Determining Homebound Status

Optum Health Solutions Musculoskeletal (MSK)

Utilization Management Policy
Policy Number: 479

Effective Date: 04/25/2024

Table of Contents

Policy Statement

Optum considers home health services for physical and occupational therapy to be appropriate and/or medically necessary if the following homebound criteria are met (CMS, 2023):

1. There exists an illness or injury requiring: 1) the aid of supportive devices such as crutches, canes, wheelchairs or walkers, or 2) the use of special transportation, or 3) the assistance of another person to leave their place of residence OR have a condition such that leaving their home is medically contraindicated.
2. There exists a normal inability to leave the home and, consequently, if leaving home would require a considerable and taxing effort.
3. The patient may be considered homebound if the absences from the home are infrequent or are for periods of relatively short duration. Some examples may include:
    - Religious services
    - Attendance at an infrequent family function, such as a funeral, graduation, or reunion
    - Healthcare treatment
    - Attendance at adult day program

Purpose

This policy has been developed to describe the criteria that Optum uses to conduct utilization review (UR) determinations concerning the appropriateness and/or medical necessity for providing skilled professional services in the home setting.

This policy also serves as a basis for peer-to peer clinical discussions to determine the setting that will produce the safest and most efficacious outcomes.

Summary

Patients most likely to use home healthcare are the elderly that have a high number of Activities of Daily Living (ADLS) and Instrumental Activities of Daily Living (IADLS) impairments, live alone, and have a low level of informal support. (Kadushin, 2004)

Documentation must support the need for skilled intervention that is medically necessary in the home setting, which demonstrates significant improvement in status within a relatively predictable period of time. (CMS, 2023)

If a question is raised as to whether the patient is confined to the home, the treating provider will be requested to provide the appropriate information that will meet the homebound definition. (CMS, 2023)

Scope

This policy applies to all in and out of network programs involving all provider types, where utilization review determinations are rendered for home health services.

Definitions

Home health care (services) refers to skilled medical care that is provided in the patient's home by licensed healthcare professionals.

Home care (custodial care) is informal health care or supportive care provided in the patient's home by unlicensed personnel (e.g., family and friends, also known as caregivers, primary caregiver, or voluntary caregivers who give informal care).

Description

The patient may be considered homebound if the absences from the home are attributable to the need to receive "health care treatment" (***Health care treatment*** may not be limited to physical treatment, and thus may be considered as psychological or social support), or are attributable to "non-health related absences" (***Non-health related absences*** may be considered if they are of relatively short duration, and or if they are infrequent. A walk around the block or short drive may be considered an appropriate non-health related home absence).

Background

Patients most likely to use home healthcare include the elderly that have a high number of Activities of Daily Living (ADLS) and Instrumental Activities of Daily Living (IADLS) impairments, live alone, and have a low level of informal support. (Kadushin, 2004) There is another group of patients (non-elderly) who because of medical, surgical, and or disabling factors may rely on and benefit from home healthcare services. It has been estimated that in the year 2000 about 2.5 million Medicare beneficiaries used home health services, which resulted in approximately 4 percent of Medicare expenditures that year. (USGAO, 2002) To assist practitioners in determining which patients meet the homebound policy instituted by the Centers for Medicare and Medicaid Services (CMS), researchers have attempted to identify various assessments and or algorithms. (Weiss, 2003; Donelson, 2001) In addition, earlier research has attempted to develop specific operational definitions.

CMS allows certain beneficiaries with post-acute care needs (i.e., joint replacement) and chronic conditions (i.e., congestive heart failure) to receive care in their home rather than in professional settings. To qualify for home health services, Medicare beneficiaries must be homebound, require professional nursing or allied care (i.e., physical therapy), be under the care of a physician, and under a plan of care that is ordered and periodically reviewed by a physician. (USGAO, 2002) The condition of homebound patients should be such that there exists a normal inability to leave the home, and consequently, leaving the home would require a considerable and taxing effort. The patient will not necessarily be denied homebound status if absences are attributable to receiving other health care treatment (i.e., attendance at adult day care centers, receiving kidney dialysis, or chemotherapy/radiation therapy), or non-health care absences, as long as they are infrequent or for periods of short duration (i.e., religious services, reunion, funeral, etc.).

The clinician is not required to include standardized phrases reflecting the patient's condition (e.g., repeating the words "taxing effort to leave the home") in the patient's chart, nor are such phrases sufficient, by themselves, to demonstrate that a home bound criterion has been met. For example, longitudinal clinical information about the patient's health status is typically needed to sufficiently demonstrate a normal inability to leave the home and that leaving home requires a considerable and taxing effort. Such clinical information about the patient's overall health status may include, but is not limited to, such factors as the patient's diagnosis, duration of the patient's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, etc.

