Home Health Services, Home Health Visits, Respite Care, and Hospice Care

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Instructions for Use

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Related Policies
None

Coverage Guidelines

Home health services are covered when Medicare coverage criteria are met.

Home Health Services

Coverage Criteria

Home health services are covered when all of the following criteria are met:

- Member must be homebound or confined to an institution that is not a hospital or is not primarily engaged in providing skilled nursing or rehabilitation services. Refer to the Medicare Benefit Policy Manual, Chapter 7, §30.1 – Confined to the Home. (Accessed October 17, 2023)
  Refer to the Homebound (Confined to the Home) section for coverage information pertaining to homebound and the Place of Residence section for place of residence.
- The member must be in need skilled nursing care on an intermittent basis (other than solely venipuncture for the purposes of obtaining a blood sample), physical therapy, speech-language pathology services, or has continued need for occupational therapy. (Refer to Definitions for intermittent visit; part time or intermittent).
  Refer to the Medicare Benefit Policy Manual, Chapter 7, §30.4 – Needs Skilled Nursing Care on an Intermittent Basis (Other than Solely Venipuncture for the Purposes of Obtaining a Blood Sample), Physical Therapy, Speech-Language Pathology Services, or Has Continued Need for Occupational Therapy. (Accessed October 17, 2023)
  Note: Home health aide and/or skilled nursing care in excess of the amounts of care that meet these definitions of part-time or intermittent may be provided to a home care patient or purchased by other payers without bearing on whether the home health aide and skilled nursing care meets the definitions of part-time or intermittent. Refer to the

Medicare Benefit Policy Manual, Chapter 7, § 50.7.1 – Impact on Care Provided in Excess of "Intermittent" or "Part-Time" Care.
(Accessed October 17, 2023)

- Member must be under the care of a physician or allowed practitioner in accordance with 42 CFR 424.22 and the home health care services must be furnished under a plan of care that is established, periodically reviewed and ordered by a physician or allowed practitioner.
  A patient is expected to be under the care of the physician or allowed practitioner who signs the plan of care. It is expected that in most instances, the physician or allowed practitioner who certifies the patient's eligibility for home health services, in accordance with §30.5 below, will be the same physician or allowed practitioner who establishes and signs the plan of care. Refer to the:
  - Medicare Benefit Policy Manual, Chapter 7, §30.2 Services Are Provided under a Plan of Care Established and Approved by a Physician or Allowed Practitioner and §30.3 – Under the Care of a Physician or Allowed Practitioner.
  - Medicare Benefit Policy Manual, Chapter 7, § 30.5 – Physician or Allowed Practitioner Certification.

  (Accessed October 17, 2023)

Homebound (Confined to the Home)

For a patient to be eligible to receive covered home health services under both Part A and Part B, the law requires that a physician or allowed practitioner certify in all cases that the patient is confined to his/her home. An individual shall be considered "confined to the home" (homebound) if the following two criteria are met:

- **Criterion One**
  - The patient must either:
    - Because of illness or injury, need:
      - The aid of supportive devices such as crutches, canes, wheelchairs, and walkers; or
      - The use of special transportation; or
      - The assistance of another person in order to leave their place of residence

      or
    - Have a condition such that leaving his or her home is medically contraindicated.
  - If the patient meets one of the Criterion One conditions, then the patient must also meet two additional requirements defined in criterion two below.
- **Criterion Two**
  - There must exist a normal inability to leave home; and
  - Leaving home must require a considerable and taxing effort.

Refer to the Medicare Benefit Policy Manual, Chapter 7, § 30.1.1 – Patient Confined to the Home. (Accessed October 17, 2023)

Place of Residence

A patient's residence is wherever he or she makes his or her home. This may be his or her own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution. However, an institution may not be considered a patient's residence if the institution meets the requirements of §1861(em)(1) of the Act. When a patient remains in a participating SNF following their discharge from active care, the facility may not be considered their residence for purposes of home health coverage.

