Application

Application of this Medical Policy applies to:
RIte Care (MED), Rhody Health Partners (RHP), Rhody Health Expansion (RHE), Children with Special Health Care Needs (CSN), Substitute Care (SUB), Commercial (HBE), INTEGRITY for Duals (FIDE), Duals CONNECT (CO-DSNP)
Application Excluded for:
Extended Family Planning (EFP)

Medicare Distinction

For INTEGRITY for Duals (FIDE) and Duals CONNECT (CO-DSNP) members: Neighborhood Health Plan of Rhode Island (Neighborhood) uses guidance from the Centers for Medicare and Medicaid Services (CMS) for coverage determinations, including medical necessity. Coverage determinations are based on applicable National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs), and other Medicare guidelines.

For FIDE Members: In the absence of an applicable or incomplete NCD, LCD, or other Medicare guidelines OR if available Medicare coverage guidance is not met, then Neighborhood will apply coverage guidance from the Rhode Island Executive Office of Health & Human Services (EOHHS), or other widely used treatment guidelines with peer-reviewed scientific evidence, such as InterQual® and/or internal Clinical Medical Policies as a means of secondary coverage through the member's Medicaid benefit.

For CO-DSNP Members: In the absence of an applicable or incomplete NCD, LCD, or other Medicare guidelines, then Neighborhood will apply coverage guidance from other widely used treatment guidelines with peer-reviewed scientific evidence, such as InterQual® and/or internal Clinical Medical Policies.

Description

Neighborhood covers skilled home health services for medically necessary care for homebound members or for members who are not homebound when Neighborhood determines that the member's home setting, or another location other than a medical office is the most appropriate setting to carry out the plan of care in order to minimize the risk of deterioration in the member's health status or to prevent placement in a more costly and restrictive setting.

Definitions:

Home Health Services: Home Health Services are those services as defined in 42 C.F.R. §440.70, include:

1. Part-time or intermittent skilled nursing
2. Skilled rehabilitative therapy including physical therapy, occupational therapy, and speech therapy
3. Qualified home health aide services, when determined to be an essential part of an authorized skilled home care program directly related to the skilled plan of care that includes the skilled need for nursing or therapy services
4. Medical social services only when determined to be an essential part of an authorized skilled home care program directly related to the skilled plan of care that includes the skilled need for nursing or therapy services
5. Durable medical equipment
6. Disposable medical supplies used in the course of an authorized home health care visit
7. Nutritional counseling, only when determined to be an essential part of an authorized skilled home care program directly related to the skilled plan of care that includes the skilled need for nursing or therapy services.

Intermittent and Part-Time Skilled Service:

- Services are intermittent if up to eight (8) hours per day of medically necessary nursing visits and home health aide services, combined, are provided seven (7) days per calendar week for temporary periods of up to 21 days.
- Services are part-time if the combination of medically necessary nursing visits and home health aide services does not exceed 35 hours per calendar week, and those services are provided on a less-than daily basis.
- To receive intermittent or part-time nursing care, the member must have a medically predictable recurring need for skilled nursing services at least once every 60 days, or the member must meet the conditions listed under letter D.
- In certain circumstances, the member needs infrequent, yet intermittent, nursing services. The following are nonexclusive examples of such services:
    i. The member has an indwelling silicone catheter and generally needs a catheter change only at 90- day intervals.
    ii. The member experiences a fecal impaction due to the normal aging process (that is, loss of bowel tone, restrictive mobility, and a breakdown in good health habits) and must be manually dis-impacted. Although these

impactions are likely to recur, it is not possible to predict a specific time frame.

iii. The member is diabetic and visually impaired. He or she self-injects insulin and has a medically predictable recurring need for a nursing visit at least every 90 days. These nursing visits, which supplement the physician's contacts with the member, are necessary to observe and determine the need for changes in the level and type of care that have been prescribed.

Skilled Services: A skilled service is a service that must be provided by a registered nurse, licensed practical nurse (under the supervision of a registered nurse), licensed physical therapist, occupational therapist, speech language pathologist or a licensed physical therapy assistant and licensed occupational therapy assistant (under the supervision of a licensed therapist) in order to be safe and effective. In determining whether a service meets the requirement of skilled care, the inherent complexity of the service, the condition of the patient, and generally accepted standards of clinical practice must be considered. Some services may be considered skilled on the basis of complexity alone. In other cases, a service that is ordinarily considered unskilled may be considered skilled on the basis of the patient's condition. A service is not considered skilled merely because it is performed by or under the direct supervision of a licensed nurse or therapist. When the service could be safely and effectively performed by the average non-medical person without direct supervision, the service would not be considered skilled.

