PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

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<tr><td colspan="3">Guideline/Procedure Number: MPUG3011 (previously MCUG3011, UG100311)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Guideline/Procedure Title: Criteria for Home Health Services</td><td colspan="3">☒ External Policy
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<tr><td colspan="2">Original Date: 08/1998</td><td colspan="4">Next Review Date: 03/12/2025
Last Review Date: 03/12/2025</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 03/12/2025</td></tr>
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I. RELATED POLICIES:

A. MCCP2022 – Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services
B. MCUP3041 – Treatment Authorization Request (TAR) Review Process
C. MCCP2031 – Private Duty Nursing Under EPSDT
D. MPCR700 – Assessment of Organizational Providers
E. MPPRO1102 – Contracted Provider Education
F. MCUP3115 – Community Based Adult Services
G. MCCP2024 – Whole Child Model for California Children's Services (CCS)
H. MCUP3143 – CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services
D. Provider Relations

III. DEFINITIONS:

A. Electronic Visit Verification (EVV): A federally mandated telephone and computer-based application program that electronically verifies in-home service visits for Medicaid-funded personal care services and home health care services for in-home visits by a provider. In California, this is known as CalEVV.
B. Partnership Advantage: Effective January 1, 2027, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.
C. Personal Care Services (PCS): Services supporting individuals with their activities of daily living, such as movement, bathing, dressing, toileting, and personal hygiene. PCS can also offer homemaker services support for instrumental activities of daily living, such as meal preparation, money management, shopping, and telephone use.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To provide guidelines for Treatment Authorization Request (TAR) submission for Home Health Services.

VI. GUIDELINE / PROCEDURE:

A. Member Selection Criteria
   1. Members receiving home health services must meet all of the following criteria.
      a. Member must be Partnership HealthPlan of California-eligible at the time services are rendered.
      b. Member must be homebound.
         1) A Member is a homebound recipient if he or she is essentially confined to his or her home due to illness or injury, and if ambulatory or otherwise mobile, is unable to be absent from his or her home except on an infrequent basis or for periods of relatively short duration; for example, for a short walk prescribed as therapeutic exercise.
      c. Member must need skilled nursing services on an intermittent or part-time basis, or physical therapy or speech therapy, or have a continuing need for occupational therapy.
         1) Partnership Medi-Cal Members: To meet the requirement for "intermittent" skilled nursing care, an individual must have a medically predictable recurring need for skilled nursing services. This may be met if the Member requires a skilled nursing service at least once every sixty (60) days and when the skilled service is determined to be medically necessary.
         2) Partnership Advantage Members: To meet the requirement for "intermittent" skilled nursing care means it is either provided or needed on fewer than 7 days each week or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).
      d. Member must be under the care of a physician or specialist.
         1) This physician may be the Member's primary care provider (PCP). The attending physician must order the services, establish the plan of treatment, and certify the necessity for home health care. Home health services may also be ordered by a nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA) operating under the supervision of a licensed physician.

B. Home Health Services
   1. The following services may be rendered by the home care agency if medical necessity criteria are met.
      a. Physical, speech, or occupational therapies are subject to benefit limitations and exclusions.
         1) Physical Therapy – Authorized services must relate directly and specifically to an active written treatment regimen established by the physician or non-physician practitioner (PA, CNS, or NP) after any needed consultation with the qualified physical therapist and must be reasonable and necessary to the treatment of the Member's illness or injury.
         2) Occupational Therapy – Authorized services must be prescribed by a physician or non-physician practitioner (PA, CNS, or NP) and must be performed by a qualified occupational therapist. Services must be reasonable and necessary for the treatment of the individual's illness or injury and the therapy must be expected to result in a significant practical improvement in the individual's level of functioning within a reasonable period of time.
         3) Speech Therapy – Authorized services include assistance to the physician or non-physician practitioner (PA, CNS, or NP) in evaluating Members to determine the type of speech or language disorder and the appropriate corrective therapy.
      b. Medical Social Services
         1) Services dealing with social, economic, and emotional factors related to the illness.
      c. Home infusion therapy services (codes G0088 and G0089) are reimbursable subject to

authorization. Services are for treatment of a disease or condition which is unresponsive to oral medications. The TAR must document the following:

