Home Health Psychiatric Care

Policy Number: BH803HHMCS0823
Effective Date: August 22, 2023
Interim Date: December 12, 2023

Table of Contents Page

Introduction & Instructions for Use

Introduction

Medicare Coverage Summaries are a set of objective and evidence-based behavioral health criteria used by medical necessity plans to standardize coverage determinations, promote evidence-based practices, and support members' recovery, resiliency, and wellbeing for Medicare behavioral health benefit plans managed by Optum® .

Instructions for Use

This guideline is used to make coverage determinations as well as to inform discussions about evidence-based practices and discharge planning for behavioral health benefit plans managed by Optum. When deciding coverage, the member's specific benefits must be referenced.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member's benefits prior to using this guideline. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this guideline and the member's specific benefit, the member's specific benefit supersedes this guideline. Other clinical criteria may apply. Optum reserves the right, in its sole discretion, to modify its clinical criteria as necessary using the process described in Clinical Criteria.

This guideline is provided for informational purposes. It does not constitute medical advice.

Optum may also use tools developed by third parties that 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. Optum may develop clinical criteria or adopt externally-developed clinical criteria that supersede this guideline when required to do so by contract or regulation.

If there is an absence of any applicable Medicare statutes, regulations, National or Local Coverage Determinations offering guidance, Optum utilizes adopted external criteria as follows:

- Level of Care Utilization System (LOCUS):
  - Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make determinations and placement decisions for adults ages eighteen and older.
- Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII):
  - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry and the American Association of Community Psychiatrists used to make determinations and to provide level of service intensity recommendations for children and adolescents ages 6-18.
- Early Childhood Service Intensity Instrument (ECSII):
  - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make determinations and to provide level of service intensity recommendations for children ages 0-5.

Optum Supplemental Clinical Criteria: developed criteria based on “acceptable clinical literature”

- Electroconvulsive Therapy (ECT)
  - National criteria used to make clinical determinations for ECT.

National criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make coverage determinations regarding experimental and investigation services and treatments.
Optum Behavioral Clinical Policies:

- Complementary and Alternative Medicine (CAM) Treatments
- Computer Based Treatment for Cognitive Behavioral Therapy (CBTCBT)
- Neurofeedback
- Transcranial Magnetic Stimulation
- Wilderness Therapy

These criteria represent current, widely-used treatment guidelines developed by organizations representing clinical specialties, or Optum developed criteria based on “acceptable clinical literature” according to 422.101(b)(6)(i). Optum selects and uses clinical criteria that are consistent with generally accepted standards of care, including objective criteria that are based on sound clinical evidence. Optum uses the criteria to make standardized coverage determinations and to inform discussions about evidence-based practices and discharge planning. The use of such criteria is highly likely to outweigh any clinical harms from delayed or decreased access to care.

Home Health Psychiatric Care

The evaluation, psychotherapy and teaching activities needed by patients suffering from a diagnosed psychiatric disorder requiring active treatment by a psychiatrically trained nurse may be covered as skilled nursing services. Patients may also require medical social services, occupational therapy, home health aide visits or other home health services related to the treatment of their psychiatric diagnosis.

Applicable States

CMS L34561/A56756

- Alabama
- Arkansas
- Florida
- Georgia
- Illinois
- Indiana
- Kentucky
- Louisiana
- Mississippi
- New Mexico
- North Carolina

- Ohio
- Oklahoma
- South Carolina
- Tennessee
- Texas

Coverage, Indications, Limitation and/or Medical Necessity

Indications (CMS L34561, 2020)

Skilled nursing services must be based on the patient's medical condition as described in the Centers for Medicare and Medicaid Services (CMS) Internet-Only Manual,(IOM), Medicare Benefit Policy Manual Pub 100-02, Chapter 7 §40.1.1.

The evaluation, psychotherapy and teaching activities needed by patients suffering from a diagnosed psychiatric disorder requiring active treatment by a psychiatrically trained nurse may be covered as skilled nursing services. Patients may also require medical social services, occupational therapy (OT), home health aide visits or other home health (HH) services related to the treatment of their psychiatric diagnosis.

If all other eligibility and coverage requirements under the home health benefit are met, skilled nursing services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a registered nurse are necessary.

