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

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Instructions for Use

Table of Contents **Page**

Related Medicare Advantage Medical Policy

- Medications/Drugs (Outpatient/Part B)

Coverage Rationale

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.
  - 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 Services.
  - 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.
    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.
- 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.

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.

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.

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".

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.

Telehealth

The face-to-face encounter can be performed via a telehealth service, in an approved originating site. An originating site is considered to be the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site located in a rural health professional shortage area or in a county outside of a Metropolitan Statistical Area.

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.

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.

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.

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.

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.

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.

Skilled Nursing Care

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.

Skilled Therapy Services

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.

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.

Home Health Aide Services

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.

Medical Social Services

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.

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.

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.

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, were covered by the HH PPS period payment, and-were 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.

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.

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 Medicare Advantage Medical Policy 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.

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.

  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.
- 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.
- 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.
- 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.
- Private duty nursing care; refer to the Medicare Benefit Policy Manual Chapter 1, §20 – Nursing and Other Services. (Refer to Definitions)
  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.
- 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.
- Services covered under the end stage renal disease (ESRD) Program; refer to the Medicare Benefit Policy Manual, Chapter 7,§80.5.
- 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.
- 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.
- Respiratory care services; refer to the Medicare Benefit Policy Manual, Chapter 7, §80.8.
- Dietary and nutrition personnel; refer to the Medicare Benefit Policy Manual, Chapter 7, §80.9.

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.

Hospice Services

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.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service; however, language may be included in the listing below to indicate if a code is non-covered. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
99503	Home visit for respiratory therapy care (e.g., bronchodilator, oxygen therapy, respiratory assessment, apnea evaluation)
99505	Home visit for stoma care and maintenance including colostomy and cystostomy

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HCPCS Code	Description
G0151	Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes
G0155	Services of clinical social worker in home health or hospice settings, each 15 minutes
G0156	Services of home health/hospice aide in home health or hospice settings, each 15 minutes
G0157	Services performed by a qualified physical therapist assistant in the home health or hospice setting, each 15 minutes
G0158	Services performed by a qualified occupational therapist assistant in the home health or hospice setting, each 15 minutes
G0159	Services performed by a qualified physical therapist, in the home health setting, in the establishment or delivery of a safe and effective physical therapy maintenance program, each 15 minutes
G0160	Services performed by a qualified occupational therapist, in the home health setting, in the establishment or delivery of a safe and effective occupational therapy maintenance program, each 15 minutes
G0161	Services performed by a qualified speech-language pathologist, in the home health setting, in the establishment or delivery of a safe and effective speech-language pathology maintenance program, each 15 minutes
G0162	Skilled services by a registered nurse (RN) for management and evaluation of the plan of care; each 15 minutes (the patient's underlying condition or complication requires an RN to ensure that essential nonskilled care achieves its purpose in the home health or hospice setting)
G0299	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes

HCPCS Code	Description
G0300	Direct skilled nursing services of a licensed practical nurse (LPN) in the home health or hospice setting, each 15 minutes
G0493	Skilled services of a registered nurse (RN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting)
G0494	Skilled services of a licensed practical nurse (LPN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting)
G0495	Skilled services of a registered nurse (RN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes
G0496	Skilled services of a licensed practical nurse (LPN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes
G2168	Services performed by a physical therapist assistant in the home health setting in the delivery of a safe and effective physical therapy maintenance program, each 15 minutes
G2169	Services performed by an occupational therapist assistant in the home health setting in the delivery of a safe and effective occupational therapy maintenance program, each 15 minutes
T1000	Private duty/independent nursing service(s), licensed, up to 15 minutes

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.

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.

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.

Centers for Medicare and Medicaid Services (CMS) Related Documents

After checking the table below and searching the Medicare Coverage Database, if no NCD, LCD, or LCA is found, refer to the criteria as noted in the Coverage Rationale section above.

Medicare Administrative Contractor (MAC) With Corresponding States/Territories	
MAC Name (Abbreviation)	**States/Territories**
CGS Administrators, LLC (CGS)	KY, OH
First Coast Service Options, Inc. (First Coast)	FL, PR, VI
National Government Services, Inc. (NGS)	CT, IL, ME, MA, MN, NH, NY, RI, VT, WI
Noridian Healthcare Solutions, LLC (Noridian)	AS, AK, AZ, CA, GU, HI, ID, MT, NV, ND, Northern Mariana Islands, OR, SD, UT, WA, WY
Novitas Solutions, Inc. (Novitas)	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX, VA**
Palmetto GBA (Palmetto)	AL, GA, NC, SC, TN, VA**, WV

Medicare Administrative Contractor (MAC) With Corresponding States/Territories	
MAC Name (Abbreviation)	**States/Territories**
Wisconsin Physicians Service Insurance Corporation (WPS)*	IA, IN, KS, MI, MO, NE
Notes	
*Wisconsin Physicians Service Insurance Corporation: Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers. **For the state of Virginia: Part B services for the city of Alexandria and the counties of Arlington and Fairfax are excluded for the Palmetto GBA jurisdiction and included within the Novitas Solutions, Inc. jurisdiction.	

