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Northwest Utilization Review

UR 8 Home Health Admission Medical Necessity Criteria

Department: Continuing Care
Section: Home Health
Applies to: KPNW Region
Review Responsibility: UMQOC
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MEDICAL NECESSITY CRITERIA AND OTHER REQUIREMENTS FOR HOME HEALTH ADMISSION

Coverage guidance: See individual member's summary of benefits for specific coverage information. Procedures and/or services may be excluded under certain service agreements and/or employer group and individual contracts. In all instances, medical necessity must be established for the procedure to be a covered health benefit.

Source	Policy
For Medicare Members	
CMS Coverage Manuals	Medicare Benefit Policy Manual, chapter 7, Home Health Services, section 30.1.1 (Patient Confined to the Home)
National Coverage Determinations (NCD)	None
Local Coverage Determinations (LCD)	None
Local Coverage Article	None
Kaiser Permanente Medical Policy for Medicare Members*	UR 8 applies. The criteria below are based on the above Medicare Benefit Policy Manual chapter. For Medicare members, use the criteria and information about Medicare below to make medical necessity determinations.
For Medicaid Members	
OR Medicaid	UR 8 does not apply.
WA Medicaid	UR 8 does not apply
Commercial and Self-Funded Members	
OR Commercial	UR 8 applies
WA Commercial	UR 8 applies
Self-Funded Plans	UR 8 applies

* Medicare: January 2014 revisions to the Medicare Benefit Policy Manual related to Skilled Nursing facility, Home Health and Outpatient skilled care clarified that a beneficiary's lack of restoration potential cannot serve as the basis for denying coverage in this context. Rather, such coverage depends upon an individualized assessment of the beneficiary's medical condition and the reasonableness and necessity of the treatment, care, or services in question. Moreover, when the individualized assessment demonstrates that skilled care is, in fact,

needed in order to safely and effectively maintain the beneficiary at his or her maximum practicable level of function, such care is covered (assuming all other applicable requirements are met). Conversely, coverage in this context would not be available in a situation where the beneficiary's maintenance care needs can be addressed safely and effectively through the use of *nonskilled* personnel.

CRITERIA

A. Patients must require skilled and intermittent care which can be safely provided in the home setting with reasonable expectation of clinical improvement or the need for these services are required to maintain the maximum practicable level of function.

Skilled care includes care services such as physical and occupational therapy, speech language therapy, medical and social services. "Skilled care" is care that must be provided by a Registered Nurse (RN), licensed physical or occupational therapist or speech and language pathologist, which is primarily rehabilitative in nature.

"Intermittent care" in general is not performed on a daily basis. In some cases, where daily care is required, it may be provided only for a period of short duration (weeks versus months).

B. Patient is homebound.

For purposes of the statute, an individual shall be considered "confined to the home" (homebound) if the following two criteria are met:

1. Criteria One: The patient must either:

    a. Because of illness or injury - need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence.

    OR

    b. Have a condition such that leaving his or her home is medically contraindicated.

If the patient meets Criteria-One conditions, then the patient must ALSO meet two additional requirements defined below:

2. Criteria Two:

    a. There must exist a normal inability to leave home;

    AND

    b. Leaving home must require a considerable and taxing effort.

If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive health care treatment. Absences attributable to the need to receive health care treatment include, but are not limited to:

- Attendance at adult day centers to receive medical care;
- Ongoing receipt of outpatient kidney dialysis; or
- The receipt of outpatient chemotherapy or radiation therapy.

Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited to furnish adult day-care services in a State, shall not disqualify an individual from being considered to be confined to his home. Any other absence of an individual from the home shall not disqualify an individual if the absence is of an infrequent or of relatively short duration.

For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. It is expected that in most instances, absences from the home that occur will be for the purpose of receiving health care treatment. However, occasional absences from the home for nonmedical purposes, e.g., an occasional trip to the barber, a walk around the block or a drive, attendance at a family reunion, funeral, graduation, or other infrequent or unique event would not necessitate a finding that the patient is not homebound if the absences are undertaken on an infrequent basis or are of relatively short duration and do not indicate that the patient has the capacity to obtain the health care provided outside rather than in the home.

OTHER REQUIREMENTS

Decisions for accepting patients for care by the Home Health Department are based on medical, nursing, therapy, and social information provided by the physician responsible for the patient's care and is determined after assessing the member's unique medical condition. Decisions are made by institutional personnel and staff of the Home Health Program.

Considerations Prior to Acceptance of patient for Home Health Services

- There are adequate and suitable department personnel and resources to provide the services required by the patient.
- Attitudes of patient and his family toward his care at home.
- There is a benefit to the patient's health to receive care at home as distinguished from care in a hospital, long-term care facility, or medical office setting.
- There is a reasonable expectation that patient's medical, nursing, therapy and social needs can be met adequately and safely in his residence, including the availability of a plan to meet medical emergencies.
- There are adequate physical facilities and equipment in the patient's residence for safe care.
- There is an assessment whether there is the availability of family or other caregiver in the home, with the ability and willingness to participate in the care and if it is required to assure the patient's safety and adequacy of care.
- There is an assessment of the degree of patient and family awareness of their rights and responsibilities.
- How recently the patient has had contact with the ordering physician.
- Assurance that services can be effectively coordinated through liaison with other organizations and individuals also providing care to the patient.
- Acceptance of any patient by Home Health is at the discretion of Continuing Care Services (CCS), which exists to provide home health services to members of the Kaiser Foundation Health Plan. Medical necessity denials are made by a MD or DO.

NOTE: In addition to the list of excluded services provided within a member's evidence of coverage (EOC), the following will be applied to all lines of business, except for Medicaid under some circumstances:

- **Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Social Security Act** specifically exclude venipuncture (blood draws) as a basis for qualifying for home health services if this is the sole skilled service the beneficiary requires. However, the home health benefit will continue to pay for a blood draw if the beneficiary has a need for another qualified skilled service and meets all home health eligibility criteria.

CONTRAINDICATIONS

None

REFERENCES

Criteria Based: Medicare Regulations. CMS Publication 11 – Home Health Manual, Chapter 2. Coverage of Services.

Medicare Benefit Policy Manual, chapter 7, Home Health Services, section 30.1.1 (Patient Confined to the Home), effective 2/24/17.