1) The service is medically necessary
2) The diagnosis and prescription are written by a physician or licensed professional practitioner
3) The name of medication/solution, route, frequency, duration, strength, and total units
4) A trained registered nurse or licensed health professional following the physician's orders provides the service, including documentation of patient status for the duration of treatment

d. Daily skilled services: These should generally should not extend beyond three (3) weeks. The physician should re-evaluate and provide medical documentation for additional services including an estimate on the length of time daily services will be required.
   1) The services must be performed by or under the direct supervision of a licensed nurse (Registered Nurse [RN], Licensed Practical Nurse [LPN], Licensed Vocational Nurse [LVN]).
e. In some cases, the services of a home health aide may be a covered benefit. In determining which services require the skill of a nurse, the following are considered:
   1) The inherent complexity of the services
   2) The condition is such that a service which would normally be classified as skilled can be provided safely and effectively only by a nurse
f. Home nursing services are provided only through certified home health agencies. Partnership may authorize home nursing services through credentialed RN/LVN/LPNs who are EPSDT supplemental service providers if, and only if, there is documented non-availability of a home health agency to provide the needed services. See policies MCCP2022 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services and MCCP2031 Private Duty Nursing Under EPSDT.
g. Lab draws via implanted device port in the home setting:Home health agencies may bill for this service under code 36591.

C. Initial TAR Process
   1. Home health services are reimbursable as an outpatient benefit when prescribed by a physician, nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA) and provided at the recipient's home in accordance with a written treatment plan reviewed by a physician, NP, CNS, or PA every 60 days.
   2. The home health agency must submit a TAR, along with a documented evaluation and written treatment plan to Partnership. The treatment plan must include the following:
      a. Date of onset of the illness
      b. Medical diagnosis necessitating the service, with a summary of the clinical history
      c. Related medical conditions
      d. Functional limitations
      e. Prognosis
      f. Description of home situation, including assistance available from household members or other care givers, including language or communication problems
      g. Therapeutic goals to be achieved by each discipline and anticipated time to achieve goals
      h. Types of services to be rendered by each discipline related to the problem with Current Procedural Terminology (CPT) codes
      i. Description of plan to instruct household members or other caregivers to provide needed care including plans to overcome barriers
   3. If the request meets medical criteria, the TAR will be approved. If not, the case will be further reviewed by the Chief Medical Officer or physician designee who will make the determination.

D. If services beyond the initially approved TAR are required, a new TAR must be submitted with home

health progress notes.

1. If another evaluation is needed within 6 months, it will be granted only if there is a significant change in the Member's condition or family situation which requires a new individual treatment plan.
2. A monthly evaluation is covered only if there is a significant change in the Member's medical condition or if the treatment plan is complex and involves a variety of services during the month.

E. In the event of a hospital admission during the time home health services are authorized and being rendered, notification to Partnership must be made. Upon discharge from the acute setting and a return to home health services, a new TAR with current clinical notes must be submitted. A new treatment plan/form 485 is not necessary.

F. Electronic Visit Verification Requirements (EVV)

1. Effective January 1, 2023, as per APL 22-014, EVV requirements must be implemented for all Medi-Cal Personal Care Services (PCS) and Home Health Care Services (HHCS) that are delivered during in-home visits by a provider, which includes visits that begin in the community and end in the home, or vice versa.
2. All Medi-Cal PCS and HHCS providers must capture and transmit the following six mandatory data components:
   a. The type of service performed
   b. The individual receiving the service
   c. The date of the service
   d. The location of service delivery
   e. The individual providing the service
   f. The time the service begins and ends
3. PCS and HHCS providers should utilize the Department of Health Services (DHCS) EVV System, or CalEVV, which is a telephone and computer-based application program that electronically verifies in-home service visits.
   a. While not recommended, if a provider uses any alternate EVV system, it must comply with all business requirements and technical specifications, including the ability to capture and transmit the required data elements to the state-sponsored EVV Aggregator.
   4. All claims for PCS and HHCS services must be submitted with allowable Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes as outlined in the Medi-Cal Provider Manual. https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual
   a. The proper Place of Service Code or Revenue Code must also be indicated on claims and/or encounters to indicate the rendering of PCS or HHCS in a Member's home. Please refer to the DHCS EVV webpage https://www.dhcs.ca.gov/provgovpart/Pages/EVV.aspx for current EVV Provider Type, Procedure, and Place of Services Codes.

VII. REFERENCES:

A. Medi-Cal Provider Manual/ Guidelines: Home Health Agencies *(home hlth)*
B. Welfare and Institutions Code Section 14132(t)
C. Department of Health Services (DHCS) All Plan Letter (APL) 22-014 Electronic Visit Verification Implementation Requirements (07/21/2022)
D. Medicare Benefit Policy Manual 100-02, Chapter 7 Home Health Services

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES: 06/21/00; 04/18/01; 01/16/02; 08/20/03; 02/16/05; 10/17/07; 10/15/08; 07/21/10; 02/15/12; 02/20/13; 08/20/14; 01/20/16; 08/17/16; 06/21/17; *08/08/18; 04/10/19; 03/11/20; 03/10/21; 08/11/21; 08/10/22; 01/11/23; 04/12/23; 04/10/24; **MPUG** 03/12/25

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.