Homebound: If the member does leave the home, the absences must be infrequent and for short periods of time (i.e., attending a religious service, funeral, or other unique event) or are for health care treatments. The member does not have to be bedridden and can be considered confined to the home (homebound) if the following two criteria are met:

Criteria 1

- Due to illness or injury, the member must need either:
  i. The aide of supportive devices such as crutches, canes, wheelchairs, and walkers; or
  ii. The use of special transportation; or
  iii. 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

Criteria 2

A. There must exist a normal inability to leave home; and
B. Leaving home must require a considerable and taxing effort (i.e. when medical conditions or symptoms like dyspnea, weakness, frailty, confusion, pain, use of crutches, a wheelchair or the need for assistance from another person make leaving home difficult).

Home Setting: Any place where the member has established his/her place of residence for the time period when home care services are being provided. This may include his/her own dwelling, an apartment, the home of a friend or family member, a group home, a homeless shelter or other temporary place of residency or a community setting. Hospitals, skilled nursing facilities intermediate care facility for the developmentally disabled, or any other institutional facility providing medical, nursing, rehabilitative, or related care, will not be considered "home setting."

- A day care setting, adult day care, or adult medical care does not meet the definition of a home setting.
- If it is determined that the assisted living facility (also called personal care homes, group homes, etc.) in which the individuals reside are not primarily engaged in providing the above services, then Neighborhood will cover reasonable and necessary home health care furnished to these members.

Coverage Determination

Neighborhood utilizes Change Health Care InterQual® criteria in reviewing medical necessity for Home Health care. This criteria aligns with CMS Medicare Benefit Policy Manual Chapter 7- Home Health Services. InterQual® includes medical necessity criteria for the following home health services:

InterQual® LOC: Home Care Q&A
Home Care Services, Adult
Home Care Services, Pediatric

Neighborhood recognizes that the criteria can never address all the issues; criteria cannot apply to every patient in every situation. Use of the criteria never replaces clinical judgment. Home health services are reasonable, and necessary must be based on an assessment of each patient's individual care needs. Therefore, denial of services based on numerical utilization screens, diagnostic screens, diagnosis, or specific treatment norms is not appropriate.

Criteria

Duals CONNECT members are required to meet the definition of homebound (see above) to receive skilled home health services in accordance with CMS guidelines for these services.

Home health services are reasonable and necessary when all the following criteria are met:

1. The member must be under the care of a physician or allowed practitioner in accordance with 42 CFR 424.22 and the home health services must be furnished under a plan of care that is established, periodically reviewed and ordered by a physician or allowed practitioner. A patient is expected to be under the care of the physician or allowed practitioner who signs the plan of care. It is expected that in most instances, the physician or allowed practitioner who certifies the patient's eligibility for home health services will be the same physician or allowed practitioner who establishes and signs the plan of care.
    a. The physician or allowed practitioner must recertify and sign the plan of care at least every sixty (60) days, or more frequently as the severity of the patient's condition requires. Reviews must be dated and signed by the physician or allowed practitioner.
    b. Content of the Plan of Care: The orders on the plan of care must specify the nature and frequency of the services to be provided to the member, and the type of professional who must provide them. The physician must sign the plan of care. An increase in the frequency of services or any addition of new services during a certification period must be authorized in advance by a physician with verbal (in accordance with state law) or written orders. The plan of care must contain:
        i. The services necessary to meet the patient-specific needs identified in the comprehensive assessment.
        ii. All pertinent diagnoses, including the member's mental status.
        iii. The types of services, supplies, and equipment ordered.
        iv. The identification of the responsible discipline(s) and the frequency and duration of all visits
        v. The prognosis, rehabilitation potential, functional limitations, permitted activities, nutritional requirements, medications, and treatments.
        vi. Any safety measures to prevent injury.
        vii. Measurable treatment goals which pertain directly to the patient's illness or injury, and the patient's resultant impairments; All relevant outcomes to be measured. For continued services for goals not met, the plan of care should include progress made toward the goal, any barriers that have or will impact the member's ability to meet the goal, the plan to address those barriers and the anticipated number of visits that are needed to meet the goals.
        viii. The discharge plans; and
        ix. Any additional items the home health agency or physician chooses to include.
2. As part of initial certification for patient eligibility for home health services, a face-to-face encounter (F2F) with the member must be performed by the certifying physician or allowed practitioner, a physician or allowed practitioner that cared for the patient in the acute or post-acute care facility (with privileges who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health), or an allowed non-physician practitioner.
    a. The F2F must be related to the primary reason the beneficiary requires home health services
    b. The F2F must occur no more than 90 days prior to the home health start of care date or within 30 days after the start of care.
    c. Telehealth services can be used to perform the F2F encounter.

