoring and insulin administration); and
   1.5 Assessment of medication adherence.

   These services shall be consistent with the following:

   - Established Medicaid policy;
   - The nature and severity of the member's illness or injury;
   - The particular medical needs of the patient; and
   - The accepted standards of medical and nursing practice.

   The requested services must meet all of the following:

   - Be ordered and directed by a treating practitioner or specialist (M.D., D.O);
   - Care must be delivered or supervised by a licensed professional in order to obtain a specific medical outcome;
   - Services must be of skilled care in nature;
   - Services must be part-time or intermittent ; and
   - Services must be clinically appropriate and not more costly than an alternative health service.

2. Home Health Aide Services Only

   In some situations, a dually eligible member (one who has coverage from both Medicare and Medicaid) requires only home health aide visits. Medicare will not pay for this service unless skilled services (skilled nursing service, physical therapy, occupational therapy or speech language therapy) are also required. However, Medicaid will reimburse for home health aide visits if only home health aide visits are required. Claims of this nature must either have a cover letter attached explaining the reasons for the lack of Medicare coverage or include this explanation in the remarks section of the claim.

3. Extended Home Health

   Extended Home Health, also known as extended skilled nursing services (a minimum of three or more hours of nursing services per day) may be provided to members under the age of 21 by the HHA if determined to be medically necessary, ordered by an AHP, and prior authorized by the MCO. The member must require skilled nursing care that exceeds the caregiver's ability to care for the member without the extended home health services.

   Extended skilled nursing services may be provided to a Medicaid member birth through age 20 when it is determined to be medically necessary for the member to receive a minimum of three hours per day of nursing services. Medical necessity for extended skilled nursing services exists when the member has a medically complex condition characterized by multiple, significant medical problems that require nursing care in accordance with the Louisiana Nurse Practice Act (La. R.S. 37:911, et seq).

   NOTE: Skilled nursing services are to be conducted in the member's residential setting. Extended home health services may be provided outside of the residential setting when the nurse accompanies the member for medical reasons such as doctor appointments, treatments or emergency room visit. Medicaid will not reimburse for skilled nursing services performed outside of state boundaries.

4. Rehabilitation Services

   Physical, occupational and speech therapy services are covered when provided by the HHA. These services are covered with prior authorization (PA).

   Physical Therapy

   Physical Therapy Services are rehabilitative services necessary for the treatment of the member's illness or injury, or restoration and maintenance of function affected by the member's illness or injury.

   These services are provided with the expectation, based on the AHP's assessment of the member's rehabilitative potential, that:

   - The member's condition will improve materially within a reasonable and generally predictable period of time; or
   - The services are necessary for the establishment of a safe and effective maintenance program.

Occupational Therapy

Occupational therapy is a medically prescribed treatment to improve or restore a function which has been impaired by illness, injury or, when the function has been permanently lost or reduced, to improve the member's ability to perform those tasks required for independent functioning.

Speech Therapy

Speech-Language Therapy Services are those services necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of a communication disability.

5. Medical Supplies

   Medical Supplies recommended by the AHP, required in the care of the member and suitable for use in any setting in which normal life activities take place are covered under the DME program when approved by the MCO.

6. Service Limitations

   Home Health Services include part-time skilled nursing services, home health aide services, physical therapy, speech and occupational therapy, and medical supplies and equipment ordered by an authorized healthcare provider (AHP) as required in the care of the member and suitable for use in any setting in which normal life activities take place.

NOTE: Medicaid prohibits multiple professional disciplines in a member's residential setting at the same time. This includes but is not limited to nurses, home health aides, and therapists. However, multiple professionals may provide services to multiple members in the same residential setting when it is medically necessary. The Bureau of Health Services Financing (BHSF) will determine medical necessity for fee-for-service members. Medical necessity will be determined by a member's managed care organization (MCO) if the member is enrolled in an MCO.

