MEDICAL POLICY STATEMENT
Ohio MyCare

Policy Name & Number	Date Effective
Home Health Services-OH MyCare-MM-1271	04/01/2024-03/31/2025
Policy Type	
MEDICAL	

Medical Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medical Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination. According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject
Home Health Services

B. Background
Home health services are skilled and supportive care services provided in the member's home to meet skilled care needs and associated activities of daily living (ADLs) to allow the member to safely reside in the home. Home health services incorporate a wide variety of skilled healthcare and supportive services provided by licensed and unlicensed professionals. These services are designed to meet the needs of members with acute, chronic, and terminal illnesses or disabilities who, without this support, might otherwise require services in an acute care or residential facility.

These guidelines for medical necessity determination identify clinical information that CareSource uses to determine medical necessity for home health services. These guidelines are based on generally accepted standards of practice, review of medical literature, as well as federal and state policies and laws applicable to Medicaid programs.

Providers should consult Chapter 5160-12 of the Ohio Administrative Code for details about coverage, limitations, service conditions, and prior-authorization requirements. MyCare providers must utilize State plan services before accessing waiver nursing or aide services.

C. Definitions
- **Home Health Agency** – A person or government entity, other than a nursing home, residential care facility, or hospice care program, that has the primary function of providing any of the following services to a patient at a place of residence used as the patient's home:
  - skilled nursing care
  - physical therapy
  - speech-language pathology
  - occupational therapy
  - medical social services
  - home health aide services, which means any of the following services provided by an employee of a home health agency:
    - hands-on bathing or assistance with a tub bath or shower
    - assistance with dressing, ambulation, and toileting
    - catheter care but not insertion
    - meal preparation and feeding
- **Home Health Aide Services** – Services that use the skills of and are performed by a home health aide employed or contracted by the Medicare Certified Home Health Agency (MCHHA) providing the service.
  Home health aide services include, but are not limited to, the following:
  - bathing, dressing, grooming, hygiene, including shaving, skin care, foot care,ear care, hair, nail and oral care that are needed to facilitate care or prevent

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deterioration of the individual's health, and including changing bed linens of an incontinent or immobile individual
  - feeding, assistance with elimination including administering enemas (unless the skills of a home health nurse are required), routine catheter care, routine colostomy care, assistance with ambulation, changing position in bed, and assistance with transfers
  - assisting with activities such as routine maintenance exercises and passive range of motion as specified in the plan of care. These activities are directly supportive of skilled therapy services but do not require the skills of a therapist to be safely and effectively performed. The plan of care is developed by either a licensed therapist or a licensed registered nurse withintheir scope of practice
  - performing routine care of prosthetic and orthotic devices
- **Home Health Nursing Services** – Services that require the skills of and are performed by a registered nurse, or a licensed practical nurse at the direction of a registered nurse. The nurse performing the home health service must possess a current, valid, and unrestricted license with the Ohio board of nursing and must be employed or contracted by an MCHHA that has an active Medicaid provider agreement. A service is not considered a nursing service merely because it is performed by a licensed nurse.
  1. Home Health Nursing Services include, but are not limited to, the following:
     a. IV insertion, removal, or discontinuation
     b. IV medication administration
     c. programming of a pump to deliver medications including, but not limited to, epidural, subcutaneous IV (except routine doses of insulin through a programmed pump)
     d. insertion or initiation of infusion therapies
     e. central line dressing changes
     f. blood product administration
  2. Home health nursing services do not include a visit when the sole purpose is for the supervision of the home health aide.
- **Homemaker Services** – Services enabling individuals to achieve and maintain clean, safe, and healthy environments, assisting individuals to manage their personal appointments and day-to-day household activities, and ensuring individuals maintain their current living arrangements. The service consists of general household activities, such as meal preparation and routine household care when persons regularly responsible for these activities are temporarily absent or unable to manage the home. Homemaker staff may act as travel attendants for individuals.
- **Medical Necessity** – Must meet **ALL** the following conditions:
  - meets generally accepted standards of medical practice
  - clinically appropriate in its type, frequency, extent, duration, and delivery setting
  - appropriate to the adverse health condition for which it is provided and is expected to produce the desired outcome
  - is the lowest cost alternative that effectively addresses and treats the medical problem
  - provides unique, essential, and appropriate information if it is used for diagnostic