Home health clinical notes must document as appropriate the following:

- The patient must be confined to the home.
  - The condition of these patients should be such that there exists a normal inability to leave home and, consequently, leaving the home would require a considerable and taxing effort.
  - A patient with a psychiatric disorder is considered to be homebound "...if his/her illness is manifested in part by a refusal to leave the home, or is of such a nature that it would not be considered safe for him/her to leave home unattended even if he/she has no physical limitations".
  - The following conditions support the homebound determination:
    - Agoraphobia, paranoia, or panic disorder
    - Disorders of thought processes wherein the severity of delusions, hallucinations, agitation and/or impairment of thoughts/cognition grossly affect the patient's judgment and decision making, and therefore the patient's safety
    - Acute depression with severe vegetative symptom
    - Psychiatric problems associated with medical problems that render the patient homebound.
- If a patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for relatively short duration, or are attributable to the need to receive medical treatment.
- Services must be provided under a Home Health Plan of Care approved and signed by the treating physician.
- Nursing services provided must meet the part-time or intermittent requirements for home health services. "In most instances, this definition will be met if a patient requires a skilled nursing service at least every 60 days."
- Services must be reasonable and necessary for treating the patient's psychiatric diagnosis and/or symptoms.
- The services of a skilled psychiatric nurse must be required to provide the necessary care, i.e., observation/assessment, teaching/training activities, management and evaluation of a patient care plan, or direct patient care of a diagnosed psychiatric condition which may include behavioral/cognitive interventions.
- Further guidance on required documentation may be found in the IOM 100-02 Chapter 7 §40.1.2.15.

Note: Psychiatric nursing must be furnished by an agency that does not primarily provide care and treatment of mental disorders. These agencies are precluded from participating as Medicare home health agencies.

Home Health Plan of Care

The POC for a psychiatric patient must be completed. Emphasis must be placed on documentation of mental status and those skills necessary to treat the psychiatric diagnosis.

Diagnostic Criteria

- A patient must have a diagnosis a defined in the Diagnostic and Statistical Manual of Mental Health Disorders, 5th Edition, DSM-5™. This diagnosis must match the diagnosis that the ordering physician is treating and/or for which the patient was hospitalized. This diagnosis must be fully documented and available in the medical record (A56756, 2022).
- The patient must be under the care of a physician who is qualified to sign the physician's certification and recertify the plan of care at least every 60 days (2 months). The physician's evaluation and subsequent recertifications must become part of the patient's medical record.
- If the skills of a psychiatric RN are required, the service must be reasonable and necessary and intermittent.
- Reasonable goals must be established and there must be a reasonable expectation that the goals will be achieved. Decreasing and/or shortening in-patient and emergency room care may be a goal for the psychiatric patient's plan of care.

Qualifications (CMS L34561)

- Psychiatrically Trained Nurses Providing Psychiatric Evaluation and Therapy In The Home
  - Psychiatrically trained nurses are nurses who have special training and/or experience beyond the standard curriculum required for a registered nurse. The services of the psychiatric nurse are to be provided under a plan of care established and reviewed by a physician.
  - Special training and/or experience requirements to be met, if the registered nurse (RN) meets one of the following criteria:
    - A RN with a Master's degree with a specialty in psychiatric or mental health nursing and licensed in the state where practicing would qualify. The RN must have nursing experience (recommended within the last 3 years) in an acute treatment unit in a psychiatric hospital, psychiatric home care, psychiatric partial hospitalization program or other outpatient psychiatric services.
    - A RN with a Bachelor's degree in nursing and licensed in the state where practicing would qualify. The RN must have one year of recent nursing experience (recommended within the last three years) in an acute treatment unit in a psychiatric hospital, psychiatric home care, psychiatric partial hospitalization program or other outpatient psychiatric services.
    - A RN with a Diploma or Associate degree in nursing and licensed in the state where practicing would qualify. The RN must have two years of recent nursing experience (recommended within the last three years) in an acute treatment unit in a psychiatric hospital, psychiatric home care, psychiatric partial hospitalization program or other outpatient psychiatric services.
  - It is highly recommended that psychiatric RNs also have medical/surgical nursing experience because many psychiatric patients meet homebound criteria due to a physical illness.
  - Nurses with these qualifications would meet the requirements necessary to provide psychiatric evaluation and therapy to Medicare home health patients. The services of a psychiatric nurse are to be provided under a plan of care established and reviewed by the treating physician.

Physician's Role

- Certifies/Recertifies the patient's homebound status.
- Approves Home Health Plan of Care which must be signed and dated prior to the home health agency billing for services.
- Prescribes medications, as necessary.
- Provides supplemental orders when medically necessary.

