

Home Health Services

Reimbursement Policy ID: RPC.0100.2100

Recent review date: 04/2026

Reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. The health plan may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy outlines guidelines for reimbursement of home health services, place of service (POS) 12.

Exceptions

Home health care services rendered on the dates of inpatient admission and discharge may be reimbursed.

Reimbursement Guidelines

Home health care services include part time skilled nursing services, aide, physical therapy, speech and occupational therapy, and medical supplies recommended by the physician as required in the care of the patient and suitable for use in the home. Home health care services are not reimbursable for POS 12 (home) during an inpatient stay.

LIMITS

- Private Duty Nursing (Extended Nursing Services): Covered when medically necessary for under age 21 only. (a minimum of three or more hours of nursing services per day)
- The enrollee must require skilled nursing care that exceeds the caregiver's ability to care for the enrollee without the extended home health services.
- For the initiation of home health services, a face-to-face encounter with the AHP and the enrollee must occur no more than 90 days prior to the start of home health services, or no later than 30 days after the start of home health services
- Personal Care Services: Covered when medically necessary for under age 21 only.

*Multiple visits on the same- authorization required

PT/OT/ST home care and skilled nursing

- First 6 visits (1 visit= 4 units combined PT/OT/ST/SN total of 24 units)- Do not require authorization
- PT/OT/ST and Skilled Nursing require authorization beginning with the 7th visit.
- Private Duty Nursing- auth required
- Home Health Aide- auth required
- Home Infusion/Injections- Use prior auth lookup tool to determine if the billed code requires an auth
- PT/OT/ST Evaluations: Limited to one evaluation per discipline per 180 days.

*Non-Par providers require authorization for services.

Skilled nursing services

Skilled nursing services are provided to a person in the home for the purpose of restoring and maintaining his or her maximal level of function and health. These services are rendered in lieu of hospitalization, confinement in an extended care facility, or going outside of the home for services. Skilled nursing services must be prescribed by a physician and be medically necessary for the member's illness or injury.

Physical, occupational and speech therapy

The health plan may cover in-home therapy services depending on the member's needs. Skilled therapies are considered reimbursable when prescribed by a physician for homebound patients to improve, develop or restore physical functions lost due to illness or injury.

Home health care services

A home health aide is a provider who assists a member with non-skilled care to meet activities of daily living, thereby maintaining the individual in his or her home environment. Services provided by home health aides may include:

- Personal care
- Assisting with a prescribed exercise regimen that supports skilled therapies but does not require the skills of a therapist.
- Assisting with activities of daily living
- Changing non-sterile dressings that do not require the skills of a licensed nurse
- Routine care of prosthetic and orthotic devices
- Supervising the individual's adherence to prescribed, self-administered medications and/or special diets
- Taking blood pressure and other health monitoring activities

Home health services, including home infusion needs, may have limitations of services, visits and may require prior authorization. Refer to our provider manual and/or the following link for authorization requirements <https://www.amerihealthcaritasla.com/provider/resources/priorauth/index.aspx>.

Electronic visit verification guidelines may apply to personal care services or home health care services. Check with AmeriHealth Caritas Louisiana for complete guidelines, found at <https://ldh.la.gov/page/electronic-visit-verification-evv>. See also reimbursement policy Electronic Visit Verification (RPC.0090.2100).

Definitions

Home health care

Medical care delivered in the patient's home, when the patient is homebound while recovering from an illness, surgery or injury or has a chronic medical condition.

Place of service (POS)

A two-digit code used on health care professional claims to indicate the setting in which a service was provided.

Durable medical equipment (DME)

DME is equipment that can withstand repeated use (at least three years) and is used in the home for a medical reason when someone is sick or injured.

Infusion therapy

Delivers medication, fluids, or nutrients directly into the bloodstream via an IV, providing a faster, more effective alternative to oral medication for complex or chronic conditions. A nurse administers the infusion therapy through a small catheter IV or a pre-installed port.

Edit Sources

- I. Current Procedural Terminology (CPT) and associated publications and services.
- II. International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10).
- III. Healthcare Common Procedure Coding System (HCPCS).
- IV. Centers for Medicare and Medicaid Services (CMS).
- V. The National Correct Coding Initiative (NCCI).
- VI. Applicable Medicaid Fee Schedule(s).

Attachments

N/A

Associated Policies

RPC.0074.2100 Durable Medical Equipment, Prosthetics, Orthotics and Supplies

RPC.0090.2100 Electronic Visit Verification

Policy History

10/2026	<ul style="list-style-type: none">Removed the next review dateReplaced the plan name with "the health plan"
05/2026	Reimbursement Policy Committee Approval
04/2026	Biennial Review <ul style="list-style-type: none">Updated reimbursement languageAdded home infusion therapy definitionAdded associated policy
06/2025	Minor updates to formatting and syntax

04/2025	Revised preamble
11/2024	Reimbursement Policy Committee Approval
	Precedes Act 319