d. When a physician or allowed practitioner orders home health care for the member based on a new condition that was not evident during a visit within the 90 days prior to start of care, then the member must be seen again within 30 days after admission.

3. The member must be in need skilled nursing care on an intermittent basis (other than solely venipuncture for the purposes of obtaining a blood sample), physical therapy, speech-language pathology services, or has continued need for occupational therapy to treat an illness, injury, or are post-partum following a high-risk pregnancy. See below for additional criteria for each specialty:

Skilled Nursing Services Skilled Nursing Services include the services of a registered nurse (RN) employed by or under contract with a home health provider. RN services include assessment of the individual's health status, identification of health care needs, determination of health care goals, and the development of the plan of care. Skilled nursing care includes teaching and counseling and is directed toward the promotion, maintenance, and restoration of health. The nurse evaluates responses of the family and individual to nursing interventions to determine the progress towards goal achievement and provider supervision to ancillary personnel.

Skilled Nursing Services are reasonable and necessary when:

A. There is a clearly identifiable, specific medical need for nursing services.
B. A nursing service is a service that must be provided by a registered nurse, or by a licensed practical nurse or licensed vocational nurse under the supervision of a registered nurse, to be safe and effective, considering the inherent complexity of the service, the condition of the patient, and accepted standards of medical and nursing practice.
C. Some services are nursing services on the basis of complexity alone (for example, intravenous and intramuscular injections, or insertion of catheters). However, in some cases, a service that is ordinarily considered unskilled may be considered a nursing service because of the patient's condition. This situation occurs when only a registered or licensed nurse can safely and effectively provide the service.
D. Nursing services for the management and evaluation of a plan of care are medically necessary when only a registered or licensed nurse can ensure that essential care is effectively promoting the member's recovery, promoting medical safety. Nursing services solely for satisfying oversight regulations without the presence of a skilled nursing service may not constitute management and evaluation of a plan of care.
E. Medical necessity of services is based on the condition of the patient at the time the services were ordered and what was, at that time, expected to be appropriate treatment throughout the certification period.

F. A member's need for nursing care is based solely on his or her unique condition and individual needs, whether the illness or injury is acute, chronic, terminal, stable, or expected to extend over a long period.

Home Health Aide Services (Nursing/Therapy Need)

Home health aide services include, but are not limited to:

- Personal care services.
- Simple dressing changes that do not require the skills of a registered or licensed nurse.
- Assistance with medications that are ordinarily self-administered and that do not require the skills of a registered or licensed nurse.
- Assistance with activities that are directly supportive of skilled therapy services, such as routine maintenance exercises and repetitive practice of functional communication skills to support speech-language pathology services; and
- **Incidental Services:** When a home health aide visits a member to provide a health-related service, the home health aide may also perform some incidental services that do not meet the definition of a home health aide service (for example, light cleaning, preparing a meal, removing trash, or shopping). However, the purpose of a home health aide visit must not be to provide these incidental services, since they are not health related services, and these services must remain a minimal proportion of assigned time.

Home health aide services are reasonable and necessary when:

A. Determined to be an essential part of an authorized skilled home health program directly related to the skilled plan of care that includes the need for skilled nursing or therapy services; and
B. The services are medically necessary to provide personal care to the member, to promote the member's health, or to facilitate treatment of the member's injury or illness under the skilled plan of care; and
C. The services provided by the home health aide must be part-time or intermittent.

Skilled Therapy Services

Skilled therapy services are reasonable and necessary when:

Services must meet all of the following conditions:

A. Directly and specifically related to an active treatment regimen.
B. Of such a level of complexity and sophistication that the judgment, knowledge, and skills of a licensed therapist are required.