Skilled Nursing Care, Registered Psychiatric Nurse Role

- Makes initial assessment visit utilizing observation/assessment skills.
- Manages medical illness per Plan of Care; performs psycho-biological interventions.
- Evaluates, teaches, and reviews medications and compliance; administers intramuscular (IM) or intravenous (IV) medication.
- Manages situational or other crises; performs assessments of potential self-harm or harm to others and refers to the treating physicians, as necessary.
- Teaching and training activities that require skilled nursing personnel to teach a patient, the patient's family, or caregivers how to manage the treatment regimen would constitute skilled nursing services.
  - Teaches self-care, mental and physical well-being, promotes independence and patient's rights.

The IOM 100-02 Chapter 7 §40.1.2.3 provides guidance in determining the reasonableness and necessity of the number of training visits and the appropriateness of re-teaching and re-training.

- Promotes and encourages patient/caregiver to maintain a therapeutic environment.
- Provides supportive counseling psychotherapy and psycho-therapeutic interventions according to education and licensure. Provides psychoeducation such as teaching/training with disease process, symptom, and safety management, coping skills and problem solving.
- Provides evaluation and management of the patient's care plan.
- Counseling services may be rendered by either a trained psychiatric nurse or a social worker. These services should not be duplicative. Concurrent counseling or psychotherapy services by multiple providers are not medically necessary.
- Although intervention with family members may be appropriate on occasion, services by a trained psychiatric nurse to family members are not covered as a home health benefit, even if the patient will benefit.

Medical Social Services

- Medical social services provided by a qualified medical social worker (MSW) or a social work assistant under the supervision of a qualified MSW, may be covered as home health services when all of following apply:
  - The patient meets the qualifying criteria for coverage of Home Health services.
  - The services of these professionals are necessary to resolve social or emotional problems which are, or are expected to be, an impediment to the effective treatment of the patient's psychiatric condition or his/her rate of recovery.
  - The plan of care clearly indicates that the skills of a qualified MSW (or a social worker assistant under the supervision of a qualified MSW) are required to safely and effectively provide the needed care.
- When the above requirements are met, coverage for social worker visits may include, but are not limited to the following:
  - Assessment of the social and emotional factors related to the patient's illness, the need for care, response to treatment and adjustment to care and the response to treatment along with the assessment of the patient's financial resources, home situation, and the availability of community resources.
  - Counseling services that are required by the patient for the treatment of their psychiatric condition (Psychotherapy services, constituting active treatment of the psychiatric condition, may be provided by MSWs).
  - Brief counseling (2 or 3 visits) of the patient's family or care-giver(s) when they are reasonable and necessary to resolve problems that are a clear and direct impediment to the treatment of patient's illness or injury or rate of recovery.
  - Appropriate action to obtain available community resources to assist in resolving the patient's problem.

Note: Medicare does not cover the services of an MSW to assist in filing the application for Medicaid or follow up on the application. Federal regulation requires the state to provide assistance in completing the application to anyone who chooses to apply for Medicaid.

Note: A patient may require separate and distinct services provided by a skilled psychiatric nurse and a MSW. However, care must be used to avoid duplication of services that could be provided by both of these disciplines, e.g., counseling of the patient.

Home Health Aide (HHA)

- Home Health Aides may perform personal care or other covered home health aide services.

Occupational Therapist (OT)

- The skills of an occupational therapist may be required to decrease or eliminate limitations in functional activity imposed by psychiatric illness or disability. Occupational therapists may address factors which interfere with the performance of specific functional activities due to cognitive, sensory, psychosocial, or perceptual deficits. Additional guidance on these services and the accepted standards may be found in the CMS Internet-Only Manual, Pub. 100-02, Medicare Benefit Policy Manual, Chapter 7, §40.2.1.
- The skills of an occupational therapist to assess and reassess a patient's rehabilitation needs and potential or to develop and/or implement an occupational therapy plan are covered when they are reasonable and necessary because of the patient's condition.
- The planning, implementing and supervision of therapeutic programs (including, but not limited to those listed below) are skilled occupational therapy services. As such these services are covered if they are reasonable and necessary for the treatment of the patient's illness or injury:

- Selecting and teaching task oriented therapeutic activities designed to restore and increase cognitive abilities and functional participation in ADLs and advanced ADLs.
- Planning, implementing, and supervising therapeutic tasks and activities designed to restore sensory-integrative function.
- Planning, implementing, and supervising of individualized therapeutic activity programs (as well as adapting the environment) as part of an overall “active treatment” program for a patient with a diagnosed psychiatric illness.
- Assessing and planning for improved home safety.

