Certified Nursing Assistant (CNA) or Home Health Aide for Adults Age 21 and Older (for Florida Only)

Policy Number: CS168FL.C
Effective Date: September 1, 2021

Instructions for Use

Table of Contents Page

Related Policies

- Home Health Care
- Skilled Care and Custodial Care Services

Application

This Coverage Determination Guideline only applies to the state of Florida.

Coverage Rationale

Members age 21 and older must meet all of the following requirements to receive certified nursing assistant (CNA) or home health aide services:

- Require services that, due to a medical condition, illness, or injury, must be delivered at the place of residence rather than an office, clinic, or other outpatient facility because either leaving home is medically contraindicated and would increase the medical risk for exacerbation or deterioration of the condition or the member is unable to leave home without the assistance of another person; and
- Be confined to the home or homebound as certified by the member's physician; and
- Require services that can be safely, effectively, and efficiently provided in the home; and
- Live in a residence other than a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities (ICF/IID) (see exceptions for ICF/IIDs in 42 CFR 483, Subpart I); and
- Require services that are Medically Necessary and reasonable for the treatment of the documented illness, injury, or condition

For a member to be eligible to receive covered certified nursing assistant (CNA) or home health aide services, a physician must certify in all cases that the patient is confined to his/her home. A member is considered confined to the home or homebound if the following criteria are met:

- One of the following:
  - Because of illness or injury, the member needs:
    - 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
  - The member has a condition such that leaving his or her home is medically contraindicated

  and

- There must exist a normal inability to leave the home and leaving home must require a considerable and taxing effort

If the individual does in fact leave the home, the individual may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive health care treatment. Absences attributable to the need to receive health care treatment include, but are not limited to:

- Attendance at adult day centers to receive medical care;
- Ongoing receipt of outpatient kidney dialysis; or
- The receipt of outpatient chemotherapy or radiation therapy

To the extent the member is absent from the home under circumstances not specifically listed above, the member is not disqualified from being determined as confined to the home or homebound. For example, an absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. It is expected that in most instances, absences from the home that occur will be for the purpose of receiving health care treatment. However, occasional absences from the home for nonmedical purposes (e.g., an occasional trip to the barber, a trip around the block, attendance at a family reunion, funeral, graduation, or other infrequent or unique events) will not result in a finding that the member is not confined to the home or homebound. The key considerations are if the absences: (a) are undertaken on an infrequent basis or are of relatively short duration; and (b) do not demonstrate that the member has the capacity to obtain the health care provided outside rather than in the home.

Documentation Requirements

- A written order and letter of Medical Necessity from the referring provider is required to initiate or continue home health services. The referring provider (MD, DO, PA, or NP) or appropriate specialist must provide a physical examination or medical consultation to the member within 30 days preceding the request for services and every 180 days thereafter.
- A new order and letter of Medical Necessity from the referring provider must be obtained before the creation of each plan of care (POC). The order and letter of Medical Necessity must be dated within 30 days preceding the initial request for services. At a minimum, a new order and letter of Medical Necessity from the physician must be obtained every 60 days thereafter for home health visits.
- At a minimum, the letter of Medical Necessity must describe all of the following:
  - Member's acute or chronic medical condition or diagnosis that causes a member to need home health care; and
  - Home health services needed; and
  - Frequency and duration of the needed services; and
  - Minimum skill level (certified nursing assistant or home health aide) of staff who can provide the services; and
  - Attestation by the referring provider that the member is unable to leave home without the assistance of another person or leaving home is medically contraindicated and would increase the medical risk for exacerbation or deterioration of the member's condition. Physician orders to initiate or continue home health services and letters of Medical Necessity must be signed and dated by the referring provider prior to the development of each POC and before submitting a request for prior authorization. The referring provider Physician's National Provider Identifier (NPI), Medicaid provider number, or medical license number must be written on the order.
- UnitedHealthcare Community Plan will reimburse home health services ordered by an advanced registered nurse practitioner or physician assistant only if the order and letter of Medical Necessity have been countersigned by the physician.
- In order to be reimbursed, home health services must be all of the following:
  - Ordered by and remain under the direction of the referring provider (a doctor of podiatric medicine can only authorize POC services that are consistent with the functions he is authorized to perform under state law) licensed under Chapter 461, 458, or 459, Florida Statutes (F.S.), or licensed in the state in which the primary care physician practices; and
  - The referring provider cannot be employed by or under contract with the home health services provider that is rendering services, unless specifically exempted under section 409.905 (4)(c)(3), F.S.; and
  - Consistent with the individualized, written, and approved POC; and
  - Provided by qualified staff; and
  - Consistent with accepted standards of medical and nursing practice; and
  - UnitedHealthcare Community Plan does not reimburse home health services solely due to age, environment, convenience, or lack of transportation.

