Clinical Policy: Extended Home Health Services

Reference Number: LA.CP.MP.511c
Date of Last Revision: ~~02/24~~04/25

Coding Implications
Revision Log

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

I. Background

Louisiana Healthcare Connections provides coverage for extended nursing services as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Coverage is based on the application of medical necessity criteria, submission of a prior authorization (PA), and ~~the~~an authorized healthcare provider (AHP) [JO(1)][LT2]plan of care (POC). These services may be provided to Medicaid-eligible members/enrollees from birth through 20 years of age.

Extended ~~Home Health~~home health, also ~~known~~referred to 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.~~

a ~~**Policy/Criteria**~~

~~**I.** Medical Necessity Criteria:~~

~~Medical necessity for extended skilled nursing services exists when the~~ member/enrollee under 21 years of age when all of the following criteria are met:

- The member/enrollee has a medically complex condition ~~characterized~~;
- A minimum of three (3) continuous hours of nursing care per day is required;
- Services are ordered by an authorized healthcare provider (AHP); and
- Services are deemed medically necessary by Louisiana Healthcare Connections.

II. Policy/Criteria

~~multiple, significant medical problems that~~**A. Medical Necessity Criteria**

All home health services, including extended skilled nursing, must be medically necessary. Services are considered medically necessary when the member/enrollee's illness, injury, or functional limitations require ~~nursing~~skilled care in accordance with the Louisiana Nurse Practice Act (La. R.S. 37:911, et seq). ~~Medical necessity for home health~~

To qualify, 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~~:

- Necessary to prevent ~~further~~ deterioration of ~~a~~the condition,
- Ordered and certified by an AHP, and
- Delivered in the member/enrollee's ~~condition regardless of whether the illness/injury is acute, chronic, or terminal.~~ place of residence.

All extended skilled nursing services ~~for members/enrollees under the age of 21~~ require ~~PA~~prior authorization by Louisiana Healthcare Connections. Requests for an increase in ~~these~~ services ~~will be subject to a~~are reviewed under full ~~review requiring all documentation used for a~~ traditional PA ~~request~~processes.

~~**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:~~

B. Criteria for Medical Necessity

Medical necessity is determined when services reasonably meet **all** of the following conditions:

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~~ that:
   - Endanger life ~~or cause~~,
   - Cause pain~~; results~~,
   - Result in illness or ~~infirmity;~~disability, or ~~have caused, or threatened to cause a~~
   - Cause physical ~~or~~ /mental ~~dysfunctional~~ impairment~~, disability~~ or ~~development~~developmental delay;

     ~~1. 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;~~

3. Reduce the need for inpatient or more intensive medical services;
2.4. Restore or improve ~~physical or mental~~ functionality~~, including developmental functioning,~~ lost or delayed ~~as the result of an~~due to illness, injury, or ~~other diagnosed~~ condition ~~or the effects of the illness, injury, or condition; or~~ ;

3.5.Provide assistanceAssist the member/enrollee in gaining access to neededaccessing medical, social, educational, andor other necessary services required to diagnose, treat, to support a diagnosed condition or the effects of the condition, in order that the member/enrolee might attain or retain independence, self-care, dignity, self-determination, personal safety and integration into family, community, facility environments and activities and quality of life.

The following circumstances are **not** considerations when considered in 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

1. 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 member/enrollee, or an allowed non-physician practitioner (NPP) and the member/enrollee 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 members/enrollees record for ALL home health service-related requests, including therapy services, medical equipment and supplies, and services for members/enrollees under the age of 21. The face-to-face encounter may be conducted by one of the following practitioners:

1. The members/enrollees physician

3. A nurse practitioner or clinical nurse specialist, working Lack of caregiver compliance with outpatient treatment requirements.

