

In the event of conflict between a Clinical Payment and Coding Policy and any plan document under which a member is entitled to Covered Services, the plan document will govern. Plan documents include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents.

In the event of conflict between a Clinical Payment and Coding Policy and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern.

Providers are responsible for accurately, completely, and legibly documenting the services performed including any preoperative workup. Billing office is expected to submit claims for services rendered using valid codes from Health Insurance Portability and Accountability Act (HIPAA) approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing (UB) Editor, American Medical Association (AMA), Current Procedural Terminology (CPT®), CPT® Assistant, Healthcare Common Procedure Coding System (HCPCS), National Drug Codes (NDC), Diagnosis Related Group (DRG) guidelines, Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines. Claims are subject to the code auditing protocols for services/procedures billed.

Coordinated Home Care Policy Guideline

Policy Number: CPCP005

Version 6.0

Clinical Payment and Coding Policy Committee Approval Date: 10/31/2018

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Description

Coordinated home care services are broken down into two main categories, skilled and unskilled services. These services can be long-term or short-term depending on the patients' needs in order to live independently. Not all home health care services discussed in this policy may be covered under any particular member's benefits. References to services herein are not a guarantee or representation of coverage. Providers are urged to refer to the member's benefits for an exclusion on home care services and to the state and federal mandates for eligible coverage. The purpose of this policy is to provide a guideline for types of coordinated home health care and appropriate code sets when billing for types of services. This policy is not intended to impact care decisions that are best needed for the member.

Definitions:

Coordinated Home Care: Organized skilled intermittent patient care initiated by a hospital or other inpatient facility to facilitate in the discharge and planning of its patients into home care under the orders of a qualified physician.

Custodial Care: Personal care that does not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed and which is to support the patient’s care and activities of daily living. Services are generally non-medical.

Home Health Care: Healthcare services provided to a patient who is at home due to a sickness or injury requiring services from a skilled and licensed professional on an intermittent or part-time basis.

Intermittent home care: Part-time (generally 1-2 hour) skilled services provided in the patient’s home.

Private Duty Nursing (PDN): Nursing services for recipients who require more individual and continuous care than is available from a visiting nurse who is providing intermittent home care. Services which can be provided by a medical assistant, nurse’s aide, home health aide or other non–nurse level caregiver are not considered as Private Duty Nursing.

Respite Care: Services that are rendered to provide short-term, temporary relief to a primary caregiver.

Skilled Care: Provides a service that requires the clinical skill and professional training of a medical professional or technical personnel. Medical care that requires the technical skills and professional training of a licensed professional nurse or rehabilitation therapist.

Reimbursement Information:

Home care eligibility is determined by the members benefits of coverage. Codes included in this policy may or may not result in payment when claims are processed. In addition to whether services are determined to be medically necessary, services that are covered under the member’s benefits of coverage must also not exceed the days or hours of coverage when submitted for payment. This policy is a guideline regarding reimbursement and should be used as such for coordinated home care services. It is not intended to state coverage criteria or a guarantee of benefit coverage.

Services associated with home healthcare can include the following set of codes. Please note the following may not be an all-inclusive list of codes. Coverage for these codes is dependent upon the member’s benefits, provider’s contractual agreement and state or federal mandates.

HCPCS Code	Description
S9123	Nursing care, in the home; by registered nurse, per hour (use for general nursing care only, not to be used when CPT codes 99500-99602 can be used)
S9124	Nursing care, in the home; by licensed practical nurse, per hour
T1002	RN services, up to 15 minutes
T1003	LPN/LVN services, up to 15 minutes
T1030	Nursing care, in the home, by registered nurse, per diem
T1031	Nursing care, in the home, by licensed practical nurse, per diem

Private Duty Nursing care may be determined using standard guideline criteria such as the following:

All of the following are needed for private duty nursing care:

- Skilled nursing care for nurse clinical monitoring that exceeds intermittent home care or custodial care
- Post-acute skilled care is not appropriate or not available
- The patient can be safely managed at a home setting
- The patients primary care provider is able to follow the patient during private duty nursing course of service
- The patient’s total acuity score is 15 or greater than 15 points based on the PDN Acuity tool calculator for 1 or more of the following listed below:
 - Behavioral health, cognitive, or developmental monitoring and management
 - Bladder or bowel management
 - Case management
 - IV infusion management
 - Medication management
 - Nutrition management
 - Rehabilitation management
 - Respiratory management
 - Nurse seizure management
 - Skin and wound management

Private duty nursing is no longer needed when the following occurs:

- All of the following
 - The patient’s condition is stable
 - The licensed nurse no longer needs to provide ongoing clinical monitoring
 - Patient or the caregiver can carry out self-management
 - The primary care point of contact and transition is confirmed
 - The patients care is better served under custodial care
- Home based care is safe and care provisions have been established

Please note this may not be an all-inclusive list of codes. Coverage for these codes is dependent upon the member’s benefits, provider’s contractual agreement and state or federal mandates. Codes associated with PDN can include the following:

HCPCS Code	Description
T1000	Private duty/independent nursing service(s), licensed, up to 15 minutes

The PDN provider may be requested to submit additional documentation to support the medical necessity of services. Additional documentation may be required upon the initial request, recertification request or the revision request. Documentation can include, but not limited to nurse progress notes, medication administration records, seizure logs, and ventilator logs.

Custodial Care (Medical Policy ADM1001.014)

Custodial care is primarily to assist patients in activities of daily living (ADL's) and for personal comfort or convenience and is often not a covered benefit. These services are defined as services that do not require technical skills, professional training and clinical assessment ability of medical, nursing personnel, or allied health professional personnel in order to be safely and effectively performed. Some examples of custodial care can include, but not limited to:

- Assisting in meal feeding, bathing, dressing and the use of the bathroom
- Assist in walking or out of a chair or bed
- Food preparation
- Supervision of distribution, preparation and administration of medication

For the appropriate custodial care codes refer to the current AMA CPT manual and/or HCPCS book. Coverage for these codes is dependent upon the member's benefits, provider's contractual agreement and state or federal mandates.

Additional Information

- For home health contract base compensation schedules, refer to the state plan provider website.
- Verify patient's maximum benefits.
- Appropriate revenue codes for home health services should be submitted on UB-04 form.
- CPT/HCPCS codes should accompany the appropriate revenue code when submitted for payment.

References:

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American Medical Association. Current Procedural Terminology (CPT)

Policy Update History:

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10/31/2018	New policy