Assisted Living Facilities (also called Group Homes and Personal Care Homes)

If it is determined that the assisted living facility (also called personal care homes, group homes, etc.) in which the individuals reside are not primarily engaged in providing the above services, then Medicare will cover reasonable and necessary home health care furnished to these individuals.

If it is determined that the services furnished by the home health agency are duplicative of services furnished by these institutions when provision of such care is required of the facility under State licensure requirements, such services will be denied.

Day Care Centers and Patient's Place of Residence

The current statutory definition of homebound or confined does not imply that Medicare coverage has been expanded to include adult day care services.

The law does not permit a home health agency (HHA) to furnish a Medicare covered billable visit to a patient under a home health plan of care outside his or her home, except in those limited circumstances where the patient needs to use medical equipment that is too cumbersome to bring to the home. Section 1861(m) of the Act stipulates that home health services provided to a patient be provided to the patient on a visiting basis in a place of residence used as the individual's home. A licensed/certified day care center does not meet the definition of a place of residence.

Refer to the Medicare Benefit Policy Manual, Chapter 7, §30.1.2 – Patient's Place of Residence. (Accessed October 17, 2023)

Use of Utilization Screens and "Rules of Thumb"

Medicare recognizes that determinations of whether home health services are reasonable and necessary must be based on an assessment of each patient's individual care needs. Therefore, denial of services based on numerical utilization screens, diagnostic screens, diagnosis or specific treatment norms is not appropriate. Refer to the Medicare Benefit Policy Manual, Chapter 7,§20.3 Use of Utilization Screens and "Rules of Thumb". (Accessed October 17, 2023)

Face-to-Face Home Health Certification Requirement

As part of the certification of patient eligibility for the Medicare home health benefit, a face-to-face encounter with the patient must be performed by the certifying physician or allowed practitioner himself or herself, a physician or allowed practitioner that cared for the patient in the acute or post-acute care facility (with privileges who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health) or an allowed non-physician practitioner (NPP).

Timeframe Requirements

- The encounter must occur no more than 90 days prior to the home health start of care date or within 30 days after the start of care.
- In situations when a physician or allowed practitioner orders home health care for the patient based on a new condition that was not evident during a visit within the 90 days prior to start of care, the certifying physician or allowed practitioner or an allowed NPP must see the patient again within 30 days after admission. Specifically, if a patient saw the certifying physician or allowed practitioner or NPP within the 90 days prior to start of care, another encounter would be needed if the patient's condition had changed to the extent that standards of practice would indicate that the physician or a non-physician practitioner should examine the patient in order to establish an effective treatment plan.

Note: UnitedHealthcare Medicare Advantage Plans follow these requirements.

Refer to the Medicare Benefit Policy Manual, Chapter 7, §30.5.1.1 – Face-to-Face Encounter. (Accessed October 17, 2023)

Outpatient Services

Outpatient services include any of the items or services which are provided under arrangements on an outpatient basis at a hospital, skilled nursing facility, rehabilitation center, or outpatient department affiliated with a medical school, and (1) which require equipment which cannot readily be made available at the patient's place of residence, or (2) which are furnished while the patient is at the facility to receive the services described in (1). The hospital, skilled nursing facility, or outpatient department affiliated with a medical school must all be qualified providers of services. However, there are special provisions for the use of the facilities of rehabilitation centers. The cost of transporting an individual to a facility cannot be reimbursed as home health services.

Refer to the Medicare Benefit Policy Manual, Chapter 7, §50.6 – Outpatient Services. (Accessed October 17, 2023)

Frequency of Review of Plan of Care

The plan of care must be reviewed and signed by the physician or allowed practitioner who established the plan of care, in consultation with home health agency (HHA) professional personnel, at least every 60 days. Refer to the Medicare Benefit Policy Manual, Chapter 7, §30.2.7. (Accessed October 17, 2023)

Note: The HHA that is providing the services to the patient has in effect a valid agreement to participate in the Medicare program. Refer to the Medicare Benefit Policy Manual, Chapter 7, §20 – Conditions To Be Met for Coverage of Home Health Service. (Accessed October 17, 2023)

