Determining Homebound Status

Policy Statement
Optum* by OptumHealth Care Solutions, LLC considers home health services for physical and occupational therapy to be appropriate and/or medically necessary if the following homebound criteria are met:

1. There exists a normal inability to leave the home and, consequently, if leaving home would require a considerable and taxing effort
2. The patient may be considered homebound if the absences from the home are attributable to the need to receive health care treatment. Some examples might be as follows:
   - Attendance at adult day centers to receive medical care
   - Ongoing receipt of outpatient kidney dialysis
   - Receipt of outpatient chemotherapy or radiation therapy
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 might be as follows:
   - Religious services
   - Attendance at an infrequent family function, such as a funeral, graduation, or reunion

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.

Key Policy Question
1. What circumstances support the need for the patient to receive skilled therapeutic services in the home setting rather than at a provider’s office, where more therapeutic equipment is available?

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Summary

1. 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

2. 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

3. 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

4. The criteria reported in those policies posted by the Centers for Medicare and Medicaid Services (CMS) are consistent with other healthcare organizations and national professional associations

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

**Introduction**

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. 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. To assist practitioners in determining which patients meet the vague homebound policy instituted by the Centers for Medicare and Medicaid Services (CMS), researchers have attempted to identify various assessments and or algorithms. In addition, earlier research has attempted to develop specific operational definitions.

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Selection Criteria
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. 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:

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)

Clinical Management
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. the 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. 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 the resultant 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. 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. Skilled care may be necessary to improve a patient’s current condition, maintain the patient’s current condition, 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.8

Conclusion
Home care skilled therapy services are available for patients, as evidenced by meeting the established CMS criteria. [Table 1, Figure 1] 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.

References

Tables

<table>
<thead>
<tr>
<th>Patient description</th>
<th>Meets criteria</th>
<th>Does not meet criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>A patient paralyzed from a stroke who is confined to a wheelchair or requires the aid of crutches in order to walk</td>
<td>X</td>
<td></td>
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<tr>
<td>A patient who is blind or senile and requires the assistance of another person in leaving their place of residence</td>
<td>X</td>
<td></td>
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<tr>
<td>An elderly person who does not meet the established criteria</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>A patients actions may be restricted by their physician to certain specified and limited activities such as getting out of bed only for a specified period of time, walking stairs only once a day, etc.</td>
<td>X</td>
<td></td>
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<tr>
<td>A patient or family that does not have adequate transportation</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>A patient with arteriosclerotic heart disease of such severity that they must avoid all stress and physical activity</td>
<td>X</td>
<td></td>
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### Policies/Positions of Other Health Care Organizations (Table 2)

<table>
<thead>
<tr>
<th>Organization</th>
<th>Policy Information</th>
<th>Position</th>
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</thead>
<tbody>
<tr>
<td>CMS</td>
<td>Medicare benefit policy manual chapter 7</td>
<td>The condition of home bound patients should be such that there exists a normal inability to leave home and, consequently, leaving home would require a considerable and taxing effort. The patient may be considered homebound if the absences from the home are infrequent or for periods of relatively short duration (i.e. religious services, barber, walk around the block, short drive, attendance at an infrequent family function, such as a funeral, graduation, or reunion), or are attributable to the need to receive health care treatment as generalized below: 1. Attendance at adult day centers to receive medical care 2. Ongoing receipt of outpatient kidney dialysis 3. The receipt of outpatient chemotherapy or radiation therapy</td>
</tr>
<tr>
<td>Anthem-BlueCross Clinical UM Guideline</td>
<td>Title: Home Health Number: CG-Med-23 Effective Date: 11/02/18</td>
<td>Follows CMS chapter 7</td>
</tr>
<tr>
<td></td>
<td>Title: Physical Therapy Number: CG- Rehab-04 Effective Date: 10/17/18</td>
<td>Describes medically necessary care vs. non-medically necessary care (for both rehabilitative and habilitative services; Describes necessary documentation (evaluation, re-evaluation, progress reports, etc.)</td>
</tr>
<tr>
<td>UnitedHealthcare-Oxford</td>
<td>Title: Home Health Care Policy Number: HOME 002. 31 T1 Effective Date: 01/01/19</td>
<td>Describes Home Health care globally with limited physical therapy overview</td>
</tr>
<tr>
<td>Humana</td>
<td>Title: Home Health Number: HGO-0329-018 Effective Date: 01/01/17</td>
<td>Describes medical coverage and touches on therapy services that follows CMS chapter 7</td>
</tr>
<tr>
<td>Health Net</td>
<td>Title: Physical Occupational and Speech Therapy Services Number: HNCA.CP.MP.103 Effective Date: 04/2011 Updated Date: 12/2018</td>
<td>Describes physical, occupational and speech therapy coverage, habilitation, skilled care, maintenance care and provides a simple definition of Home Bound Status: Treatment of the member in the home may be medically necessary if the treatment can be safely and adequately performed in the member’s home environment, and the diagnosed impairment or condition makes transportation to an outpatient rehab facility impractical or medically inappropriate”, which follows CMS chapter 7 and chapter 15</td>
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<tr>
<td>Aetna</td>
<td>Title: Physical Therapy Number: 0325 Effective Date: 07/20/99 Updated Date: 08/03/18</td>
<td>Describes what physical therapy is and gives basic definitions of the different modalities, manual therapies, and active treatments provided by a physical therapist; Describes medically necessary skilled care, non-skilled care, and maintenance care. The policy provides a basic definition of Home-Based Physical Therapy: “Aetna considers home-based physical therapy medically necessary in selected cases based upon the member's needs (i.e., the member must be homebound). This may be considered medically necessary in the transition of the member from hospital to home, and may be an extension of case management services”.</td>
</tr>
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Utilization Management Policy