Since home health care management requires the skills of a licensed professional, there is an expectation that the treating provider will manage the patient as follows (APTA, 2018):

1. Examination upon initial patient encounter
    - Complete history taking (medical, surgical, family, etc.)
    - Systems review (cardiovascular/pulmonary, integumentary, musculoskeletal, And neuromuscular)
    - Utilizing appropriate tests and measures to help prove or disprove the working hypothesis
2. Evaluation (thought process to synthesize all information collected during the examination)
3. Diagnosis (impairments, functional limitations, social/roles people play)
4. Prognosis/Plan of Care
    - Prognosis (predicted functional outcome and required duration to obtain those outcomes)
    - Plan of Care (includes goals, interventions to be used, frequency and duration of services required to achieve the established goals, discharge plans)
5. Follow-up progress reports (if needed)

Regardless of the setting treatment is delivered, the treating provider is held accountable for demonstrating that care is reasonable and necessary. Medical necessity (i.e., need) must be established by the patients' diagnosis, functional limitations, impairments, etc. Skilled care (i.e., professional skills) must be documented such that the level of complexity and sophistication or the condition of the patient can be safely and effectively performed only by the therapist. (APTA, 2018; CMS, 2023) Expected improvement (i.e., functional outcome) in status must be significant and in a generally reasonable or predictable period of time.

This requirement is accomplished when the treating provider functionally reassesses the patient and compares those objective measurement(s) to prior objective assessment measurement(s). The therapist must document the measurement results along with the therapist's determination of the effectiveness of therapy, or lack thereof. (CMS, 2023) If lack of progress is noted, it is recommended that the reasons for lack of progress be noted and the justification for why continued treatment is necessary after regression or plateau. (CMS, 2023) Skilled care may be necessary to improve a patient's current condition, maintain the patient's current condition, and or prevent or slow further deterioration of the patient's condition. Regardless of the expectation of improvement, skilled services must be provided by a licensed professional that require a high level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a licensed provider. If a service can be self-administered or safely and effectively furnished by an unskilled person or caregiver, without the direct or general supervision of a licensed provider, the service cannot be regarded as skilled. Further, the unavailability of a competent person to provide a non-skilled service, despite the importance of the service to the patient, does not make it a skilled service when a licensed provider furnishes the service.

Home care skilled therapy services are available for patients who meet the established CMS criteria as outlined below. It is the responsibility of the treating provider to demonstrate through documentation or additional communication as requested that the homebound patient requires medically necessary skilled care and demonstrates significant functional improvement in a generally predictable time period. All policies reviewed and identified in the literature, follow the established homebound criteria as developed by CMS.

