OPTUM®

Utilization Management Policy

Determining Homebound Status

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Related Policies

Determination of Maximum Therapeutic Benefit
Maintenance – Custodial Care

Policy Number	**479**
Original Effective Date:	4/2009
Current Approval Date:	4/27/2023
Next Review:	4/2024
Category:	Determination

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 example 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?*

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[3]
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[1,8]
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[1]
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).[1]

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.[3] 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.[7] 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.[4,5] In addition, earlier research has attempted to develop specific operational definitions.[6]

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.[7] 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.).[1]

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.[1]

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:[2]

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.[2,8,9] Expected improvement (i.e. functional outcome) in status must be significant and in a generally reasonable or predictable period of time.[8,9]

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.[1] 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.[8] 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.[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

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Tables

Examples of Patient Scenarios to Justify Home Bound Status (Table 1)

Patient description	Meets criteria	Does not meet criteria
A patient paralyzed from a stroke who is confined to a wheelchair or requires the aid of crutches in order to walk	X	
A patient who is blind or senile and requires the assistance of another person in leaving their place of residence	X	
An elderly person who does not meet the established criteria		X
A patient's 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.	X	
A patient or family that does not have adequate transportation		X
A patient with arteriosclerotic heart disease of such severity that they must avoid all stress and physical activity	X	

Policies/Positions of Other Health Care Organizations (Table 2)

Organization	Policy Information	Position
CMS	Medicare benefit policy manual chapter 7	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
Anthem-BlueCross Clinical UM Guideline	Title: Home Health Number: CG-Med-23 Effective Date: 12/28/22	Follows CMS chapter 7
Anthem-BlueCross Clinical UM Guideline	Title: Physical Therapy Number: CG- Rehab-04 Effective Date: 04/01/20	Describes medically necessary care vs. non-medically necessary care (for both rehabilitative and habilitative services); Describes necessary documentation (evaluation, re-evaluation, progress reports, etc.)
Anthem-BlueCross Clinical UM Guideline	Title: Occupational Therapy Number: CG- Rehab-05 Effective Date: 04/01/20	Describes medically necessary care vs. non-medically necessary care (for both rehabilitative and habilitative services); Describes necessary documentation (evaluation, re-evaluation, progress reports, etc.)
UnitedHealthcare-Oxford	Title: Home Health Care Policy Number: HOME 002. 39 Effective Date: 01/01/23	Describes Home Health care globally with limited physical/occupational therapy overview
Humana	Title: Home Health Number: HUM-0329-027 Effective Date: 06/23/22	Describes medical coverage and touches on therapy services that follows CMS chapter 7
Health Net	Title: Physical, Occupational, and Speech Therapy Services Number: HNCA.CP.MP.103 Effective Date: 07/2020	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
Aetna	Title: Physical Therapy Number: 0325 Effective Date: 07/20/99 Updated Date: 05/06/22	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".

Decision Guide (Figure)

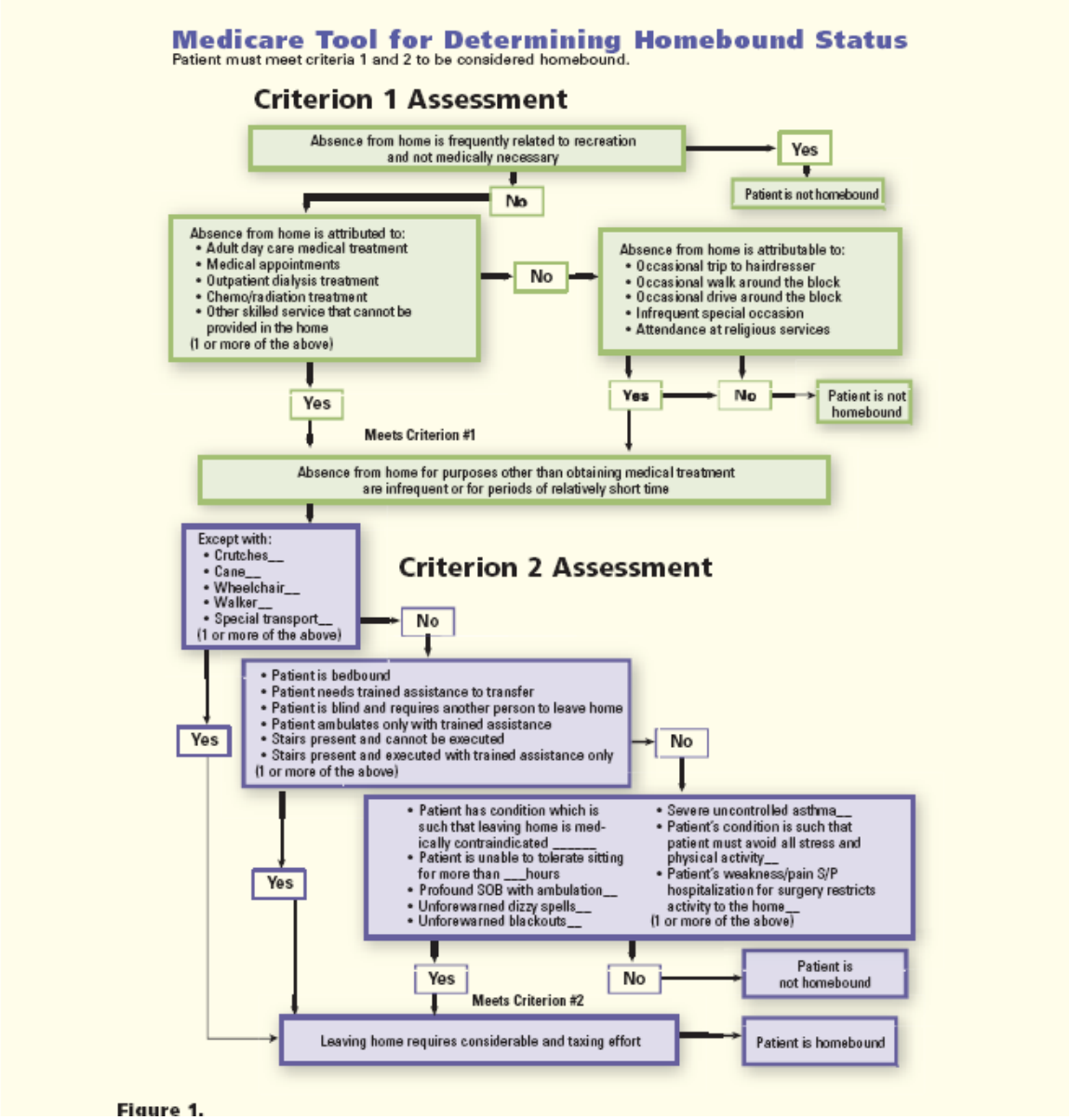

Figure 1.

Policy History/Revision Information

Date	Action/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
5/03/2022	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.
4/27/23	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.

Contact Information

Please forward any commentary or feedback on Optum utilization management policies to: phpolicy_inquiry@optum.com with the word "Policy" in the subject line.

coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the member's SPD or COC, the member's SPD or COC will govern.