Maintenance Program (CMS L34561)

- Coverage of therapy services, including occupational therapy services, for a maintenance program is based on the individual's need for skilled care in that maintenance program:
  - Coverage of therapy services to perform a maintenance program is not determined solely on the presence or absence of a beneficiary’s potential for improvement from the therapy, but rather on the beneficiary’s need for skilled care. Assuming all other eligibility and coverage requirements are met, skilled therapy services are covered when an individualized assessment of the patient’s clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist or by a qualified therapist assistant under the supervision of a qualified therapist (“skilled care”) are necessary for the performance of a safe and effective maintenance program. Such a maintenance program to maintain the patient’s current condition or to prevent or slow further deterioration is covered so long as the beneficiary requires skilled care for the safe and effective performance of the program. When, however, the individualized assessment does not demonstrate such a necessity for skilled care, including when the performance of a maintenance program does not require the skills of a therapist or by a qualified therapist assistant under the supervision of a qualified therapist because it could safely and effectively be accomplished by the patient or with the assistance of non-therapists, including unskilled caregivers, such maintenance services will not be covered (CMS Medicare Benefit Policy Manual, Chapter 7, §40.2.1, 2020).

Billing When Separate Visits Were Made for Medical and Psychiatric Nursing Care (CMS A56756, 2022)

- Psychiatric nursing care is not separately billable from non-psychiatric nursing care. Both of these services constitute skilled nursing care and may be furnished by the psychiatric nurse, in the course of a single visit. Therefore, visits will not be covered for one nurse to provide psychiatric nursing care and another to provide non-psychiatric nursing care, unless the non-psychiatric nursing care is of such a highly specialized and technical nature, that the service could not be safely rendered by the psychiatric nurse (e.g. infusion therapy).

Concurrent Admission to Home Health and Partial Hospitalization Program (CMS L34561)

- Because partial hospitalization services are intended to meet all the patient's psychiatric care needs, patients admitted to a Partial Hospitalization Program (PHP) are not generally considered appropriate for psychiatric home health services. Medical necessity must be substantiated on a case by case basis. If there are concurrent admissions, the home health claims will be reviewed to verify the medical necessity of the service(s) provided and that the homebound criterion is met.

Psychiatric Nursing in Group Setting (CMS L34561)

- Group interventions for psychiatric home health patients are not covered under the home health benefit. The plan of care and treatment must be individualized.

Discharge Criteria (CMS L34561)

- Patients should cease receiving psychiatric home health services when:
  - Physician orders discharge
  - Patient discontinues/refuses service with physician or nurse
  - Patient is not compliant with the treatment plan, despite appropriate provider interventions
  - Patient/family requests discharge
  - The treatment objectives and stated functional outcome goals have been attained or are no longer attainable
  - The patient is no longer homebound
  - Other appropriate discharge protocols, e.g., the patient moves or is transferring to another agency, etc.
  - A maintenance program is established, if appropriate.

Utilization Guidelines (CMS A56756, 2022)

- For patients with Alzheimer's disease please refer to the Local Coverage Determination (LCD) Home Health Skilled Nursing Care-Teaching and Training: Alzheimer's Disease and Behavioral Disturbances.
- The Plan of Care and/or OASIS should include whether the therapy is rehabilitative/restorative or maintenance.

Documentation Requirements

Documentation Requirements (L34561)

- A clinical note must be written for each home health visit. The home health clinical notes must document as appropriate:
  - the history and physical exam pertinent to the day's visit, (including the response or changes in behavior to previously administered skilled services) and the skilled services applied on the current visit, and
  - the patient/caregiver's response to the skilled services provided
- If a family member/caregiver is involved in the patient's care the documentation must also include this, and
  - the plan for the next visit based on the rationale of prior results,
  - a detailed rationale that explains the need for the skilled service in light of the patient's overall medical condition and experiences,
  - the complexity of the service to be performed, and
  - any other pertinent characteristics of the beneficiary or home
- Clinical notes should be written so that they adequately describe the reaction of a patient to his/her skilled care. Clinical notes should also provide a clear picture of the treatment, as well as "next steps" to be taken. Vague or subjective descriptions of the patient's care should not be used. For example, terminology such as the following would not adequately describe the need for skilled care:
  - Patient tolerated treatment well
  - Caregiver instructed in medication management
  - Continue with POC
- In order for Home Health patients to be eligible to receive services under the Medicare Home Health benefit the following must be documented for certification/recertification:
  - Patient is under a physician care
  - Homebound status-with documentation of confinement to home in medical records
  - Established Plan of Care-must be signed and dated by the certifying physician
  - Face-to-Face-no more than 90 days prior or 30 days after start of home health care
  - Skilled need-services must be medically necessary, and documentation of the skilled need should be in the patients' medical records.
- If the requirements for certification are not met then claims for subsequent episodes of care, which require a recertification, will not be covered- even if the requirements for recertifications are met. Recertifications are needed at least every 60 days when there is a need for continuing home care.
  - Documentation must be legible, relevant, and sufficient to justify the services billed. In general, services must be covered therapy services provided according to Medicare requirements.
  - Legible documentation should be brief and factual. Use descriptive charting: be problem-specific.
  - Legible documentation should clearly support the medical necessity for services.
  - Each visit note should include legible documentation of any psychiatric or medical assessment, an evaluation of the patient's mental status, level of function and progress toward goals. Document objectively when describing behaviors and/or findings.
  - Legibly document changes in the patient's condition and the actions taken, e.g., notification of the physician.
  - Legibly document the assessment of home milieu and supportive environment.
  - Teaching has to be directed at improving function. Document identified teaching needs in response to psychiatric symptoms. Document all patient/family education, the reason for education, what was taught, and the patient's response. If repetitive teaching is required, documentation must clearly show the medical necessity of that teaching. Where it becomes apparent after a reasonable period of time that the patient, family, or caregiver will not or is not able to be trained, then further teaching and training would cease to be reasonable and necessary. The reason why the training was unsuccessful should be documented in the record.
  - Document the patient's understanding and compliance of the medication regimen and treatment plan, and how verified.