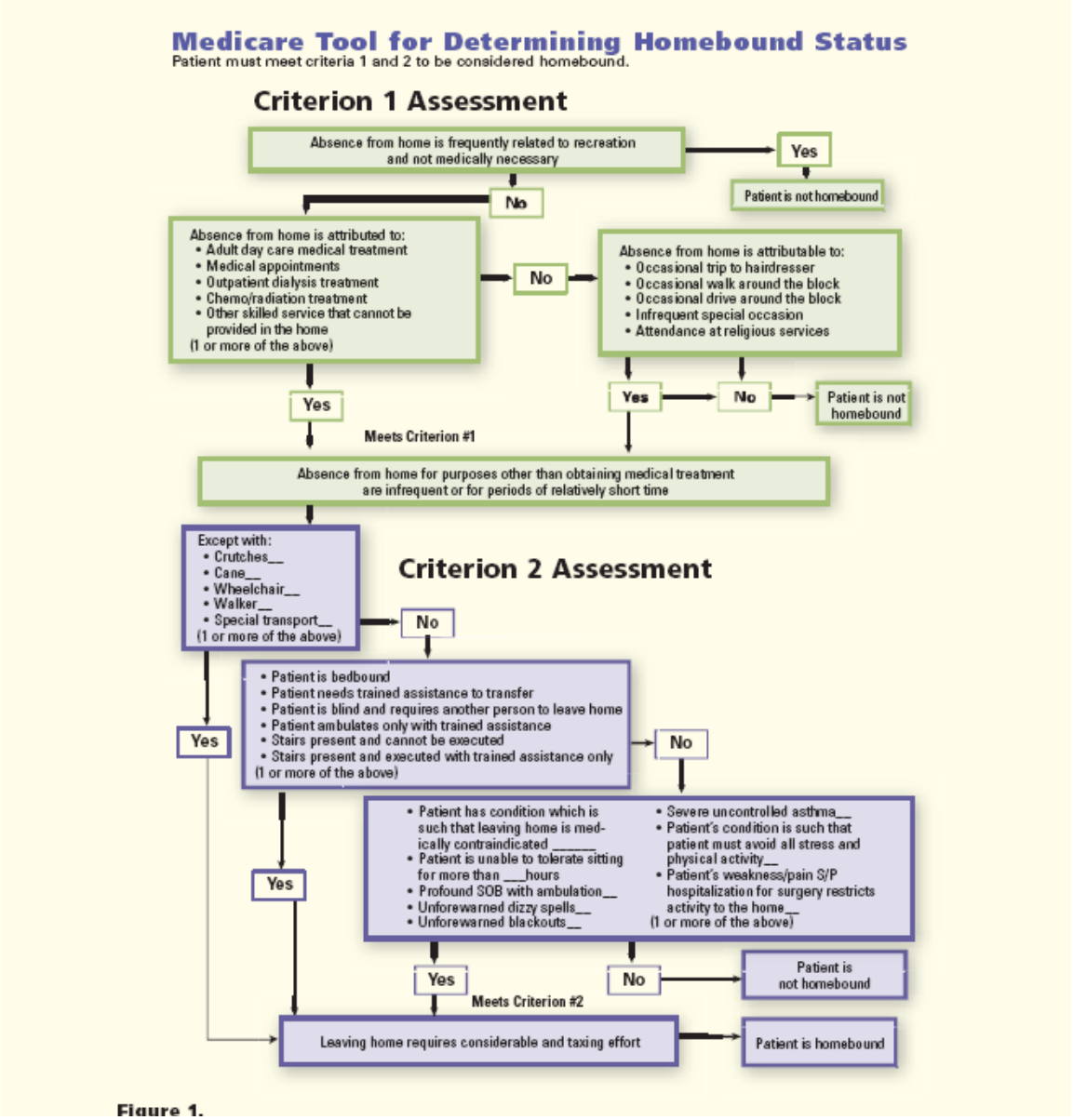

Figure 1.

References

Centers for Medicare and Medicaid Services. Medicare benefit policy manual chapter 7: Home health services. Revised: December 21, 2023. Accessed: 02/08/2024. Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf

American Physical Therapy Association. Elements of documentation within the patient/client management model. January 31, 2018. Accessed: 02/08/2024. Available at: https://www.apta.org/your-practice/documentation/defensible-documentation/elements-within-the-patientclient-management-model

Kadushin, G. Home health care utilization: a review of the research for social work. Health & Social Work. 2004; 29(3): 219-44.

Weiss RL, Milone-Nuzzo P, Zuber RF. A tool to assess homebound status. Home Healthcare Nurse. 2003; 21(11): 774-777.

Donelson SM, Murtaugh, CM, Feldman PH, Hijjazi K, Bruno L, Zeppie S, et al. Clarifying the definition of homebound and medical necessity using OASIS data: Final report executive summary. 2001, March.

United States General Accounting Office. Medicare home health: Clarifying the homebound definition is likely to have little effect on costs and access. Published: April 26, 2002. Available at: http://www.gao.gov/new.items/d02555r.pdf. Accessed: 02/08/2024.

Centers for Medicare and Medicaid Services. Medicare benefit policy manual chapter 15: Covered medical and other health services. Revised: December 21,2023. Accessed: 02/08/2024. Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.PDF

Anemaet WK, Krulish LH, Lindstrom KC, Herr R, Carr MN. Evaluating physical therapy utilization under PPS: Revised and updated. Home Healthcare Nurse. 2004; 22(8): 549-559.

Review and Approval History

Date	Description
4/30/2009	Original effective date
4/08/2010	Annual review and approval completed
10/26/2010	Policy rebranded to “OptumHealth Care Solutions, Inc. (OptumHealth)”
4/07/2011	Annual review and approval completed
4/19/2012	Annual review and approval completed
4/18/2013	Clinical Management section revised; Annual review and approval completed
4/17/2014	Annual review and approval completed; Table 2 revised; References updated; Policy rebranded “Optum* by OptumHealth Care Solutions, Inc.”
4/16/2015	Annual review and approval completed
4/21/2016	Annual review and approval completed
4/20/2017	Annual review and approval completed; Updated Table 2 and references; Legal entity name changed from “OptumHealth Care Solutions, Inc.” to “OptumHealth Care Solutions, LLC.”
4/26/2018	Annual review and approval completed: expanded selection criteria, updated table 2 and the references
4/25/2019	Annual review and approval completed: updated table 2 and the references
4/23/2020	Annual review and approval completed: updated table 2 and the references
4/22/2021	Annual review and approval completed: updated table 2 and the references
5/3/2022	Annual review and approval completed: updated table 2 and the references
6/29/2022	Updated legal entity name “OptumHealth Care Solutions, LLC.” to *Optum™ Physical Health (“Optum”) includes OptumHealth Care Solutions, LLC; ACN Group IPA of New York, Inc.; ACN Group IPA of California, Inc. d/b/a OptumHealth Physical Health of California; Managed Physical Network, Inc.; and OrthoNet Holdings, Inc. which includes OrthoNet New York IPA, Inc., OrthoNet West, Inc., OrthoNet, LLC, OrthoNet of the South, Inc.
4/27/2023	Annual review and approval completed; no significant changes made to the document. Updated contact email from policy.inquiry@optumhealth.com to phpolicy_inquiry@optum.com.
3/06/2024	Annual review completed. Document content transitioned to new policy template. No substantive changes to clinical content. Approved by Optum Guideline Advisory Committee
4/25/2024	Annual review and approval completed. Document content transitioned to new policy template. No significant changes made to the document.