Service limits for Home Health services are as follows:
Birth through age 20:

- No annual service limits;
- Prior authorization (PA) is required for multiple visits on the same day when medically necessary; and
- PA is required for extended home health services.

Ages 21 or older:

- Medicaid will reimburse only one visit per profession per day.
- PA is required for all nursing and rehabilitation services in a residential setting:
- Skilled-Nursing and Home Health Aide services;
- Physical Therapy;
- Occupational Therapy; and
- Audiology Services.

Medical Necessity Criteria

Medical necessity for home health services must be determined by medical documentation that supports the member's illness, injury and/or functional limitations. All home health services must be medically reasonable and appropriate. To be considered medically reasonable and appropriate, the care must be necessary to prevent further deterioration of a member's condition regardless of whether the illness/injury is acute, chronic, or terminal.

The services must be reasonably determined to:

- Diagnose, cure, correct, or ameliorate defects, physical and mental illnesses, and diagnosed conditions of the effects of such conditions;
- Prevent the worsening of conditions, or the effects of conditions, that endanger life or cause pain; results in illness or infirmity; or have caused, or threatened to cause a physical or mental dysfunctional impairment, disability or development delay;
- Effectively reduce the level of direct medical supervision required or reduce the level of medical care or services received in an inpatient or residential care setting; Restore or improve physical or mental functionality, including developmental functioning, lost or delayed as the result of an illness, injury, or other diagnosed condition or the effects of the illness, injury, or condition; or,
- Provide assistance in gaining access to needed medical, social, educational, and other services required to diagnose, treat, to support a diagnosed condition or the effects of the condition, in order that the member might attain or retain independence, self-care, dignity, self-determination, personal safety and integration into family, community, facility environments and activities.

Home health skilled-nursing and aide services are considered medically reasonable and appropriate when the member's medical condition and records accurately justify the medical necessity for services to be provided in the member's residential setting rather than in a physician's office, clinic, or other outpatient setting.

Home health services are appropriate when a member's illness, injury, or disability causes significant medical hardship and will interfere with the effectiveness of the treatment if the member has to go to a physician's office, clinic, or other outpatient setting for the needed service. Any statement on the plan of care (POC) regarding this medical hardship must be supported by the totality of the member's medical records.

The following circumstances are not considerations when determining medical necessity for home health services:

- Inconvenience to the member or the member's family;
- Lack of personal transportation; and,
- Failure or lack of cooperation by the member or the member's legal guardians or caretakers to obtain the required medical services in an outpatient setting.

Plan of Care

The AHP must certify that the member meets the medical criteria to receive the service in the member's residential setting and is in need of the home health services on an

intermittent basis. The AHP must order all home health services and sign a plan of care (POC) submitted by the HHA. If the HHA is unable to obtain a signed POC for an initial request, an unsigned POC may be submitted for a 30-day period only. The signed POC must be submitted with the new PA request in order for services to be approved.

The AHP must reauthorize the POC every 60 days.

Face-to-Face Encounter Requirements

For the initiation of home health services, a face-to-face encounter with the AHP and the member must occur no sooner than 90 days prior to the start of home health services, or no later than 30 days after the start of home health services.

The face-to-face encounter may be conducted by one of the following practitioners:

1. The beneficiary's AHP;
2. A nurse practitioner or clinical nurse specialist, working in collaboration with the beneficiary's AHP;
3. A physician assistant under the supervision of the beneficiary's AHP;
4. A certified nurse -midwife, as defined in section 1861(gg) of the Social Security Act; or
5. The attending acute or post-acute physician for beneficiaries admitted to home health immediately after an acute or post-acute stay.

Prior authorization Requirements

The home health agency (HHA) must submit a plan of care (POC) and request prior authorization for extended skilled nursing services (also referred to as Extended Home Health or EHH), multiple daily nursing visits for members under age 21 who are not receiving extended skilled nursing services, adults ages 21 and older, or rehabilitation services (therapies). Prior authorization (PA) approval must be received before services are provided.