Decision Guide (Figure)

Medicare Tool for Determining Homebound Status

Patient must meet criteria 1 and 2 to be considered homebound.

Criterion 1 Assessment

- Absence from home is frequently related to recreation and not medically necessary
  - Yes
  - No

  Absence from home is attributable to:
  - Adult day care medical treatment
  - Medical appointments
  - Outpatient diagnosis treatment
  - Chemotherapy treatment
  - Other skilled service that cannot be provided in home (1 or more of the above)

  Absence from home for purposes other than obtaining medical treatment is infrequent or for periods of relatively short time

Criterion 2 Assessment

- Yes
- No

  Except for:
  - Cane
  - Walker
  - Wheelchair

  Yes
  - Patient is handicapped
  - Patient needs trained assistance to transfer
  - Patient is blind and requires another person to leave home
  - Patient eliminates only with trained assistance
  - Stairs present and cannot be ascended
  - Stairs present and equipped with trained assistance only (1 or more of the above)

  Yes
  - Patient has condition which is such that leaving home is medically contraindicated
  - Patient is unable to tolerate sitting for more than ___ hours
  - Proven 20/20 with ambulation
  - Weakness and dizzy spells
  - Unusual sense of balance

  No

  Yes
  - Severe uncontrolled asthma
  - Patient's condition is such that patient must avoid all stress and physical activity
  - Patient's weakness/pain SP
  - Hospitalization for surgery restricts activity in home (1 or more of the above)

  No

  Yes
  - Leaving home requires considerable and taxing effort
  - Patient is not homebound

  No
  - Patient is homebound

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Policy History/Revision Information

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
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<tr>
<td>4/30/2009</td>
<td>Original effective date</td>
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<tr>
<td>4/08/2010</td>
<td>Annual review and approval completed</td>
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<tr>
<td>10/26/2010</td>
<td>Policy rebranded to “OptumHealth Care Solutions, Inc. (OptumHealth)”</td>
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<tr>
<td>4/07/2011</td>
<td>Annual review and approval completed</td>
</tr>
<tr>
<td>4/19/2012</td>
<td>Annual review and approval completed</td>
</tr>
<tr>
<td>4/18/2013</td>
<td>Clinical Management section revised; Annual review and approval completed</td>
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<tr>
<td>4/17/2014</td>
<td>Annual review and approval completed; Table 2 revised; References updated; Policy rebranded “Optum* by OptumHealth Care Solutions, Inc.”</td>
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<tr>
<td>4/16/2015</td>
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<tr>
<td>4/21/2016</td>
<td>Annual review and approval completed</td>
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<tr>
<td>4/20/2017</td>
<td>Annual review and approval completed; Updated Table 2 and references; Legal entity name changed from “OptumHealth Care Solutions, Inc.” to “OptumHealth Care Solutions, LLC.”</td>
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<tr>
<td>4/26/2018</td>
<td>Annual review and approval completed: expanded ‘selection criteria’; updated table 2 and the references</td>
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<tr>
<td>4/25/2019</td>
<td>Annual review and approval completed: updated table 2 and the references</td>
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Contact Information

Please forward any commentary or feedback on Optum utilization management policies to: policy.inquiry@optumhealth.com with the word “Policy” in the subject line.

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