Policy:	GG.1546
Title:	**Home Health Services**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	*/s/ Michael Hunn 12/20/2024*
Effective Date:	08/01/2015
Revised Date:	12/01/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the provision of Home Health Services for Members.

II. POLICY

A. Home Health Services shall require Prior Authorization in accordance with CalOptima Health Policies GG.1508: Authorization and Processing of Referrals, and GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers.

B. CalOptima Health or a Health Network shall determine the Medical Necessity of Home Health Services based on an assessment of a Member's individual care needs. A Member shall not be denied Home Health Services based on numerical utilization screens, diagnostic screens, diagnosis, or specific Treatment norms.

C. To qualify for Home Health Services, a Member shall meet the following requirements:

1. Member is under the care of a Primary Care Provider (PCP) or other physician and

2. Member is receiving services under an established and approved Individual Care Plan (ICP), which is periodically reviewed by a Physician and delivered by a Home Health Agency.

D. The following are excluded from coverage as Home Health Services:

1. Home Health Services provided via a telecommunications system pursuant to Section 1895(e) of the Social Security Act;

2. Transportation;

3. Housekeeping services;

4. Services covered under End Stage Renal Disease (ESRD); and

5. Prosthetic devices.

E. A Home Health Agency that provides Home Health Services to a Member shall have an effective and valid services agreement with CalOptima Health.

III. PROCEDURE

A. An initial request for authorization shall include a completed Authorization Request Form (ARF) and all pertinent medical information.

B. A request for continued service shall include an Authorization Request Form and an ICP. The ICP documentation shall indicate an ongoing knowledge of any changes in the Members condition or other needs and how they are being met and include the following:

1. All pertinent diagnoses;
2. Member's mental status;
3. Required services, supplies, and equipment;
4. Frequency of visits;
5. Prognosis;
6. Rehabilitation potential;
7. Functional limitations;
8. Activities permitted;
9. Nutritional requirements;
10. All medications and Treatments;
11. Safety measures to protect against injury;
12. Instructions for timely discharge or referral; and
13. Physician's approval of the ICP.

C. CalOptima Health or a Health Network shall authorize Home Health Services until a Member's needs are met, as determined by the ICP and provider. The following services are included:

1. Skilled nursing services;
2. Home health services;
3. Physical therapy;
4. Speech-language pathology services;
5. Occupational therapy services;
6. Medical social services;
7. Medical supplies;
8. Pharmaceutical Services;

9. Durable Medical Equipment (DME);

10. Laboratory and radiology services;

11. Physician services; and

12. Other Medically Necessary services and/or equipment that may be required to allow a Member to receive medically related services in the least restrictive setting.

D. The provider, in consultation with a Home Health Agency professional, shall review and sign an ICP at least every sixty (60) calendar days. The Provider may recertify the ICP for an additional sixty (60) calendar days and authorization shall be given until the Member's needs are met.

E. For a OneCare Member, CalOptima Health or a Health Network shall issue a Notice of Medicare Non-Coverage (NOMNC) prior to termination of Home Health Services, in accordance with CalOptima Health Policy MA.6023: Notice of Medicare Non-Coverage and Notice of a Detailed Explanation of Non-Coverage.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health, Health Network Service Agreement
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers
E. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
F. CalOptima Health Policy MA.6023: Notice of Medicare Non-Coverage and Notice of a Detailed Explanation of Non-Coverage
G. Social Security Act, §1895(e)
H. Title 22, California Code of Regulations (CCR), §51337
I. Title 28, California Code of Regulations (CCR), §1300.67
J. Centers for Medicare & Medicaid Services (CMS) Medicare Benefit Policy Manual: Chapter 7 Home Health Services (Rev. 11447, 06-06-22)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
02/24/2016	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2005	MA.6012	Home Health Services	OneCare

Action	Date	Policy	Policy Title	Program(s)
Revised	09/01/2008	MA.6012	Home Health Services	OneCare
Revised	11/01/2015	GG.1546	Home Health Services	Medi-Cal OneCare OneCare Connect
Retired	12/22/2015	MA.6012	Home Health Services	OneCare
Revised	10/01/2016	GG.1546	Home Health Services	Medi-Cal OneCare OneCare Connect
Revised	10/01/2017	GG.1546	Home Health Services	Medi-Cal OneCare OneCare Connect
Revised	01/01/2019	GG.1546	Home Health Services	Medi-Cal OneCare OneCare Connect
Revised	10/01/2020	GG.1546	Home Health Services	Medi-Cal OneCare OneCare Connect
Revised	06/01/2021	GG.1546	Home Health Services	Medi-Cal OneCare OneCare Connect
Reviewed	12/31/2022	GG.1546	Home Health Services	Medi-Cal OneCare
Reviewed	12/01/2023	GG.1546	Home Health Services	Medi-Cal OneCare
Reviewed	12/01/2024	GG.1546	Home Health Services	Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
Covered Services	Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education

Term	Definition
	Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.
Durable Medical Equipment (DME)	Medi-Cal: Medically Necessary medical equipment that is prescribed for the Member by the Provider and is used in the Member's home, in the community or in an institution that is used as a home. DME: 1. Can withstand repeated use. 2. Is used to serve medical purposes. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home. OneCare: Equipment prescribed by a licensed practitioner to meet medical equipment needs of the patient that: 1. Can withstand repeated use. 2. Is used to serve medical purposes.

Term	Definition
	3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
End Stage Renal Disease (ESRD)	For the purposes of this policy, a stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life.
Health Network	A Physician Hospital Consortium (PHC), Physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Home Health Agency	A public or private agency or organization that offers home care services including skilled nursing services and at least one other therapeutic service in the residence of the client through Physicians, nurses, therapists, social workers, and homemakers whom they recruit and supervise.
Home Health Services	Medically related services provided to Members in a home setting rather than in a medical facility such as a hospital or a primary health care center.
Individual Care Plan (ICP)	Medi-Cal: A plan of care developed after an assessment of the Member's social and health care needs that reflects the Member's resources, understanding of his or her disease process, and lifestyle choices. OneCare: A written plan of care developed after an assessment of a Member's social and health care needs that reflects what services the Member will receive to reach and keep his or her best physical, mental, and social well-being.
Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through diagnosis or Treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of Medical Necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare: Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-

Term	Definition
	appropriate growth and development, and attain, maintain, or regain functional capacity.
Member	A beneficiary enrolled in a CalOptima Health program.
Pharmaceutical Services	Covered drugs and related professional services provided to a Member pursuant to applicable state and federal laws, CalOptima Health's Pharmacy Services Program Manual, and the standard of practice of the pharmacy profession of the state in which the Pharmacy is located.
Primary Care Provider. /Physician (PCP)	A Provider /Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model program, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a Non-Physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a Physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a Specialty Care Provider or clinic.
Prior Authorization	Medi-Cal: A formal process requiring a health care Provider to obtain advance approval of Medically Necessary Covered Services, including the amount, duration and scope of services, except in the case of an emergency. OneCare: A process through which a Physician or other health care Provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to a Member.
Provider	Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.