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purposes
  - not provided primarily for the economic benefit of the provider nor for the convenience of the provider or anyone else other than the recipient
- **Skilled Therapies** – A collective term encompassing physical therapy, occupational therapy, speech-language pathology, and audiology.
- **Waiver Personal Care Services** – Services provided pursuant to the person-centered services plan that assist the individual with activities of daily living (ADL) and instrumental activities of daily living (IADL) needs. If the individual's person-centered services plan states that the service provided is to be personal care aide services, the service shall never be billed as a nursing service. If the provider cannot perform IADLs, the provider shall notify ODM or its designee, in writing, of the service limitations before inclusion on the individual's person-centered services plan.

D. Policy

I. Home health services, including home health aide and home health nursing, are provided to any CareSource Ohio MyCare member when they are considered medically necessary.

II. Duplicative services are not covered.
   A. There must be documentation of all other therapies/services the member is receiving, when relevant to home health services.
   B. If the member is receiving other assistance (eg, meal delivery program, family caregiver, and additional supportive services), this information and the hours involved must be provided to adequately evaluate medical necessity of home health services.
   C. The aide provided must be appropriate to the member. Guidelines are provided (see Table, below) to assist in determining the amount of care a member requires.

III. Home health services:
   A. **Routine home health services** are considered medically necessary for MyCare members when **ALL** the following criteria are met:
      1. There has been a face-to-face encounter between the individual and a qualifying treating physician, advanced practice registered nurse, or physician assistant.
      2. The face-to-face encounter occurred within 90 days prior to the start of home health services, or within 30 days following the start of home health services.
      3. There is the most recent written plan of treatment by the agency, as evidenced by one of the following: the Ohio Department of Medicaid (ODM) 07137 “Certificate of Medical Necessity for Home Health Services and Private Duty Nursing Services” **OR** the individual's current plan of care if all of the data elements specified for home health services on the ODM 07137 are included.
      4. At the time of billing, the plan of care/treatment plan contains the signature, credentials, and the date of the qualifying treating physician, advanced practice registered nurse or physician assistant.

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5. The home health services will be provided by a Medicare Certified Home Health Agency (MCHHA).
6. The services are provided on a part-time or intermittent basis as follows:
   a. **Total Hours Per Visit:** four hours (individuals who require more than four hours of care per visit may qualify for private duty nursing, which is outside the scope of this policy)
   b. **Total Hours Per Day:** eight hours combined per day of home health nursing, home health aide, and skilled therapies
   c. **Total Hours Per Week:** fourteen hours combined per week of home health nursing and home health aide services

   NOTE: additional hours of care may be considered based upon medical necessity.

B. **Following discharge from an inpatient hospital stay**, home health services are considered medically necessary when **ALL** the following criteria are met:
1. There has been a face-to-face encounter between the individual and a qualifying treating physician, advanced practice registered nurse, or physician assistant.
2. The face-to-face encounter occurred within 90 days prior to the start of home health services, or within 30 days following the start of home health services.
3. There is the most recent written plan of treatment by the agency as evidenced by the ODM 07137 “Certificate of Medical Necessity for Home Health Services and Private Duty Nursing Services”.
4. The individual is discharged from a covered inpatient hospital stay of at least three days, with the discharge date recorded on form ODM 07137.
5. The individual has a comparable level of care as evidenced by either: enrollment in a home and community-based services (HCBS) waiver OR a medical condition that temporarily meets the criteria for an institutional level of care.
6. The individual requires home health nursing, or a combination of private duty nursing, home health nursing, or waiver nursing and/or skilled therapy services at least one per week.
7. The home health services will be provided by a Medicare Certified Home Health Agency (MCHHA).
8. The services are provided on a part-time or intermittent basis as follows:
   a. **Total Hours Per Visit:** 4 hours (individuals who require more than four hours of care per visit may qualify for private duty nursing, which is outside the scope of this policy)
   b. **Total Hours Per Day:** 8 hours combined per day of home health nursing, home health aide, and skilled therapies
   c. **Total Hours Per Week:** 28 hours combined per week of home health nursing and home health aide services for up to 60 consecutive days from the date of discharge from an inpatient hospital stay

   NOTE: additional hours of care may be considered based upon medical necessity.