- Document the administration of intramuscular (IM) and/or intravenous (IV) medications, their effectiveness, and any side effects of the patient's medication regime.
- Document patient safety issues.
- Documentation should show that periodic venipuncture for blood levels for psychiatric medications, such as Lithium, Tegretol, Clozaril and others, and other related laboratory work, are performed when necessary and pertinent reports of results are in the medical record. This ensures patient compliance and appropriate therapeutic levels. The frequency of testing should be consistent with acceptable standards of medical practice for continued monitoring of a diagnosis, medical problem, or treatment regimen. The home health record must document the rationale for the blood draw as well as the results of the test(s).
- The person rendering the service must sign each visit note. If psychiatric services were rendered it must have been performed by a psychiatric RN.

References

The American Academy of Child and Adolescent Psychiatry (AACAP). (2023). *Child and Adolescent Service Intensity Instrument (CASII) and the Child and Adolescent Level of Care Utilization System (CALOCUS)*. AACAP website: CALOCUS-CASII (aacap.org).

The American Academy of Child and Adolescent Psychiatry (AACAP). (2023). Early Childhood Service Intensity Instrument (ECSII). AACAP website: ECSII.

American Association of Community Psychiatry (AACP). (2020). *Level of Care Utilization System for Psychiatric and Addiction Services*. AACP website: AACP – LOCUS Demo Version 20 (communitypsychiatry.org).

Centers for Medicare and Medicaid Services. (2022). Local Coverage Article, Billing and Coding: Home Health - Psychiatric Care A56756, Palmetto GBA. CMS website: www.cms.gov.

Centers for Medicare and Medicaid Services. (2020). Local Coverage Determination, Home Health Psychiatric Care, L34561-Palmetto GBA. CMS website: www.cms.gov.

Centers for Medicare and Medicaid Services. (2022). Medicare Benefit Policy Manual, Chapter 7, Home Health Services; §40.1.1; §40.1.2.15; §40.2.1; §40.1.2.3. CMS website: www.cms.gov.

Optum Behavioral Clinical Policies. (2023). Complementary and Alternative Medicine (CAM) Treatments. Optum Provider Express website: Optum Behavioral Clinical Policies.

Optum Behavioral Clinical Policies. (2023). Computer Based Treatment for Cognitive Behavioral Therapy (CBTCBT). Optum Provider Express website: Optum Behavioral Clinical Policies.

Optum Behavioral Clinical Policies. (2023). Neurofeedback. Optum Provider Express website: Optum Behavioral Clinical Policies.

Optum Behavioral Clinical Policies. (2023). Transcranial Magnetic Stimulation. Optum Provider Express website: Optum Behavioral Clinical Policies.

Optum Behavioral Clinical Policies. (2023). Wilderness Therapy. Optum Provider Express website: Optum Behavioral Clinical Policies.

Optum Supplemental Clinical Criteria.(2023). Electroconvulsive Therapy (ECT). Optum Provider Express website: Optum Supplemental Clinical Criteria.

Revision History

Date	Summary of Changes
July, 2020	Annual Review
July, 2021	Annual Review
July, 2022	Annual Review
August 22, 2023	Annual Review
December 12, 2023	Interim Update: Added language to Introduction & Instructions for Use section per CMS Final Rule 2024 requirements; updated References section