CMS Benefit Policy Manual

Medicare Benefit Policy Manual, Chapter 1
Medicare Benefit Policy Manual, Chapter 7
Medicare Benefit Policy Manual, Chapter 9

CMS Claims Processing Manual

Medicare Claims Processing Manual, Chapter 11-Processing Hospice Claims

Medicare Managed Care Manual

Medicare Managed Care Manual, Chapter 4, §10.2-Basic Rule and §10.4-Hospice Coverage

Policy History/Revision Information

Date	Summary of Changes
01/01/2025	**Related Policies** • Updated reference link to the Medicare Advantage Medical Policy titled *Medications/Drugs (Outpatient/Part B)*

12/01/2024	**Template Update**
	• Reformatted and reorganized policy; transferred content to new template
	• Changed policy type classification from "Coverage Summary" to "Medical Policy"
	• Updated *Instructions for Use*
	Related Policies
	• Added reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Medications/Drugs (Outpatient/Part B)*
	Coverage Rationale
	• Removed content/language addressing the following services (refer to the Medicare Coverage Database for applicable coverage guidelines):
	  ○ Heparin injections
	  ○ Home prothrombin time/international normalized ratio (INR) monitoring (HCPCS code G0249)
	Face-to-Face Home Health Certification Requirement
	Telehealth
	• Added language to indicate:
	  ○ The face-to-face encounter can be performed via a telehealth service, in an approved originating site
	  ○ An originating site is considered to be the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs
	  ○ Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site located in a rural health professional shortage area or in a county outside of a Metropolitan Statistical Area
	Negative Pressure Wound Therapy Using a Disposable Device
	• Replaced language indicating "payment for home health (HH) visits related to wound care, but not requiring the furnishing of an entirely new disposable negative pressure wound therapy (NPWT) device, *will be* covered by the HH prospective payment system (PPS) *episode* payment, *and must be* billed using the HH claim" with "payment for HH visits related to wound

Date	Summary of Changes
	care, but not requiring the furnishing of an entirely new disposable NPWT device, *were* covered by the HH PPS *period* payment *were* billed using the HH claim" **Applicable Codes** • Updated list of applicable CPT/HCPCS codes (previously located in the *Coverage Rationale* section); removed 97535, 99601, 99509, and G0270 **Centers for Medicare & Medicaid (CMS) Related Documents** • Added list of applicable *Medicare Administrative Contractors (MACs) With Corresponding States/Territories* • Added notation to indicate: ○ The Wisconsin Physicians Service Insurance Company (WPS) Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers ○ For the state of Virginia: Part B services for the city of Alexandria and the counties of Arlington and Fairfax are excluded for the Palmetto GBA jurisdiction and included within the Novitas Solutions, Inc. jurisdiction • Added reference link to the: ○ *Medicare Benefit Policy Manual, Chapter 1* ○ *Medicare Benefit Policy Manual, Chapter 7* ○ *Medicare Benefit Policy Manual, Chapter 9* ○ *Medicare Claims Processing Manual, Chapter 11-Processing Hospice Claims* ○ *Medicare Managed Care Manual, Chapter 4, §10.2-Basic Rule and §10.4-Hospice Coverage* **Supporting Information** • Archived previous policy version MCS044.11

Instructions for Use

The Medicare Advantage Policy documents are generally used to support UnitedHealthcare coverage decisions. It is expected providers retain or have access to appropriate documentation when requested to support coverage. This document may be used as a guide to help determine applicable:

- Medical necessity coverage guidelines; including documentation requirements, and/or
- Medicare coding or billing requirements.

Medicare Advantage Policies are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates. This Policy is provided for informational purposes and does not constitute medical advice. It is intended to serve only as a general reference and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes this policy. For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.

Medicare Advantage Policies are developed as needed, are regularly reviewed, and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policies at any time by publishing a new version on this website. Medicare source materials used to develop these policies may include, but are not limited to, CMS statutes, regulations, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and manuals. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. The information presented in this Policy is believed to be accurate and current as of the date of publication. Where there is a conflict between this document and Medicare source materials, the Medicare source materials apply. Medicare Advantage Policies are the property of UnitedHealthcare. Unauthorized copying, use, and distribution of this information are strictly prohibited.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing certain items or services referenced in this Medical Policy have not been fully established in applicable Medicare guidelines because there is an absence of any applicable Medicare statutes, regulations, NCDs, or LCDs setting forth coverage criteria and/or the applicable NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD. As a result, in these circumstances, UnitedHealthcare applies internal coverage criteria as referenced in this Medical Policy. The internal coverage criteria in this Medical Policy 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.

Providers are responsible for submission of accurate claims. Medicare Advantage Policies are intended to ensure that coverage decisions are made accurately. UnitedHealthcare Medicare Advantage Policies use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

For members in UnitedHealthcare Medicare Advantage plans where a delegate manages utilization management and prior authorization requirements, the delegate's requirements need to be followed.