C. Performed by a licensed therapist, or by a licensed therapy assistant under the supervision of a licensed therapist.
D. Considered under accepted standards of medical practice to be a specific and effective treatment for the member's condition.
E. Medically necessary for treatment of the member's condition; and
F. Must be considered skilled.

Maintenance Therapy

Maintenance therapy services are reasonable and necessary when:

A. Services are required to maintain the patient's current function or to prevent or slow further deterioration; and
B. Are of such complexity and sophistication that the skills of a qualified therapist are required to perform the procedure safely and effectively, and
C. The member's special medical complications require the skills of a qualified therapist to perform a therapy service safely and effectively that would otherwise be considered unskilled.

Medical Social Services

Medical social services are reasonable and necessary when:

A. Determined to be an essential part of an authorized skilled home care program directly related to the skilled plan of care that includes need for skilled nursing or therapy services.
B. Performed by a licensed Medical Social Worker.
C. These services are necessary to resolve social or emotional problems that are or are expected to be an impediment to the effective treatment of the patient's medical condition or rate of recovery.

Coding:

CPT Code	Description	Line of Business
S9097	Home visit for wound care	All
T1030	Nursing care, in the home, by registered nurse, per diem	All
T1031	Nursing care, in the home, by licensed practical nurse, per diem	All
G0151	Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes	All
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes	All
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes	All

G0156	Services of home health/hospice aide in home health or hospice settings, each 15 minutes	Medicaid, INTEGRITY, & CONNECT
S5125	Attendant care services; per 15 minutes	Commercial (only when furnished under a skilled plan of care)

Limitations and Exclusions

Medicaid, INTEGRITY, & CONNECT Members:

1. Must comply with all applicable requirements set forth in RI General Laws, 210-RICR-20-05-1, including but not limited to:
    - Skilled Home Health providers must be certified by the Centers for Medicare and Medicaid Services (CMS) to participate in the Medicare program as a provider of home health services.
    - The provider may not assign direct care staff to provide services to a member with whom the direct care staff resides.
    - The provider may not assign direct care staff to provide services to a member to whom the direct care staff has a family relationship. A family relationship is defined as:
        - Parent-child (including stepparent/stepchild) regardless of whether the member is the parent or child of the direct care staff and regardless of the age of the child;
        - Grandparent-grandchild (including step-grandparent/step-grandchild) regardless of whether the member is the grandparent or grandchild of the direct care staff and regardless of the age of the grandchild;
        - Sibling (including stepsiblings); and
        - Spouse
    - The provider may not assign direct care staff to provide services to a member for whom the direct care staff:
        - Has any type of guardianship;
        - Has any type of power of attorney;
        - Is the authorized representative designated on the individual member's application for Medicaid benefits

All covered lines of business:

1. Skilled Home Health Services:

1. Require a physician's order and physician approved written plan of care that is renewed at least every sixty (60) days.
2. Are not covered:
    - if provided in a hospital, nursing facility, intermediate care facility for the developmentally disabled, adult day center, or any other institutional facility providing medical, nursing, rehabilitative, or related care.
    - if not provided in a home setting, as defined above.
    - for respite, companionship, infant/child sitting, general supervision, meal services, homemaking, heavy cleaning, or household repair.
    - for personal care when there is not also a skilled need.
    - in the absence of a need for medically necessary skilled nursing services or skilled therapy services, such as but not limited to ADL and routine and age-appropriate infant and childcare for the sole purposes of providing extra assistance to the caretaker.
    - when a family member or other caregiver is providing services that adequately meet the member's needs, it is not medically necessary for the home health agency to provide such services.
    - if services can be safely and effectively performed or self-administered by the average nonmedical person without the direct supervision of a registered or licensed nurse are not considered nursing services and are excluded, unless there is no one able (for reasons other than convenience) to provide the services and the services are necessary to avoid institutionalization.
    - if services are related to activities for the general good and welfare of patients (for example, general exercises to promote overall fitness and flexibility, and activities to provide diversion or general motivation).
    - if venipuncture is the only purpose of the home health visit when there is comparable care available in the community.
    - if services are provided to anyone besides the member (i.e. family members, others residing in the home, etc.).