Coverage Limitations and Exclusions

The following are specific exclusions that are not covered as home health services:

- A skill level other than what is prescribed in the physician order and approved POC
- Assistance with homework
- Babysitting
- Care, grooming, or feeding of pets and animals
- Certification of the POC by a physician
- Companion sitting or leisure activities
- Escort services
- Housekeeping (except light housekeeping to make the environment safe), homemaker, and chore services
- Intermittent home health visits rendered less than an hour apart
- Nursing assessments related to the POC
- Professional development training or supervision of home health staff or other home health personnel
- Respite care to facilitate the parent or legal guardian attending to personal matters
- Services funded under section 110 of the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Educational Act
- Services furnished by relatives as defined in section 429.02(18), F.S., household members, or any person with custodial or legal responsibility for the recipient
- Services provided in any of the following locations:
  - Hospitals
  - Intermediate care facility for individuals with intellectual disabilities
  - Nursing facilities
  - Prescribed pediatric extended care centers
  - Residential facilities or assisted living facilities when the services duplicate those provided by the facility
- Services rendered prior to the development and approval of the POC
- Travel time to or from the recipient's place of residence
- Yard work, gardening, or home maintenance work

Definitions

Check the federal, state or contractual definitions that supersede the definitions below.

Medically Necessary or Medical Necessity: The medical or allied care, goods, or services furnished or ordered must meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services, does not, in itself, make such care, goods or services Medically Necessary or a Medical Necessity or a covered service.

Medically Necessary or Medical Necessity for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

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. Benefit coverage for health services is determined by federal, state or contractual requirements 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 Coverage Determination Guidelines may apply.

HCPCS Code	Description
G0156	Services of home health/hospice aide in home health or hospice settings, each 15 minutes
S9122	Home health aide or certified nurse assistant, providing care in the home; per hour
T1004	Services of a qualified nursing aide, up to 15 minutes
T1021	Home health aide or certified nurse assistant, per visit

References

Agency for Health Care Administration, Florida Medicaid, Definitions Policy, August 2017 at: https://ahca.myflorida.com/medicaid/review/General/59G_1010_Definitions.pdf. Accessed: July 23, 2021.

Agency for Health Care Administration, Florida Medicaid, Home Health Visit Services Coverage Policy, November 2016 at: https://ahca.myflorida.com/medicaid/review/Specific/59G-4-130_Home_Health_Visit_Services_Coverage_Policy.pdf. Accessed: July 23, 2021.

Agency for Health Care Administration, Florida Medicaid, Home Health Services Coverage and Limitations Handbook, October 2014.

Centers for Medicare & Medicaid Services (CMS). Medicare Benefit Policy Manual, Chapter 7 - Home Health Services at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf. Accessed: July 23, 2021.

Policy History/Revision Information

Date	Summary of Changes
09/01/2021	• Routine review; no change to coverage guidelines • Archived previous policy version CS168FL.B

Instructions for Use

This Coverage Determination Guideline provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this guideline, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Coverage Determination Guideline is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Coverage Determination Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.