C. Face-to-Face Encounter

A face-to-face encounter must be completed as follows:

1. Occurs within:
   - 90 days prior to the start of services, or
   - 30 days after the start of services.
2. Must be related to the primary reason for home health services.
3. Can be performed by:
   - Physician;
   - Nurse practitioner (in collaboration with the members/enrolleesa physician);

2. A physician assistant under the supervision of the members/enrollees physician

3. A certified nurse -midwife, as defined in section 1861(gg) of the Social Security Act; or

- The attendingClinical nurse specialist;
- Physician assistant;
- Certified nurse-midwife;
- Attending acute or /post-acute physician for members/enrollees 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 members/enrollees medical record.

D. Location of the provision of care

Skilled nursing services are to be conducted Documentation must be included in the member/enrollee's residential setting. Extended home health servicesrecord and used to support the POC.

D. Service Location

1. Services are provided in the **member/enrollee's place of residence**, defined as the setting where normal life activities occur.
2. The member/enrollee must not be in a:
   - Hospital,
   - Nursing facility,
   - Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID), or
   - Any setting where Medicaid pays for room and board.

1.3.Nurses may be provided accompany the member/enrollee outside of the residential settingresidence when the nurse accompanies the member/enrollee for medical reasons such as doctormedically necessary (e.g., doctor's appointments, treatments or emergency room visit).

1. 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 members/enrollees illness, injury, or disability causes significant medical hardship and will interfere with the effectiveness of the treatment if the member/enrollee 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 members/enrollees medical records.~~

~~3. The physician must reauthorize the POC every 60 days.~~

~~The member/enrollee must require~~ **E. Plan of Care (POC)**

1. Must be developed and signed by the treating AHP.
2. Must certify:
   - The medical necessity of services;
   - That care is required on an intermittent basis in the residence.
3. The POC must be reviewed and updated every **60 days**.

Statements of hardship must be supported by the full medical record and not based on convenience or lack of transportation.

F. Caregiver Limitation

The need for extended skilled nursing ~~care that exceeds~~must exceed the caregiver's ability to safely care for the member/enrollee without ~~the extended home health services~~professional support.

~~When requesting prior~~**G. Prior Authorization Requirements**

~~**F.**~~ Prior authorization is required for **all** 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~~request must include:
   - All requested hours;
   - Signed POC; and
   - AHP's prescription.

Requests for increased hours will ~~not reimburse for~~ require full documentation to support the change.

H. Non-Covered Criteria

Extended skilled nursing services ~~performed~~will **not** be approved under the following conditions:

1. Member/enrollee is over the age of 21;
1.2. Services are delivered outside of ~~state boundaries.~~Louisiana;

1. ~~Extended home health services or multiple daily nursing visits for persons ages 21 and older are not covered.~~

3. ~~**Assistance to**~~ Services are provided in any inpatient/residential setting reimbursed by Medicaid;
4. Services do not meet the medical necessity criteria described above.

III. Louisiana Healthcare Connections Responsibilities

Louisiana Healthcare Connections is responsible for:

1. Reviewing and authorizing medically necessary extended skilled nursing requests for Medicaid-eligible members under age 21;
2. Ensuring services align with the Louisiana Medicaid Home Health Manual;
3. Assisting members/enrollees and families with identifying participating providers;
4. Communicating with providers to ensure POCs and documentation are accurate and current.

IV. Member/Enrollee Support

~~**II**~~ Members/~~**Enrollees**~~

~~To assist members/~~enrollees or their legal guardians may contact Louisiana Healthcare Connections Member Services for assistance in locating a participating 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

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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
G0156		Services of home health aide/hospice aide in home health or hospice settings, 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
Annual Review. Changed “beneficiary” to “member/enrollee”. References Reviewed and updated. Added HCPS Code G0156.	2/24	4/26/24
Annual Review. Format changes without changes to criteria. Reference reviewed and updated.	4/25	

References

1. Louisiana Medicaid Home Health Services Provider Manual. Issued September 20, 2010.

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.

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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.

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