Clinical Policy: Extended Home Health Services

Reference Number: LA.CP.MP.511c
Date of Last Revision: 2/23

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Background

Louisiana Healthcare Connections provides coverage for extended nursing services as part of Early and Periodic Screening, Diagnostic and Treatment (EPSDT based on application of medical necessity criteria, submission of a prior authorization and the plan of care.
Extended Home Health, also known as extended skilled nursing services may be provided a Medicaid recipient who is age birth through 21 when it is determined to be medically necessary for the recipient to receive a minimum of three continuous hours per day of nursing services, accordance with the Louisiana Nurse Practice Act (La. R.S. 37:911, et seq). Medical necessity for extended nursing services exists when the recipient has a medically complex condition characterized by multiple, significant medical problems that require nursing care.

Policy/Criteria

I. Medical Necessity Criteria:
Medical necessity for extended skilled nursing services exists when the beneficiary has a medically complex condition characterized by multiple, significant medical problems that require nursing care in accordance with the Louisiana Nurse Practice Act (La. R.S. 37:911, et seq). Medical necessity for home health services must be determined by medical documentation that supports the member/enrollee'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/enrollee's condition regardless of whether the illness/injury is acute, chronic, or terminal. All extended skilled nursing services for beneficiaries under the age of 21 require PA. Requests for an increase in these services will be subject to a full review requiring all documentation used for a traditional PA request.

A. All of these must be met to be considered medically necessary as part of the provision of care guidelines. The provision of requested services is expected to:

1. Diagnose, cure, correct, or ameliorate defects, physical and mental illnesses, and diagnosed conditions of the effects of such conditions;
2. 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;
3. 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;

4. 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
5. 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 beneficiary might attain or retain independence, self-care, dignity, self-determination, personal safety and integration into family, community, facility environments and activities.

B. The following circumstances are not considerations when determining medical necessity for home health services:
   1. Inconvenience to the member/enrollee or the member/enrollee's family;
   2. Lack of personal transportation; and
   3. Failure or lack of cooperation by the member/enrollee or the member/enrollee's legal guardians or caretakers to obtain the required medical services in an outpatient setting.

C. For the initiation of home health services, a face-to-face encounter with the physician and the beneficiary, or an allowed non-physician practitioner (NPP) and the beneficiary 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. Documentation of a face-to-face encounter as detailed above must be kept in the beneficiary's record for ALL home health service-related requests, including therapy services, medical equipment and supplies, and services for beneficiaries under the age of 21. The face-to-face encounter may be conducted by one of the following practitioners:
   1. The beneficiary's physician
   2. A nurse practitioner or clinical nurse specialist, working in collaboration with the beneficiary's physician
   3. A physician assistant under the supervision of the beneficiary's physician
   4. A certified nurse -midwife, as defined in section 1861(gg) of the Social Security Act; or
   5. The attending acute or post-acute physician for beneficiaries admitted to home health immediately after an acute or post-acute stay

   The allowed NPP performing the face-to-face encounter must communicate the clinical findings of the encounter to the ordering physician. Those clinical findings must be incorporated into the beneficiary's medical record.

D. Location of the provision of care
   1. Skilled nursing services are to be conducted in the member/enrollee's residential setting. Extended home health services may be provided outside of the residential setting when the nurse accompanies the member/enrollee for medical reasons such as doctor appointments, treatments or emergency room visit
   2. The member/enrollee's medical condition and records should accurately justify the medical necessity for services to be provided in the

member/enrollee's residential setting rather than in a physician's office, clinic, or other outpatient setting.

E. Submission of a Plan of Care
1. The attending physician must certify that the member/enrollee meets the medical criteria to receive the service in the member/enrollee'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 POC submitted by the home health agency.
2. Home health services are appropriate when a beneficiary's illness, injury, or disability causes significant medical hardship and will interfere with the effectiveness of the treatment if the beneficiary 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 beneficiary's medical records.
3. The physician must reauthorize the POC every 60 days.

F. The member/enrollee must require skilled nursing care that exceeds the caregiver's ability to care for the beneficiary without the extended home health services.

G. When requesting prior authorization for extended home health, all hours of care must be included with the PA request. In addition, the physician's prescription and a copy of the POC must be attached to the appropriate PA form

H. Criteria that do not meet medical necessity:
1. The member/enrollee cannot be in a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities (ICF-IID), or any setting in which payment is or could be made for inpatient services that include room and board.
2. The Plan will not reimburse for skilled nursing services performed outside of state boundaries.
3. Extended home health services or multiple daily nursing visits for persons ages 21 and older are not covered.

II Assistance to Members/Enrollees

To assist members/enrollees in locating a provider to submit a prior authorization request for medically necessary home health services, the member/enrollee or caregiver may contact Louisiana Health Care Connections for assistance.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only and may not support medical necessity. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPS Code	Modifier	Description
G0299	TT, U2, U3	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes
G0300	TT, U2, U3	Direct skilled nursing services of a licensed practical nurse (LPN) in the home health or hospice setting, each 15 minutes
S9123	TG, TN, TT, TU, TV, UH, UJ	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	TG, TN, TT, TU, TV, UH, UJ	Nursing care, in the home; by licensed practical nurse, per hour

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Original approval date		11/21
Changed name of policy from PDN to Extended Home Health Services. Added background including language from the LAC §305. Extended Nursing Services for Ages 0-21, pages 352. This new section replaces the Description, previous Policy/Criteria and Procedure sections. Updated Policy/Criteria section to add sections C-H. Added HCPS Codes from LDH HH FS for 00-20. Changed member to member/enrollee.	2/23	5/26/23

References

1. Louisiana Medicaid Home Health Services Provider Manual

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

This clinical policy is the property of LHCC. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.