Physician or Allowed Practitioner Recertification

Medicare does not limit the number of continuous 60 day recertifications for beneficiaries who continue to be eligible for the home health benefit. The physician or allowed practitioner certification may cover a period less than but not greater than 60 days. For more detailed guidance, refer to the Medicare Benefit Policy Manual, Chapter 7, §30.5.2 - Physician or Allowed Practitioner Recertification. (Accessed October 17, 2023)

Impact of Other Available Caregivers and Other Available Coverage on Medicare Coverage of Home Health Services

Where the Medicare criteria for coverage of home health services are met, patients are entitled by law to coverage of reasonable and necessary home health services. A patient is entitled to have the costs of reasonable and necessary services reimbursed by Medicare without regard to whether there is someone available to furnish the services. However, when a family member or other person is or will be providing services that adequately meet the patient's needs, it would not be reasonable and necessary for HHA personnel to furnish such services.

Similarly, a patient is entitled to reasonable and necessary Medicare home health services even if the patient would qualify for institutional care (e.g., hospital care or skilled nursing facility care) and Medicare payment should be made for reasonable and necessary home health services where the patient is also receiving supplemental services that do not meet Medicare's definition of skilled nursing care or home health aide services.

Refer to the Medicare Benefit Policy Manual, Chapter 7, § 20.2 - Impact of Other Available Caregivers and Other Available. (Accessed October 17, 2023)

Skilled Nursing Care (CPT Codes 99503 and 99505 and HCPCS Codes G0299, G0493, G0495, G0162, G0300, G0493, G0494, and G0496)

To be covered as skilled nursing services, the services must require the skills of a registered nurse, or a licensed practical (vocational) nurse under the supervision of a registered nurse, must be reasonable and necessary to the treatment of the patient's illness or injury as discussed in §40.1.1 and must be intermittent as discussed in §40.1.3. Coverage of skilled nursing care does not turn on the presence or absence of a patient's potential for improvement from the nursing care, but rather on the patient's need for skilled care.

For more detailed benefit information and examples, refer to the Medicare Benefit Policy Manual, Chapter 7, §40.1 – Skilled Nursing Care. (Accessed October 17, 2023)

Skilled Therapy Services (CPT Codes 97535 and 99601 and HCPCS Codes G0151, G0152, G0153, G0157, G0158, G0159, G0160, G0161, G0162, G2168, and G2169)

To be covered as skilled therapy, the services must require the skills of a qualified therapist and must be reasonable and necessary for the treatment of the patient's illness or injury. Coverage does not turn on the presence or absence of an individual's potential for improvement, but rather on the patient's need for skilled care.

For guidelines and principles governing reasonable and necessary physical therapy, speech-language pathology services and occupational therapy and specific examples, refer to the Medicare Benefit Policy Manual, Chapter 7, §40.2 – Skilled Therapy Services. (Accessed October 17, 2023)

Maintenance Therapy

Where services that are required to maintain the patient's current function or to prevent or slow further deterioration are of such complexity and sophistication that the skills of a qualified therapist are required to perform the procedure safely and effectively, the services would be covered physical therapy services. Further, where the particular patient's special medical complications require the skills of a qualified therapist to perform a therapy service safely and effectively that would otherwise be considered unskilled, such services would be covered physical therapy services.

For specific coverage guidelines regarding maintenance therapy and examples, refer to the Medicare Benefit Policy Manual, Chapter 7, §40.2.2 – Application of the Principles to Physical Therapy. (Accessed October 17, 2023)

Home Health Aide Services (CPT Code 99509 and HCPCS Code G0156)

For home health aide services to be covered:

- The patient must meet the qualifying criteria as specified in Home Health Services Coverage Criteria section; and
- The services provided by the home health aide must be part-time or intermittent (refer to Definitions); and

- The services must meet the definition of home health aide services; and
- The services must be reasonable and necessary to the treatment of the patient's illness or injury.

Note: A home health aide must be certified consistent the competency evaluation requirements.

The reason for the visits by the home health aide must be to provide hands-on personal care of the patient or services needed to maintain the patient's health or to facilitate treatment of the patient's illness or injury.

