

Policy	MM-0110
Effective Date	09/01/2024
Reviewed/Revised Date	6/22/2026
Next Review Date	6/22/2027
Origination Date	06/01/2024
Originated Department	Clinical Operations

Home Health Services

Audience
Medical Management

Purpose
<p>Medical policies provide general support for applying Mountain Health Co-Op member policy document coverage decisions, and the member-specific benefit plan document must be referenced. The terms of the member-specific Policy document may differ from the standard benefit plan based on this medical policy. If there is a conflict between a member-specific policy document and the Mountain Health Co-Op medical policy, the document supersedes this policy. Any person(s) applying this medical policy must identify member eligibility, the member-specific policy document, and related policies or guidelines before applying this medical policy, including the existence of any state or federal guidance. Mountain Health Co-Op medical policies are designed for informational purposes only and are not an authorization, explanation of benefits, or contract. Receipt of benefits is subject to the satisfaction of all terms and conditions of the member-specific policy document coverage. Mountain Health Co-Op reserves the sole discretionary right to modify all policies and guidelines at any time.</p>

Definition
<p>History: Home Health care refers to skilled care delivered directly in a patient’s home. This type of care is provided by a licensed medical professional, including nurses, therapists, and aids for the purpose of treating or managing an illness, injury, or medical condition.</p> <p>A home health aide (HHA) assists a member n their home environment with non-skilled custodial care to meet activities of daily living, such as bathing and mobility. HHAs may also provide routine care of prosthetic/orthotic devices, record vital signs or other health monitoring values such as blood glucose, assist with a prescribed home exercise program, assist with elimination, or assist in feeding a prescribed diet. HHAs are trained and certified professionals but do not fall under the realm of “skilled” professionals because their level of training is general. HHA services are rendered</p>

in conjunction with intermittent skilled home health care services provided by a registered or licensed practical nurse, physical therapist, occupational therapist, or speech therapist.

Policy/Procedure

Clinical Indications:

The utilization review nurse may approve up to 12 initial home health visits if the request is associated with a hospital discharge and the following criteria are met. Home health services facilitate discharge from the hospital and reduces risk of readmission.

Medically Necessary:

1. Home health services are considered **medically necessary** when **all** the following criteria **A through C** are met:
 - 1.1. The individual is confined to the home:
 - 1.1.1. In general, the patient is unable to leave home, or leaving home requires a considerable amount of effort; and
 - 1.1.2. If the patient does leave the home, the absences are infrequent, for short periods of time, or are for health care treatment.
 - 1.2. The service must be prescribed by a health care provider practicing within the scope of their license; **and**
 - 1.3. The services(s) requires treatment provided directly by:
 - 1.3.1. Qualified technical or professional health personnel such as registered nurses, licensed practical (vocational)nurses, physical therapists, licensed social workers, speech pathologists, or audiologists; **and**
2. Home Infusion treatments are **medically necessary** because they are more appropriately performed in the home setting, even if the member is not home-bound.

Medically Necessary:

Home health services are considered **not medically necessary** when:

1. The treatment plan provided by the primary care physician does not show the continued need for skilled intervention; or
2. Goals have been met per plan of care.

Mountain Health Co-Op may cover certified home health aide services if coverage is specified in the member's contract.

Indications for which home health aides would be considered for coverage include:

1. Assistance with personal care such as bathing, dressing, grooming, feeding, toileting, elimination, or catheter and colostomy care.
2. Simple wound dressing changes do not require a licensed nurse's skills.
3. Assisting with medications that are ordinarily self-administered and do not require the skill of a licensed nurse for safe and effective provision.
4. Assisting with activities that directly support skilled therapy services but do not require the skill of a therapist to be safely and effectively performed, such as routine maintenance exercises.

5. Routine care of prosthetic and orthotic devices.

Mountain Health Co-Op does NOT cover home health aide services for the following:

1. The visit is solely for household tasks, transportation, companionship, or socialization.
2. Services that are not medically necessary.
3. Services that do not require a skilled need.
4. Services provided in a hospital, nursing facility (NF), or intermediate care facility (ICF).

Mountain Health Co-Op will NOT cover more than one home health aide visit per day unless the service is indicated due to the patient's clinical condition and has been pre-authorized.

Mountain Health Co-Op will NOT cover personal care aide visits

Applicable Coding

HCPCS Codes

- G0156** Services of home health/hospice aide in home health or hospice settings, each 15 minutes
- S9122** Home health aide or certified nurse assistant, providing care in the home per hour
- T1021** Home health aide or certified nurse assistant, per visit

CPT Codes

No applicable codes

References

1. Centers for Medicaid and Medicare Services (CMS); (2018) "Home Health Agencies Interpretive Guidelines". Memo# QSO-18-25 HHA. <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/Q>
2. Najera LK, Heavey BA. Nursing strategies for preventing home health aide abuse. Home Healthcare Nurse. 1997;15(11):758- 767; quiz 769-770.
3. Rossman, E. (1997). On-the-Job Performance of Home Health Aides: A Structural Interpretation. Human Organization, 56(4), 393-399. Retrieved February 6, 2020, from www.jstor.org/stable/44127876
4. Centers for Medicare & Medicaid Services (CMS). Medicare Benefit Policy Manual, Chapter 7: Home Health Services. Rev. 258, Issued March 22, 2019. Available at: <https://www.cms.gov/manuals/downloads/bp102c07.pdf>. Accessed September 16, 2021.
5. Centers for Medicare & Medicaid Services (CMS). National Coverage Determination (NCD) 290.2: Home Nurse Visits to Patients Requiring Heparin Injection. Available at: <https://www.cms.gov/medicare-coverage-database>. Accessed September 16, 2021.
6. Centers for Medicare & Medicaid Services (CMS). National Coverage Determination (NCD) 290.1: Home Health Visits to a Blind Diabetic. Version 2. Effective October 1,

2006. Available at: <https://www.cms.gov/medicare-coverage-database>. Accessed September 16, 2021.

- Centers for Medicare & Medicaid Services (CMS). National Coverage Determination (NCD) 240.7: Postural Drainage Procedures and Pulmonary Exercises. Effective September 1, 1988. Available at: <https://www.cms.gov/medicare-coverage-database>. Accessed September 16, 2021.

Vendors

- Health Plan Services (HPS)
- MedComm

Review/Revision/Approval History

Date	Description
06/01/2024	New Policy
06/22/2026	Reviewed and approved by Policy Committee Merged Home Health Aide Services and Home Health Services policies into a single Clinical Criteria document to streamline review and administration

Disclaimer

This document is for informational purposes only and should not be relied on in the diagnosis and care of individual patients. Medical and Coding/Reimbursement policies do not constitute medical advice, plan preauthorization, certification, an explanation of benefits, or a contract. Members should consult appropriate healthcare providers for medical advice, care, and treatment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member's benefit plan, effective when services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. Including or excluding a procedure, diagnosis, or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as they apply to an individual member.

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