Clinical Policy: Home and Community-Based Services

Reference Number: DE.CP.MP.02 Coding Implications
Date of Last Revision:03/25 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

This policy describes the clinical criteria for Long Term Services and Supports for Delaware First Health DSHP Plus LTSS members residing in a home and community-based environment. Home and community-based services provide support in the home to address cognitive and functional deficits, which may be a result of medical conditions. Services assist in safely maintaining residence in the home and community environment and lessen the risk for nursing home placement.

Policy/Criteria

I. It is the policy of Delaware First Health that for Long Term Services and Supports (LTSS) members *attendant care services* will be considered as **medically necessary** based on the Timed Task Tool within the Person-Centered Service Plan.

Note: *Special considerations* - Self-Directed Attendant Care (SDAC) - The support for Self-Directed Home Community Based Services (HCBS) provides assistance to members who elect to self-direct their attendant care.

II. It is the policy of Delaware First Health that for LTSS members *respite care services* will be considered as **medically necessary** based on documentation of the following:

A. Dimensions of determination:
   1. Level of functioning for safety reasons;
   2. Caregiver stress-defined by responses for caregiver assessment questions in the Person-Centered Service Plan and Comprehensive Assessment;
      a. Minimal stress;
      b. Moderate stress;
      c. Major stress;
      d. Sudden absence (defined by documented absence of caregiver due to medical emergency);
   3. Informal supports;
   4. Living situation;
   5. Need for supervision;

B. Criteria for consideration include but are not limited to:
   1. Location of service delivery (e.g., home vs facility);
   2. Caregiver stress:
      a. Minimal stress;
      b. Moderate stress;
      c. Major stress;

d. Sudden absence (defined by documented absence of caregiver due to medical emergency);
e. The service does not duplicate another provider's service.

C. *Respite care* services are limited to no more than 14 calendar days per year. Additional services may be considered on a case-by-case basis by a medical director when one or more of the following apply[2]:
1. No other service options are available to the member, including services provided through an informal support network;
2. The absence of the service would present a significant health and welfare risk to the member;
3. Respite service provided in a nursing facility, member's home, or assisted living facility is not utilized to replace or relocate member's primary residence.

Note: *Special Considerations*: SDAC - The support for Self-Directed HCBS provides assistance to members who elect to self-direct their respite services.

III. It is the policy of Delaware First Health that for LTSS members *adult day services* are considered **medically necessary** at an enhanced rate when the following indications are met:
A. Staff time is needed to care for members who demonstrate ongoing behavioral patterns that require additional prompting and/or intervention;
B. The behavior and need for intervention must occur at least weekly.

IV. It is the policy of Delaware First Health that for LTSS members *day habilitation* services are considered **medically necessary** for members who demonstrate a need based on cognitive, social, and/or behavioral deficits such as those that may result from an acute brain injury (ABI).

V. It is the policy of Delaware First Health that for LTSS members *personal emergency response systems (PERS)* are considered **medically necessary** when the following criteria are met:
A. Member is at high risk of institutionalization if they have challenges securing help in an emergency, due to decreased functional or cognitive status;
B. Member lives alone or is alone for significant parts of the day and would otherwise require supervision.

VI. It is the policy of Delaware First Health that for LTSS members *nutritional supports* are **medically necessary** when the following criteria are met:
A. Service must be prior authorized by a case manager in conjunction with the consultation of a health care professional's recommendation for service;
B. One or more of the following:
1. Weight less than 90% of usual body weight;
2. Weight loss over a one to six month period;
3. Loss of more than five pounds within a preceding month;
4. Serum albumin is less than 3.2 or very high indicating dehydration, difficulty swallowing or chewing, or persistent diarrhea;

5. Wasting syndrome affected by a number of factors including intake, nutrient malabsorption, and physiological and metabolic changes.

VII. It is the policy of Delaware First Health that for LTSS members *specialized medical equipment and supplies* not covered under the Medicaid State Plan will be covered for Delaware First Health LTSS members when all of the following apply:

A. One of the following:
   1. Devices, controls, or appliances specified in the plan of care that enable the member to increase their ability to perform ADLs;
   2. Devices, controls, or appliances that enable the member to perceive, control, or communicate with the environment in which they live;
   3. Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;
   4. Such other durable medical equipment (DME) and non-DME not available under the Delaware Medicaid State Plan that is necessary to address member's functional limitations;
   5. Necessary medical supplies not available under the Delaware Medicaid State Plan;
B. Items reimbursed under the DSHP Plus LTSS benefit package are in addition to any medical equipment and supplies furnished under the State Plan and exclude those items that are not of direct medical or remedial benefit to the member;
C. Does not duplicate a service provided under the State Plan as an expanded EPSDT service.