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IV. Home health services do NOT include respite care.

V. Members that have CareSource for their Medicare **and** Medicaid coverage are considered opt-in members. The following information pertains to these members only:
   A. The Medicare benefit should be explored based on member's skilled service needs prior to use of Medicaid services.
   B. Process for approval of state plan services
      The care manager (CM) will complete member's initial assessment and determine member's needs utilizing the Aide Norms Tool or similar.
      1. State plan services must be implemented as appropriate before waiver services are considered.
      2. State plan home health services are covered only if provided on a part-time or intermittent basis as outlined in section III, above.
      3. State plan home health services can only be provided by a Medicare certified agency.
      4. State plan home health aide services may include incidental services as long as they do not substantially extend the time of the visit. Incidental services are necessary household tasks that must be performed by someone to maintain a home and can include light chores, laundry, light house cleaning, preparation of meals, and taking out the trash. The main purpose of a home health aide visit cannot be solely to provide these incidental services since they are not health related services. Incidental services are to be performed only for the individual and not for other people in the individual's place of residence.
      5. State plan home health services must be provided in the member's home.
      6. State plan home health services must be prior authorized by CareSource Utilization Management.
      7. No state plan home health service is authorized on the service plan. If the assessment indicates member has needs greater than the allowable coverage under state plan home health services, the CM will authorize services under the Waiver benefit.
   C. Homemaker services are not determined through a PA through UM and are instead determined by a CM (0903.01 homemaker services for MyCare waiver members procedure).
      1. The CM will determine if a member is a legacy waiver or non-legacy waiver member. Verification can be determined through the Area Agency on the Aging ("AAA") by utilization of the PIMS system, verification in Ohio Benefits or MITS.
      2. Care Manager will complete the appropriate assessment tools to determine the member's needs, for example, the Aide Norms Tool.
      3. The CM will determine what hours are appropriate to assign to the personal care code (T1019UA) and what hours are appropriate to assign to the homemaker code (S5130).
      4. Application of the homemaking code only applies to legacy Passport

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members and non-legacy waiver members in the event the personal care code of T1019UA is utilized by the provider.

5. Homemaking services do not include providing personal care services and should be assigned only when the member has no personal care needs. CM must document the times of service for personal care and for homemaking on the service plan within the appropriate authorization. CM should specify how services will be provided on the Aide Norms Tool and in the service plan authorization, including days and times of service.
6. If the member transitions from a legacy waiver with an incorrect billing code CareSource will not continue with an incorrect billing code/rate. CareSource must ensure the service level remains unchanged but is able to "correct" the billing code/rate in accordance with OAC.
7. Only ODA certified providers can provide the homemaker service. To determine provider certification and the appropriate rule to follow the CM should reach out to the CareSource team lead or manager.

D. Group billing (0902.01 group billing for MyCare waiver members procedure)
   1. The CM will determine if a member is a legacy waiver member or non-legacy waiver member. Verification can be determined through the Area Agency on the Aging ("AAA") by utilization of the PIMS system or verification in Ohio Benefits or MITS.
   2. The CM will assess the needs of member(s) residing at the same address and determine if the group billing should be applied.
   3. CM will complete the appropriate assessment tools to determine each member's needs, including the Aide Norms Tool and the Private Duty Nursing Tool.
   4. The CM will authorize the appropriate personal care code based on whether the member is a legacy waiver or is a non-legacy waiver member. When utilizing group billing for personal care services, the HQ modifier will be applied based on the determination of whether the member originated from the legacy waiver or is a non-legacy waiver member.
   5. If the member(s) is a legacy waiver member who transitioned to MyCare from Passport, the authorization will be T1019UA. Group billing will be applied when the members receive simultaneous or consecutive personal care visits. The first member to receive services will be coded as T1019UA and payment will be at 100% of the statutory or contracted rate. The second and/or subsequent member(s) to receive services will be coded as T1019UAHQ and will receive payment at 75% of the statutory or contracted rate in accordance with OAC rule 173-39-02.
   6. If the member(s) is a legacy waiver member who transitioned to MyCare from Ohio Home Care Waiver the authorization will be T1019. Group billing will be applied when the members receive services simultaneously. All members receiving care should be coded as T1019HQ and payment will be made at 75% of the statutory or contracted rate in accordance with the OAC rule 5160-58-04.
   7. If the member transitioned from a legacy waiver with an incorrect billing code.