2. Parents or any individual with legal or financial responsibility for the member are not eligible to be reimbursed to provide home care services.
3. Home health aide services that are not an essential part of the skilled home care program. When a member is receiving intermittent skilled nursing services solely for purpose of medication administration, home-health aide services may not be considered medically necessary.
4. Duplication and/or overlap of same/similar services is not allowed. When there is duplication or overlap of services, the lowest level of care needed to safely meet the member's needs may be covered.
5. The following are excluded from coverage under this benefit:
    1. Drugs and Biologics
    2. Services covered under End-Stage Renal Disease programs;
    3. Prosthetic Devices;

4. Respiratory Care Services;
5. Dietary and Nutritional Personnel, when not incidental to services required by the care plan

6. Agencies may provide transportation when incidental to providing services as approved in the plan of care; however, it is excluded from home health coverage. Costs of transportation of equipment, materials, supplies, or staff may be allowable as administrative costs, but no separate payment will be made, and no additional hours may be requested or billed specifically for this purpose. Neighborhood is approving only the provision of home care services and accepts no liability or responsibility for transportation. The inclusion of transportation as part of a Treatment Plan must relate to facilitating the accomplishment of defined and previously approved treatment objectives. Transportation can only relate to the member receiving home care services and is not to be included in a treatment plan solely for convenience. The provider/agency must demonstrate that it has procedures in place to protect the safety of child being transported by staff and vehicles engaged in transportation:
    1. Current and adequate vehicle insurance that allows for transporting children.
    2. Current vehicle registration and valid State inspection.
    3. The driver's history must be free of accidents for the past year, with no history of DWI. Parents have signed a waiver for each driver releasing any Neighborhood liability and responsibility for anything that occurs as a result of transportation activities.
    4. Neighborhood will not approve 2:1 coverage during transportation.
    5. Seat belts and/or child restraints must be utilized as required by State law.
7. Home care and home health providers must remain in compliance with all applicable Rhode Island General Laws and Rhode Island Department of Health regulations.

References:

- Centers for Medicare and Medicaid Services. Medicare Managed Care Manual. Chapter 4, Sections 90.1, 90.4.1, 90.4.2, 90.5
- Centers for Medicare & Medicaid Services (CMS). Manuals. Publication # 100-02. Medicare Benefit Policy Manual, Chapter 7 – Home Health Services.
- Executive Office of Health and Human Services (EOHHS) Home Health Provider Manual
- InterQual®
- Rhode Island General Laws, Title 210 – Executive Office of Health and Human Services, Chapter 20 - Medicaid Payments and Providers, Subchapter 05 - Requirements and Limits Applicable to Specific Providers, Part 1 – Home Care and Home Health Providers.

- Contract between The State of Rhode Island EOHHS and Neighborhood Health Plan of Rhode Island for Medicaid Managed Care Services, July 1, 2025.
- Contract between United States Department of Health and Human Services Centers for Medicare and Medicaid Services in partnership with The State of Rhode Island EOHHS and Neighborhood Health Plan of Rhode Island for Medicaid Managed Care Services, July 1, 2022.

Authorization Request Forms

Access prior authorization request forms by visiting Neighborhood's website at www.nhpri.org.

1. Click on Providers
2. Click on Provider Resources
3. Click on Forms
4. Click on "Click here for a list of prior authorization request forms" – forms are listed alphabetically.

A phone messaging system is in place for requests/inquiries both during and outside of business hours. Providers can call 1-800-963-1001 for assistance.

Covered Codes: For information on coding, please reference the Authorization Quick Reference Guide.

CMP Number	**021**
CMP Cross Reference:	**#020 – Home Care Services** **#022 – Private Duty Skilled Nursing**
Created:	2/14/24
Annual Review Month:	February
Review Dates:	2/12/25, 8/20/25
Revision Dates:	8/20/25
CMC Review Date:	2/14/24, 2/12/25, 8/20/25

Medical Director Approval Dates:	2/14/24, 2/12/25, 8/20/25
Effective Dates:	2/14/24, 2/12/25, 8/20/25

Neighborhood reviews clinical medical policies on an annual basis.

Disclaimer:

Neighborhood has developed medical policies to assist us in administering health benefits. This medical policy is made available to you for informational purposes only and does not constitute medical advice. It is not a guarantee of payment or a substitute for your medical judgment in the treatment of your patients. Members should always consult their physician before making any decisions about medical care. Treating providers are solely responsible for medical advice and treatment of members. Benefits and eligibility are determined by the member's coverage plan; a member's coverage plan will supersede the provisions of this medical policy. For information on member-specific benefits, call member services. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. Neighborhood reserves the right to review and revise this policy for any reason and at any time, with or without notice.