The physician or allowed practitioner's order should indicate the frequency of the home health aide services required by the patient.

Home health aide services may include but are not limited to:
- Personal care.
- Simple dressing changes that do not require the skills of a licensed nurse.
- Assistance with medications which are ordinarily self-administered and do not require the skills of a licensed nurse to be provided safely and effectively.
- Assistance with activities which are directly supportive of skilled therapy services but do not require the skills of a therapist to be safely and effectively performed such as routine maintenance exercises and repetitive practice of functional communication skills to support speech-language pathology services.
- Provision of services incidental to personal care services not care of prosthetic and orthotic devices.

Notes:
- When a home health aide visits a patient to provide a health-related service as discussed above, the home health aide may also perform some incidental services which do not meet the definition of a home health aide service (e.g., light cleaning, preparation of a meal, taking out the trash, shopping, etc.).
- However, the purpose of a home health aide visit may not be to provide these incidental services since they are not health related services, but rather are necessary household tasks that must be performed by anyone to maintain a home.

For specific examples of home health aide services, refer to the Medicare Benefit Policy Manual, Chapter 7, §50.2 – Home Health Aide Services. (Accessed October 17, 2023)

Medical Social Services (HCPCS Code G0155)

Medical social services provided by a qualified medical social worker or a social work assistant under the supervision of a qualified medical social worker may be covered as home health services where the patient meets the qualifying criteria outlined in Coverage Criteria section; and
- The services of these professionals are necessary to resolve social or emotional problems that are or are expected to be an impediment to the effective treatment of the patient's medical condition or rate of recovery.
- The plan of care indicates how the services which are required necessitate the skills of a qualified social worker or a social work assistant under the supervision of a qualified medical social worker to be performed safely and effectively.

Services of these professionals which may be covered include, but are not limited to:
- Assessment of the social and emotional factors related to the patient's illness, need for care, response to treatment and adjustment to care.
- Assessment of the relationship of the patient's medical and nursing requirements to the patient's home situation, financial resources and availability of community resources.
- Appropriate action to obtain available community resources to assist in resolving the patient's problem.
  Note: Medicare does not cover the services of a medical social worker to complete or assist in the completion of an application for Medicaid because Federal regulations require the State to provide assistance in completing the application to anyone who chooses to apply for Medicaid.
- Counseling services that are required by the patient.
- Medical social services furnished to the patient's family member or caregiver on a short-term basis when the HHA can demonstrate that a brief intervention (that is, two or three visits) by a medical social worker is necessary to remove a clear and direct impediment to the effective treatment of the patient's medical condition or to the patient's rate of recovery. To be considered "clear and direct," the behavior or actions of the family member or caregiver must plainly obstruct, contravene, or prevent the patient's medical treatment or rate of recovery. Medical social services to address general problems that do not clearly and directly impede treatment or recovery as well as long-term social services furnished to family members, such as ongoing alcohol counseling, are not covered.

Note: Participating in the development of the plan of care, preparing clinical and progress notes, participating in discharge planning and in-service programs, and acting as a consultant to other agency personnel are appropriate administrative costs to the HHA.

Refer to the Medicare Benefit Policy Manual, Chapter 7, §50.3 – Medical Social Services. (Accessed October 17, 2023)

Medical Supplies, Durable Medical Equipment, and Negative Pressure Wound Therapy

This section applies to medical supplies (except for drugs and biologicals other than covered osteoporosis drugs), the use of durable medical equipment and furnishing negative pressure wound therapy using a disposable device.

Medical Supplies

Medical supplies are items that, due to their therapeutic or diagnostic characteristics, are essential in enabling HHA personnel to conduct home visits or to carry out effectively the care the physician or allowed practitioner has ordered for the treatment or diagnosis of the patient's illness or injury. All supplies which would have been covered under the cost-based reimbursement system are bundled under home health PPS. Payment for the cost of supplies has been incorporated into the per visit and episode payment rates. Supplies fit into two categories. They are classified as:

- Routine - because they are used in small quantities for patients during the usual course of most home visits; or
- Nonroutine - because they are needed to treat a patient's specific illness or injury in accordance with the physician or allowed practitioner's plan of care and meet further conditions discussed in more detail in the referenced Medicare manual section below.