VIII. It is the policy of Delaware First Health that for LTSS members *minor home modifications* are **considered necessary** when the following indications are met:

A. All services shall be provided in accordance with applicable State or local building codes;
B. Services cost up to $6,000 per project; $10,000 per benefit year; and $20,000 per lifetime.
C. None of the following exclusions apply:
   1. Adaptations that add to the total square footage of the home;
   2. Installation of stairway lifts or elevators and those adaptations that are considered improvements to the residence or that are of general utility and not of direct medical or remedial benefit to the member, such as installation, repair, or replacement of roof, ceiling, walls, or carpet or other flooring;
   3. Installation, repair, replacement of heating or cooling units or systems;
   4. Installation or purchase of air or water purifiers or humidifiers;
   5. Installation or repair of driveways, sidewalks, fences, decks, and patios.

IX. It is the policy of Delaware First Health that for LTSS members *home delivered meals* are **considered necessary** when the following apply:

A. Up to two meals per day. Nutritionally well-balanced meals, other than those provided under Title III C-2 of the Older Americans Act or through Social Service Block Grant (SSBG) funds, that provide at least one-third but no more than two-thirds of the current daily Recommended Dietary Allowance (as estimated by the Food and Nutrition Board of Sciences – National Research Council) and that will be served in the member's home;

B. Special diets shall be provided in accordance with the member's plan of care when ordered by the member's physician;
C. These meals are delivered to the member's community residence and not to other settings such as adult day programs or senior centers.

X. It is policy of Delaware First Health that for LTSS members *transition services for those moving from a nursing facility to the community* are **considered necessary** and can include security deposit, telephone connection fee, groceries, furniture, linens, etc., up to $2,500 per transition.

XI. It is the policy of Delaware First Health that for LTSS members the following services are considered **not medically necessary** for members residing in assisted living and nursing facilities:
A. Adult day services;
B. Day habilitation;
C. Cognitive services;
D. Personal emergency response systems (PERS);
E. Nutritional supports;
F. Minor home modifications;
G. Home delivered meals.

Background

LTSS home and community-based services are non-skilled services covered under the DSHP Plus LTSS benefit package. Services include:

- Community-based residential alternatives that include assisted living facilities
- Attendant Care Services/Self Directed Attendant Care (SDAC)
- Respite Care Services
- Adult Day Services
- Day Habilitation
- Cognitive services
- Personal Emergency Response Services (PERS)
- Nutritional Supports
- Specialized medical equipment and supplies not covered under the Medicaid State Plan
- Minor Home Modifications
- Home Delivered Meals
- Transition services for those moving from a nursing facility to the community

LTSS service benefits must be authorized by Delaware First Health and be appropriate for the member. LTSS services are covered for Delaware First Health members enrolled in DSHP Plus LTSS and are eligible or have pending eligibility on the date the service is provided. Per the MCO MSA Agreement, Long Term Services and Supports to DSHP Plus LTSS members services need to be determined as medically necessary.

Community-based residential alternatives that include assisted living facilities-Community-based residential services offer a cost-effective, community based alternative to nursing facility care for persons who are elderly and/or adults with physical disabilities. This includes assisted care living facilities. Community-based residential services include personal care and supportive services (homemaker, chore, attendant services, and meal preparation) that are furnished to participants who reside in a homelike, non-institutional setting. Assisted living includes a 24-hour onsite response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety, and security. Services also include social and recreational programming, and medication assistance (to the extent permitted under State law). As needed, this service may also include prompting to carry out desired behaviors and/or to curtail inappropriate behaviors. Services that are provided by third parties must be coordinated with the assisted living provider. Personal care services are provided in assisted living facilities as part of the community-based residential service. To avoid duplication, attendant care (as a separate service) is not available to members residing in assisted living facilities.[2]

Attendant Care- To provide assistance with ADLs and IADLs, including assistance with preparation of meals, and housekeeping chores which are incidental to the care furnished or are essential to the health and welfare of the member. The scope and nature of these services do not otherwise differ from personal care services. A service that provides assistance with eating, bathing, dressing and personal hygiene, and other activities of daily living. The service includes assistance with preparation of meals but does not include the cost of meals. The service may also include housekeeping tasks such as bed making, dusting, and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the member. Personal care services include but may not be limited to the following[2]:

- Assistance to the member to complete personal hygiene (bathing, grooming, mouth care, etc.);
- Assistance with bladder and bowel requirements that include assisting the member to and from the bathroom or with bedpan routines;
- Assisting the member in following through with physician orders;
- The Personal Care provider cannot administer any medications, but may bring medications to the member and remind the member to take the medicine at specific times;
- Assisting with food, nutrition, and diet activities, including preparing meals, when required and other incidental services, (i.e., housekeeping chores) essential to the health and welfare of the member;
- Performing household services (changing bed linen or arranging furniture) when such services are essential to the member's health and comfort.

The services may be provided in the member's home or other location.

Respite Care is the provision of services on a short-term basis due to the absence of, or need to relieve, the member's natural supports on a planned or an emergency basis.[2] In-home Respite Care services preserve the primary caregiving relationship. A primary caregiver is defined as any

person who lives with the member and regularly provides or arranges help as needed with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). This person may or may not be related by birth or marriage. The service provides general supervision, meal preparation, and hands-on assistance with personal care that are incidental to supervision during the period of service delivery.

