



Home Health Services

Reimbursement Policy ID: RPC.0100.2400

Recent review date: 12/2024

Next review date: 07/2026

Select Health of South Carolina reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. Select Health of South Carolina may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy outlines guidelines for reimbursement of home health services, place of service (POS) 12.

Exceptions

Home health care services rendered on the dates of inpatient admission and discharge may be reimbursed.

Reimbursement Guidelines

Home health care services are healthcare services delivered in a person's place of residence, excluding nursing homes and institutions, and include intermittent skilled nursing; a home health aide; physical, occupational, and speech therapy services; and physician-ordered supplies. Home health care services are not reimbursable for POS 12 (home) during an inpatient stay.

Home health services have a limit of 50 visits per year. Home health services require prior authorization after the first six visits. One authorization will cover all services rendered (visit, therapies, supplies, etc.) on the date(s) authorized; a separate authorization is not required for each service.

Home-based services: These services require prior authorization.

- Home health care (physical therapy, occupational therapy, speech therapy), home health aides, and skilled nursing (after 18 combined visits regardless of modality).

Home health care/family support services

Home health care provided to homebound members requires prior authorization from the Select Health Population Health department. The home health authorization includes physical, occupational, and speech home visits; a separate authorization is not required for these services. Members are limited to 50 visits per fiscal year for home health care services. Home social work services received from Family Support Services (FSS) do not apply to the 50-visit limitation. Home health care services must be ordered by a physician as part of a written plan of care. The ordering health care professional/ provider must review and sign the Select Health plan of care at least every 60 days. The objectives of the Select Health plan of care should be to improve the member's level of health, relieve pain, and to prevent regression of member's stable condition. The Select Health plan of care should restrict such care to the minimum number of visits necessary to meet these objectives. The care must be appropriate to the home setting and to the patient's needs. The Select Health plan of care should have documented goals, needs, and care rendered, identifying the treatment to be rendered: services, supplies, items, or personnel needed by the patient and the expected outcome.

Skilled nursing services

Skilled nursing services are provided to a person in the home for the purpose of restoring and maintaining his or her maximal level of function and health. These services are rendered in lieu of hospitalization, confinement in an extended care facility, or going outside of the home for services. Skilled nursing services must be prescribed by a physician and be medically necessary for the member's illness or injury.

Physical, occupational and speech therapy

Select Health of South Carolina may cover in-home therapy services depending on the member's needs. Skilled therapies are considered reimbursable when prescribed by a physician for homebound patients to improve, develop or restore physical functions lost due to illness or injury.

Home health care services

A home health aide is a provider who assists a member with non-skilled care to meet activities of daily living, thereby maintaining the individual in his or her home environment. Services provided by home health aides may include:

- Personal care
- Assisting with a prescribed exercise regimen that supports skilled therapies but does not require the skills of a therapist.
- Assisting with activities of daily living
- Changing non-sterile dressings that do not require the skills of a licensed nurse
- Routine care of prosthetic and orthotic devices
- Supervising the individual's adherence to prescribed, self-administered medications and/or special diets
- Taking blood pressure and other health monitoring activities

Home health services may have limitations of services, visits and may require prior authorization. Refer to your provider manual and/or the following link for authorization requirements <https://www.selecthealthofsc.com/provider/resources/prior-auth.aspx>.

Definitions

Home health care

Medical care delivered in the patient's home, when the patient is homebound while recovering from an illness, surgery or injury or has a chronic medical condition.

Place of service (POS)

A two-digit code used on health care professional claims to indicate the setting in which a service was provided.

Durable medical equipment (DME)

DME is equipment that can withstand repeated use (at least three years) and is used in the home for a medical reason when someone is sick or injured.

Edit Sources

- I. Current Procedural Terminology (CPT) and associated publications and services.
- II. International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10).
- III. Healthcare Common Procedure Coding System (HCPCS).
- IV. Centers for Medicare and Medicaid Services (CMS).
- V. The National Correct Coding Initiative (NCCI).
- VI. South Carolina Medicaid Fee Schedule(s).

Attachments

N/A

Associated Policies

N/A

Policy History

06/2025	Minor updates to formatting and syntax
04/2025	Revised preamble
12/2024	Reimbursement Policy Committee Approval
04/2024	Revised preamble
08/2023	Removal of policy implemented by Select Health of South Carolina from Policy History section
01/2023	Template Revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section