Home Health Services

Routine skilled nursing and home health aide services for members who are age 21 and older require PA. For the initiation of all home health services a face-to-face encounter between the AHP and the beneficiary must occur no sooner than 90 days prior to the start of home health services, or no later than 30 days after the start of home health services.

Evidence of the face-to-face encounter is required by the MCO for routine skilled nursing and home health aide services for members ages 21 and older. If providers do not have this documentation prior to the initiation of services then the initial PA request must be for 30 days only. Providers must submit documentation of the face-to-face encounter with the new PA request in order for services to be approved.

An AHP's order must be submitted with the PA request. A POC will be accepted in lieu of a separate AHP's order if the frequency of visits are specified. If providers are unable to obtain a signed POC for a reconsideration request, an unsigned POC may be submitted for reconsideration requests for a 30-day period only. The signed POC must be submitted with the new PA request in order for services to be approved.

Rehabilitation Services

All home health rehabilitation services (physical, occupational and speech therapy) require prior authorization. All rehabilitation services (except for initial evaluations and wheelchair seating evaluations, which are restricted to one evaluation per discipline per beneficiary every 180 days) require prior authorization from the MCO. All evaluations must have an AHP's prescription that must be kept in the member's file

All initial PA requests must include a copy of the AHP's referral and the results of the evaluation of the member that documents the need for therapy. All renewal PA requests must include a copy of the AHP's referral and progress notes that document the need for the continuation of therapy.

Extended Skilled Nursing Services (Extended Home Health)

When requesting prior authorization for extended home health, all hours of care must be included with the PA request. In addition, the AHP's prescription, and a copy of the POC must be attached to the appropriate PA form. Cases approved for extended home health should be billed using appropriate codes for a registered nurse (RN) and a licensed practical nurse (LPN) in conjunction with the total number of hours provided, indicating the units as hours.

Prior Authorization Procedure of Extended Home Health Services at Hospital Discharge

In order to provide continuity of care for members, the following procedure will be used for members requiring extended home health care upon discharge from the hospital.

Prior to hospital discharge, the PA process can begin. The following information must be sent to the MCO:

- A letter of medical necessity from the AHP;
- A signed prescription indicating the number of hours of extended home health that are being requested;
- A copy of the admission assessment (history and physical);
- Progress notes;
- Discharge orders;
- A copy of the discharge summary, if available; and
- A copy of the unsigned POC. The unsigned POC will be accepted only if the member is being discharged from the hospital and is included with the above information. The POC assessment cannot be done in the hospital but must be done in the member's residential setting.

Definitions:

N/A

References:

Louisiana Department of Health, Home Health Services Provider Manual, Chapter twenty-three of the Medicaid Services Manual; Issued July 10, 2023

Version Control:

8/18/22: Policy creation-Approved by LDH for Readiness

4/20/23: UM Policy Committee-Added face-to-face encounter information.

9/7/23: UM Policy Committee-Updated policy to reflect change made in Home Health Provider Manual.

9/11/23: Changed to new template for Annual Review Due by 5.15.24. KWise, MCD Clinical Delivery Experience

2/19/24: LDH Approval date.

2/23/24: Minor changes to template due to updated policy sent to LDH for approval. KWise, RN MCD Clinical Delivery Experience

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Non-Compliance:

Failure to comply with any part of Humana's policies, procedures, and guidelines may result in disciplinary actions up to and including termination of employment, services, or relationship with Humana. In addition, state and/or federal agencies may take action in accordance with applicable laws, rules, and regulations.

Any unlawful act involving Humana systems or information may result in Humana turning over all evidence of unlawful activity to appropriate authorities. Information on handling sanctions related to noncompliance with this policy may be found in the Expectations for Performance, and Critical Offenses policies, both of which may be found in the Associate Support Center via Humana's secure intranet on Hi! (Workday & Apps/Associate Support Center).