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CareSource is not obligated to continue with an incorrect billing code/rate. The service level *must* remain unchanged, but CareSource is able to correct the billing code/rate in accordance with the OAC.

8. When a member did not transition from a legacy waiver, the group billing requirements of the entity that certified/approved the provider will apply. If the provider is both ODM and ODA certified CareSource may apply either ODM's or ODA's rule on group billing. To determine provider certification and the appropriate rule to follow, the CM should reach out to the CareSource team lead or manager.
9. Waiver nursing services are group billed when nursing services are provided at the same time regardless of legacy waiver. Services would be coded T1002 HQ or T1003 HQ for both members.
10. The application of group billing applies to all types of personal care and nursing providers, including independent providers.

VI. General guidelines for care based on the Aide Norms Tool:

Task Type	**General Guideline**
Mobility (bed, transfer, locomotion)	5 min/ADL inside and 15 min outside. Positioning Q2 hr
Bathing	30 min/day – includes prep/clean up; transfers
Grooming	15 min/day – includes all hair care, oral care, nails – general hygiene care
Medication	5 min/dose time regardless of number of medications
Toileting	Bladder: 10 min/2 hr awake; 2x/night; add 5 min if incontinent. Bowel: 10 min/BM, add 10 min if incontinent
Dressing	15 min/day; plus 5 min/device (prosthetic)
Eating	30 min/meal with 3 meals and 2 snacks per day
Linen Changes	10 min/week

E. Conditions of Coverage

NA

F. Related Policies/Rules

NA

G. Review/Revision History

	DATE	ACTION
Date Issued	03/16/2022	New policy.
Date Revised	06/16/2022	Out-of-cycle update: split criteria III.A.3 so latter states "at time of billing"
	02/01/2023	Annual review: updated references, clarified hours of care based on medical necessity
	01/17/2024	Annual review: updated references, adjusted Medicare benefit language in D.V.A. Approved at Committee.

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Date Effective	04/01/2024	
Date Archived	03/31/2025	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References

1. Administrative Procedures for Comprehensive Health Care for Children in Placement, OHIO ADMIN. CODE 5101:2-42-66 (2019).
2. Definitions, OHIO ADMIN. CODE 3701-19-01 (2020).
3. Definitions, OHIO ADMIN. CODE 3701-60-01 (2023).
4. Home Health and Private Duty Nursing: Visit Policy, OHIO ADMIN. CODE 5160-12-04 (2021).
5. Home Health Services: Provision Requirements, Coverage and Service Specification, OHIO ADMIN. CODE 5160-12-01 (2021).
6. Managed Care: Covered Services, OHIO ADMIN. CODE 5160-26-03 (2022).
7. Home health services. *Medicare Benefit Policy Manual*. Centers for Medicare and Medicaid Services; 2003. Reviewed June 6, 2022. Accessed December 7, 2023. www.cms.gov
8. Medicare Certified Home Health Agencies: Qualification and Requirements, OHIO ADMIN. CODE 5160-12-03 (2015).
9. Payment For Home Health Nursing Services and Home Health Aide Services, OHIO ADMIN. CODE 4123-6-38 (2022).
10. Payment For Nursing and Caregiver Services Provided by Persons Other Than Home Health Agency Employees, OHIO ADMIN. CODE 4123-6-38.1 (2022).
11. Reimbursement: Exceptions, OHIO ADMIN. CODE 5160-12-07 (2015).
12. Reimbursement: Home Health Services, OHIO ADMIN. CODE 5160-12-05 (2021).

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