Refer to the Medicare Benefit Policy Manual, Chapter 7, §50.4.1 – Medical Supplies. (Accessed October 17, 2023)

Durable Medical Equipment

Durable medical equipment which meets the requirements of the Medicare Benefit Policy Manuals, Chapter 6, "Hospital Services Covered Under Part B," §80, and Chapter 15, "Covered Medical and Other Health Services" §110, is covered under the home health benefit. Refer to the Medicare Benefit Policy Manual, Chapter 7, §50.4.2 – Durable Medical Equipment.
(Accessed October 17, 2023)

Negative Pressure Wound Therapy Using a Disposable Device

Payment for HH visits related to wound care, but not requiring the furnishing of an entirely new disposable NPWT device, will be covered by the HH PPS episode payment and must be billed using the HH claim.

Refer to the Medicare Benefit Policy Manual, Chapter 7, §50.4.4 – Negative Pressure Wound Therapy Using a Disposable Device. (Accessed October 17, 2023)

Covered Osteoporosis Drugs

Sections 1861(m) and 1861(kk) of the Act provide for coverage of FDA approved injectable drugs for the treatment of osteoporosis. These drugs are expected to be provided by an HHA to female beneficiaries who are currently receiving services under an open home health plan of care, who meet existing coverage criteria for the home health benefit and who meet the criteria listed below. These drugs are covered on a cost basis when provided by an HHA under the circumstances listed below.

The home health visit (i.e., the skilled nurse's visit) to administer the drug is covered under all fee-for-service Medicare (Part A or Part B) home health coverage rules. Coverage of the drug is limited to female beneficiaries who meet each of the following criteria:

- The individual is eligible for Medicare Part B coverage of home health services (the nursing visit to perform the injection may be the individual's qualifying service); and
- The individual sustained a bone fracture that a physician, or allowed practitioner, or certified nurse midwife certifies was related to post-menopausal osteoporosis; and
- The individual's physician, or allowed practitioner, or certified nurse midwife certifies that she is unable to learn the skills needed to self-administer the drug or is otherwise physically or mentally incapable of administering the drug, and that her family or caregivers are unable or unwilling to administer the drug.

Refer to the Medicare Benefit Policy Manual, Chapter 7, §50.4.3 – Covered Osteoporosis Drugs. (Accessed October 17, 2023)

Heparin Injections

Home health nurse visits to teach the member or the caring person to give subcutaneous injections of low dose heparin if it is prescribed by a physician for a homebound member is covered when criteria are met.

Refer to the NCD for Home Health Nurse Visits to Patients Requiring Heparin Injection (290.2). (Accessed October 17, 2023)

Intravenous Immune Globulin (IVIG) in Home

Intravenous immune globulin (IVIG) for the treatment of primary immune deficiency diseases is covered in the home when coverage criteria are met. Refer to the Coverage Summary titled Medications/Drugs (Outpatient/Part B) for coverage guidelines.

Religious Nonmedical Health Care Institution Services

Religious nonmedical health care institution services furnished in the home are covered.

Note: The term "home health agency" also includes a religious nonmedical health care institution, but only with respect to items and services ordinarily furnished by such an institution to individuals in their homes, and that are comparable to items and services furnished to individuals by a home health agency that is not a religious nonmedical health care institution.

Refer to the Medicare Benefit Policy Manual, Chapter 1, §130.4 – Coverage of Religious Nonmedical and Services Furnished in the Home. (Accessed October 17, 2023)

Home Prothrombin Time/INR Monitoring (HCPCS Code G0249)

Home prothrombin time/INR monitoring for anticoagulation management is covered to monitor the INR ratio when criteria are met. Refer to the NCD for Home Prothrombin Time/International Normalized Ratio (PT/INR) Monitoring for Anticoagulation Management (190.11). (Accessed October 17, 2023)

Non-Covered Services

The following services in the home are not covered:

- Home health services furnished when the member is not needing any other skilled service (e.g. physical therapy, speech language pathology services or continued occupational therapy)**;** refer to the Skilled Nursing Care section.
- Part time or intermittent skilled nursing or home health aide services (when combined) greater than 8 hours a day or more than 28 hours per week except when authorized on a case-by-case basis to be more than 8 hours a day and 35 hours or fewer hours per week; refer to the Medicare Benefit Policy Manual, Chapter 7, §50.7 – Part-Time or Intermittent Home Health Aide or Skilled Nursing Services. (Accessed October 17, 2023)
  Skilled nursing care solely for the purpose of drawing a member's blood for testing; refer to the Medicare Benefit Policy Manual, Chapter 7,§40.1.2.13 – Venipuncture and the Medicare Benefit Policy Manual, Chapter 7, §30.4. (Accessed October 17, 2023)
- Drugs and biologicals are excluded from payment under the Medicare home health benefit. For more specific home health benefit information and skilled nursing services, refer to the Medicare Benefit Policy Manual, Chapter 7, §80.1. (Accessed October 17, 2023)
- Transportation of a patient, whether to receive covered care or for other purposes, is excluded from home health coverage. Costs of transportation of equipment, materials, supplies, or staff may be allowable as administrative costs, but no separate payment is made; refer to the Medicare Benefit Policy Manual, Chapter 7, §80.2. (Accessed October 17, 2023)
- Housekeeping services, i.e., services for which the sole purpose is to enable the patient to continue residing in their home (e.g., cooking, shopping, Meals on Wheels, cleaning, laundry) are excluded from home health coverage; refer to the Medicare Benefit Policy Manual, Chapter 7, §80.4 – Housekeeping Services. (Accessed October 17, 2023)
- Private duty nursing care (HCPCS T1000); refer to the Medicare Benefit Policy Manual Chapter 1, §20 – Nursing and Other Services. (Refer to Definitions) (Accessed October 17, 2023)
  Note: Some benefit plans may offer an additional benefit for private duty nursing when medically necessary. For Private Duty Nursing medical necessity criteria, refer to the InterQual® LOC: Home Care Q & A, Private Duty Nursing (PDN) Assessment**.** Click here to view the InterQual® criteria.
- Oral prescription drugs provided by a home health provider unless the member has a supplemental pharmacy benefit, and the oral medications are obtained through a contracted UnitedHealthcare Medicare pharmacy provider; refer to the Medicare Benefit Policy Manual, Chapter 7, §40.1.2.4 – Administration of Medications. (Accessed October 17, 2023)

- Home health services for a blood draw unless the member has a need for another qualified skilled service and meets all home health eligibility criteria.
  Note: For coverage of home blood draws (venipunctures) by an independent laboratory technician, refer to the Medicare Benefit Policy Manual.
- Telehealth for delivery of home health services; refer to the Medicare Benefit Policy Manual, Chapter 7, §110 – Use of Telehealth in Delivery of Home Health Services. (Accessed October 17, 2023)
- Services covered under the end stage renal disease (ESRD) Program; refer to the Medicare Benefit Policy Manual, Chapter 7,§80.5. (Accessed October 17, 2023)
- Prosthetic items are excluded from home health coverage. However, catheters, catheter supplies, ostomy bags, and supplies related to ostomy care are not considered prosthetic devices if furnished under a home health plan of care and are not subject to this exclusion from coverage but are bundled while a patient is under a HH plan of care; refer to the Medicare Benefit Policy Manual, Chapter 7, §80.6. (Accessed October 17, 2023)
- Medical social services furnished solely to family members of the patient's family and that are not incidental to covered medical social services being furnished to the patient are not covered; refer to the Medicare Benefit Policy Manual, Chapter 7, §80.7. (Accessed October 17, 2023)
- Respiratory care services; refer to the Medicare Benefit Policy Manual, Chapter 7, §80.8. (Accessed October 17, 2023)
- Dietary and nutrition personnel (CPT Code G0270); refer to the Medicare Benefit Policy Manual, Chapter 7, §80.9. (Accessed October 17, 2023)

Caregiver Services

Medicare does not cover caregiver benefits.

