Home Health Services

Plan: AmeriHealth Caritas Louisiana

Clinical Policy ID: CCP.4013

Recent review date: 6/2024

Next review date: 10/2025

Policy contains: Home health skilled nursing and aide services.

AmeriHealth Caritas Louisiana has developed clinical policies to assist with making coverage determinations. AmeriHealth Caritas Louisiana's clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of medically necessary, and the specific facts of the particular situation are considered by AmeriHealth Caritas Louisiana, on a case by case basis, when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. AmeriHealth Caritas Louisiana's clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. AmeriHealth Caritas Louisiana's clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, AmeriHealth Caritas Louisiana will update its clinical policies as necessary. AmeriHealth Caritas Louisiana's clinical policies are not guarantees of payment.

Policy statement

Home health services are clinically proven and, therefore, may be medically necessary for members when the following criteria are met:

Member Requirements

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.

Provider Requirements

To participate in the Home Health Program the providing agency must be Medicare-certified for Medicare/Medicaid by the Licensing and Certification Unit of the Health Standards Section of the Louisiana Department of Health. All providers enrolled in the Louisiana Medicaid Program must adhere to the conditions of participation as outlined in the provider agreement.

All home health services must be provided by staff employed by or under contract with the home health agency (HHA) (see LAC 48:I, Chapter 91. Also, refer to 42 CFR 417.416 and Sec 2194 of the State Operations Manual CMS Pub. 7 for specific requirements).

All staff must meet all required licensure requirements in accordance with Medicaid policies, federal, state and other applicable laws.

Provision of Services

Home health services include medically necessary skilled nursing, rehabilitation (physical, occupational and speech therapies), home health aide and medical supplies provided to members only if the service is provided in the member's residential setting or any noninstitutional setting in which normal life activities take place.

NOTE: The member's residential setting cannot be a hospital, nursing home, or an intermediate care facility for individuals with intellectual disabilities (ICF-IID, with limited exceptions), or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

Plan of Care

The attending physician 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 attending physician must order all home health services and sign a plan of care (POC) submitted by the HHA on the CMS-485 form. For more information on the Form CMS-485 visit the Centers for Medicare and Medicaid Services (CMS) website. This certification and the physician's POC must be maintained in the member's record and on file at the HHA.

Periodic Review of Plan of Care

The authorized healthcare provider 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 authorized healthcare provider 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.

Evidence of the face-to-face encounter is required for routine skilled nursing and home health aide services for members age 21 and older. If providers do not have this documentation prior to the initiation of services then the initial Prior Authorization (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.

For the initiation of medical equipment, the face-to-face encounter must be related to the primary reason the member requires medical equipment and must occur no more than six months prior to the start of services.

Any of the following will be accepted by the as evidence of a face-to-face encounter between a physician and the member, or an allowed NPP and the member:

- A written statement on the certifying authorized healthcare provider's letterhead or prescription pad attesting to a face-to-face encounter between the authorized healthcare provider and the member; or
- The HHA's face-to-face encounter form that the HHA requires the member's certifying authorized healthcare provider to complete as a routine business practice; or
- Medical notes or documentation from the authorized healthcare provider demonstrating evidence of a face-to-face encounter within the required timeframe.

Documentation of a face-to-face encounter as detailed above must be kept in the member's record for ALL home health service related requests, including therapy services, medical equipment and supplies, and services for members under the age of 21.

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

- The member's authorized healthcare provider;
- A nurse practitioner or clinical nurse specialist, working in collaboration with the member's authorized healthcare provider;
- A physician assistant under the supervision of the member's authorized healthcare provider;
- A certified nurse -midwife, as defined in section 1861(gg) of the Social Security Act; or
- The attending acute or post-acute physician for members admitted to home health immediately after an acute or post-acute stay.

The clinical findings must be incorporated into the member's medical record.

The authorized healthcare provider responsible for ordering the services must:

- Document that the face-to-face encounter which is related to the primary reason the member requires home health services, occurred within the required and specified timeframes above;
- Identify the practitioner who conducted the encounter; and
- Indicate the date of the face-to-face encounter.

Required Assistance to Members

In an effort to assist members in locating a provider to submit a prior authorization request for medically necessary home health services, the member may contact AmeriHealth Caritas Louisiana.

In addition, the Bureau of Health Services Financing (BHSF) may conduct surveys with members who have been authorized to receive extended home health services. The purpose of these surveys is to ensure that BHSF will contact the appropriate provider to determine what additional assistance may be required to ensure access to the authorized services.

Emergency Preparedness Plan

The HHA must have an emergency preparedness plan that conforms to the current Louisiana Office of Emergency Preparedness (OEP) model plan. The plan is designed to manage the consequences of declared disasters or other emergencies that disrupt the HHAs ability to provide care and treatment or threaten the lives or safety of its clients.

The HHA is responsible for obtaining a copy of the current Home Health Emergency Preparedness Model Plan from OE.

Additionally, per CMS, the HHA must comply with the reporting requirements of the At-Risk Registry. The HHA shall update the "Louisiana At-risk Registry" or other current state-required reporting mechanism as needed or as required.

At a minimum, the HHA must have a written plan that includes:

- The evacuation procedures for agency clients who require community assistance as well as for those with available caregivers to evacuate to another location;
- The delivery of essential care and services to agency clients whether they are in a shelter or other locations;
- The provisions for the management of staff, including distribution and assignment of responsibilities and functions;
- A plan for coordinating transportation services required for evacuating agency clients to another location; and
- A declaration that the agency will notify the client's family or caregiver if the client is evacuated to another location.

The HHA must submit the plan to the parish OEP for review. Refer to LAC 48:I.9101 for details regarding the minimum standards for HHA emergency preparedness.

References

Louisiana Department of Health. 2010. Home Health Provider Manual. Beneficiary Requirements. Chapter 23, Section 23.3. Issued 07/10/2023.

Louisiana Department of Health. 2010. Home Health Provider Manual. Provider Requirements. Chapter 23, Section 23.4. Issued 12/12/2023.

Policy updates

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