HOME HEALTH VISITS TO A BLIND DIABETIC (NCD 290.1)

Guideline Number: MPG138.04
Approval Date: January 09, 2019

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Overview

Many individuals who are blind and require daily insulin for the control of a diabetic condition are able to administer their injections without assistance (other than possibly that which may be furnished by family members or friends). There are organizations which encourage and train blind diabetics, both to fill their own syringes and to inject themselves. There are also a number of devices available for blind individuals to fill their syringes accurately. However, the individuals who may need assistance with prefilling their syringes may also require periodic observation and evaluation, even though their diabetes is fairly stabilized. In such cases, probably few in number, home health services may be required for this purpose.

Guidelines

To qualify for home health benefits, a blind diabetic must be confined to his home, under the care of a physician, and in need of either skilled nursing services on an intermittent basis or physical therapy or speech-language pathology services. A person may qualify for home health benefits based on his or her need for skilled nursing services on an intermittent basis, physical therapy, speech-language pathology, or occupational therapy. Occupational therapy is eliminated as a basis for entitlement to home health services. However, if a person has otherwise qualified for home health services because of the need for skilled nursing care, physical therapy or speech-language pathology, the patient's eligibility for home health services may be extended solely on the basis of the continuing need for occupational therapy. (See the Medicare Benefit Policy Manual, Chapter 7, "Home Health Services," §20.) There must be a plan of treatment, established and periodically reviewed by a physician, which indicates that there is a recurring need for home health services to supplement the physician's contacts with the patient; e.g., skilled nursing visits for observing and determining the need for changes in the level and type of care which has been prescribed. (See the Medicare Benefit Policy Manual, Chapter 7, "Home Health Services," §30.) Once an initial regimen has been established, the frequency of need for further home health services can vary greatly from patient to patient, depending on their condition and the likelihood of its changing. Some may need visits only every 90 days, for example, while others may require them much more frequently. If a nurse makes a visit to provide skilled services, and also prefills syringes, the purpose of the visit, which was to provide skilled services, does not change. However, if the sole purpose of the nurse's visit is to prefill insulin syringes for a blind diabetic, it is not a skilled nursing visit although it may be reimbursed as such as indicated below.

Filling a syringe can be safely and effectively performed by the average nonmedical person without the direct supervision of a licensed nurse. Consequently, it would not constitute a skilled nursing service even if it is performed by a nurse. (See the Medicare Benefit Policy Manual, Chapter 7, "Home Health Services," §30.2.2.) The personal care duties normally performed by home health aides include assisting the patient with medications ordered by a physician which are ordinarily self-administered. (See the Medicare Benefit Policy Manual, Chapter 7, "Home Health Services," §50.2.) Performance of such a service by an aide is consistent with the Medicare conditions of participation for home health agencies. Therefore, home health aide services would be appropriate for those blind diabetics who are qualified for home health benefits and who cannot fill their syringes. An adequately trained home health aide could make intermittent visits, usually on a weekly basis, to the home for the purpose of filling that supply of insulin ordered by the physician.
If State law, however, precludes a home health aide from prefilling insulin syringes, payment may be made for this service as part of the cost of skilled nursing services when performed by a nurse for a blind diabetic who is otherwise unable to prefill his or her syringes. There are no adverse consequences with respect to reimbursement to the home health agency for providing the service in this manner.

If State law does not preclude a home health aide from prefilling insulin syringes, but the home health agency chooses to send a nurse to perform only this task, the visit is reimbursed as if made by a home health aide.

**Note:** As indicated, to qualify for home health benefits, a patient must require skilled nursing services on an intermittent basis or physical therapy or speech-language pathology. If a beneficiary does not qualify for home health benefits but only needs someone to prefill syringes with the correct dosage of insulin, then no program payment can be made.

### APPLICABLE CODES

The following list(s) of codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. 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.

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<th>HCPCS Code</th>
<th>Description</th>
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<tr>
<td>G0156</td>
<td>Services of home health/hospice aide in home health or hospice settings, each 15 minutes</td>
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<tr>
<td>G0162</td>
<td>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 non skilled care achieves its purpose in the home health or hospice setting)</td>
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<tr>
<td>T1021</td>
<td>Home health aide or certified nurse assistant, per visit (Not Covered by Medicare)</td>
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### PURPOSE

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers’ submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

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

UnitedHealthcare follows Medicare guidelines such as LCDs, NCDs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the References section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

### REFERENCES

**CMS National Coverage Determinations (NCDs)**
- NCD 290.1 Home Health Visits to a Blind Diabetic

**CMS Benefit Policy Manual**
- Chapter 7; § 20 Conditions To Be Met for Coverage of Home Health Services, § 30 Conditions Patient Must Meet to Qualify for Coverage of Home Health Services, § 40 Covered Services Under a Qualifying Home Health Plan of Care, § 50 Coverage of Other Home Health Services

**CMS Claims Processing Manual**
- Chapter 10; § 40 Completion of Home Health Agency Billing

**MLN Matters**
- Article MM10310, Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2018
- Article MM10992, Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2019
- Article SE1436, Certifying Patients for the Medicare Home Health Benefit

**UnitedHealthcare Commercial Policies**
- Home Health Care
GUIDELINE HISTORY/REVISION INFORMATION

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

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<tr>
<th>Date</th>
<th>Action/Description</th>
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<tr>
<td>04/01/2019</td>
<td>• Reorganized policy template; relocated Terms and Conditions and Purpose section</td>
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<tr>
<td>01/09/2019</td>
<td>• Annual review for MAPG Committee presentation and approval</td>
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TERMS AND CONDITIONS

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. 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 the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines 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 Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication, and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines 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.

Medicare Advantage Policy Guidelines are the property of UnitedHealthcare. Unauthorized copying, use and distribution of this information are strictly prohibited.

*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.