Note: Some UnitedHealthcare Medicare members may have additional benefits for caregivers. Contact the customer service department or refer to the member's Evidence of Coverage (EOC) to determine coverage eligibility.

Respite Care

Respite care is only covered by Medicare when provided as part of the Medicare hospice benefit.

Note: Some UnitedHealthcare Medicare members may have additional benefits for caregivers. Contact the customer service department or refer to the member's EOC to determine coverage eligibility.

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) for home health services exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. (Accessed October 17, 2023)

Hospice Services (HCPCS Codes G0156, G0157, G0158, and G0300)

Hospice is covered by Original Medicare under Part A for members who elect to receive hospice care. Refer to the Medicare Claims Processing Manual, Chapter 11-Processing Hospice Claims and the Medicare Managed Care Manual, Chapter 4, §10.2-Basic Rule and §10.4-Hospice Coverage.

For Medicare detailed coverage guidelines for hospice services, refer to the Medicare Benefit Policy Manual, Chapter 9 – Coverage of Hospice Services under Hospital Insurance. (Accessed October 17, 2023)

Definitions

Intermittent Visit: For purposes of benefit eligibility, under §§1814(a)(2)(C) and 1835(a)(2)(A) of the Act, "intermittent" means skilled nursing care that 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). Medicare Benefit Policy Manual, Chapter 7, § 40.1.3 – Intermittent Skilled Nursing Care. (Accessed October 17, 2023)

Part Time or Intermittent Services: Skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or subject to review on a case by case basis as to the need of care, less than 8 hours each day and 35 hours or fewer per week). Medicare Benefit Policy Manual, Chapter 7, §50.7 – Part-Time or Intermittent Home Health Aide and Skilled. (Accessed October 17, 2023)

Private Duty Nursing Services: The services provided by a private-duty nurse or other private-duty attendant. Private-duty nurses or private-duty attendants are registered nurses, licensed practical nurses, or any other trained attendant whose services ordinarily are rendered to, and restricted to, a particular patient by arrangement between the patient and the private-duty nurse or attendant. Such persons are engaged or paid by an individual patient or by someone acting on their behalf, including a hospital that initially incurs the costs and looks to the patient for reimbursement for such noncovered services. Medicare Benefit Policy Manual Chapter 1, §20 – Nursing and Other Services. (Accessed October 17, 2023)

Policy History/Revision Information

Date	Summary of Changes
08/01/2024	**Coverage Guidelines** • Removed reference link to the Medicare Advantage Coverage Summary titled *Laboratory Tests and Services* (retired Aug. 1, 2024)

03/13/2024	**Template Update**
	• Updated *Instructions for Use*
	Coverage Guidelines
	Home Health Services
	Coverage Criteria
	• Removed notation indicating:
	  ○ UnitedHealthcare uses the criteria [in the policy] to supplement the general Medicare criteria regarding home health care in the *Medicare Benefit Policy Manual, Chapter 7 - Home Health Services*
	  ○ UnitedHealthcare or it's delegates may utilize InterQual®, a commercially available evidence-based clinical decision tool to make medical necessity determinations, if there is no National Coverage Determination (NCD), applicable Local Coverage Determination (LCD)/Local Coverage Article (LCA), or Medicare manual guidance on coverage, or where the existing guidance provides insufficient clinical detail; refer to the InterQual® LOC: Home Care Q & A
	Administrative
	• Archived previous policy version MCS044.10

Instructions for Use

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The benefit information in this Coverage Summary is based on existing national coverage policy; however, Local Coverage Determinations (LCDs) may exist and compliance with these policies are required where applicable.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. UnitedHealthcare utilizes the additional criteria noted above to supplement Medicare coverage guidelines in order to determine medical necessity consistently. The additional coverage criteria was developed through an evaluation of the current relevant clinical evidence in acceptable clinical literature and/or widely used treatment guidelines. UnitedHealthcare evaluated the evidence to determine whether it was of sufficient quality to support a finding that the items or services discussed in the policy might, under certain circumstances, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

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