Adult Day Services are services furnished in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the member. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day). Physical, occupational and speech therapies indicated in the member's plan of care will be furnished as component parts of this service.[2]

Day Habilitation includes assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that takes place in a non-residential setting, separate from the member's private residence. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day). Day habilitation services focus on enabling the member to attain or maintain their maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in other settings.[2]

Cognitive Services are necessary for the assessment and treatment of members who exhibit cognitive deficits or interpersonal conflict, such as those that are exhibited as a result of a brain injury. Cognitive services include two key components[2]:

- Multidisciplinary assessment and consultation to determine the member's level of functioning and service needs. This cognitive services component includes neuropsychological consultation and assessments, functional assessment, and the development and implementation of a structured behavioral intervention plan;
- Behavioral therapies include remediation, programming, counseling and therapeutic services for members and their families, which have the goal of decreasing or modifying the member's significant maladaptive behaviors or cognitive disorders that are not covered under the Delaware Medicaid State Plan. These services consist of the following elements: individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law), services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness, individual activity therapies that are not primarily recreational or diversionary, family counseling (the primary purpose of which treatment of the member's condition) and diagnostic services.

Personal Emergency Response Systems (PERS) describes the installation and service of an electronic device connected to a member's phone that includes a portable "help" button, when provided to a member at high risk of institutionalization to secure help in an emergency. The PERS is connected to the member's phone and programmed to signal a response center once a

"help" button is activated. The member may also wear a portable "help" button to allow for mobility.[2]

Nutritional supports is a service for members diagnosed with HIV/AIDS that are not covered under Delaware's Medicaid State Plan. This service ensures proper treatment in those experiencing weight loss, wasting, malabsorption and malnutrition. Such oral nutritional supplements are offered as a service to those identified at nutritional risk. This service covers supplements not otherwise covered under the State Plan service. The service does not duplicate a service provided under the State Plan as an EPSDT service. The service must be prior authorized by a case manager in conjunction with the consultation of a health care professional's recommendation for service.

Minor Home Modifications- Provision and installation of certain home mobility aids (e.g., a wheelchair ramp and modifications directly related to and specifically required for the construction or installation of the ramp, hand rails for interior or exterior stairs or steps, grab bars and other devices) and minor physical adaptations to the interior of a member's place of residence that are necessary to ensure the health, welfare and safety of the member, or which increase the member's mobility and accessibility within the residence, such as widening of doorways or modification of bathroom facilities.[2]

Home Delivered Meals is the provision of nutritionally sound meals to be delivered to the residence of the member who has difficulty shopping for or preparing meals without assistance.[2]

Independent activities of daily living (Chore) service- Chore services constitute housekeeping services that include assistance with shopping, meal preparation, light housekeeping, and laundry. This is an in-home service for frail older persons or adults with physical disabilities. The service assists them to live in their own homes as long as possible.[2]

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
99600	Home health waiver- Home Visit Svc
99509	Home health waiver- Home Visit Day/Life Activity Mod U1
99509	Personal Care Worker- Personal Care -Consumer Directed

HCPCS® Codes	Description
S5100	Adult Day Care- Day Care Services Adult-per 15 minutes
S5101	Adult Day Care- Day Care Services Adult- per half day
T2035	Community Transition Waiver Services- Assistive Technology
T2038	Community Transition Waiver Services- Community Transition Services per service
T2030	Community Transition Waiver Services- Assisted Living per month
H2030	Community Transition Waiver Services- MH Clubhouse Svcs per 15 minutes
S5160	Emergency Response system- Installation and testing
S5161	Emergency Response system- Monthly Service Fee
S5161	Emergency Response system- Monthly Service Fee -U1-Fall detection
S5162	Emergency Response system- Purchase only
K0739	Repair or nonroutine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes
T2014	Habilitation- Habilitation, Prevocational, Waiver, per diem
T2018	Habilitation- Habilitation, Supported Employment, Waiver, per diem
T2019	Habilitation- Habilitation Supported Employment, Waiver, per15 minutes
H2024	Habilitation- Supported Employment LTSS per day
S9445	Habilitation- Patient Education, per session
H2014	Habilitation- Skills Training and development, per 15 minutes
T2016	Habilitation- Residential Habilitation, waiver; per diem
T2017	Habilitation- Residential Habilitation, waiver; per 15 minutes
T2033	Habilitation- Residential Care (Nos), waiver; per diem
T1028	Habilitation- Assess Home physical and Family Environment to determine suitability to meet patient's medical needs
T2020	Habilitation- Day Habilitation, waiver; per diem
T2021	Habilitation- Day Habilitation, waiver; per 15 minutes
S5135	Habilitation- Adult Companion Services per 15 minutes
S5136	Habilitation- Adult Companion Services per diem
G9004	Habilitation- Coordinated Care fee initial
G9005	Habilitation- Coordinated Care fee
T2024	Habilitation- Service Assessment
T2040	Habilitation- Financial Management, self-directed, per 15 minutes
T2041	Habilitation- Supports Brokerage per 15 minutes (self directed)
S8940	Habilitation- Hippotherapy per 15 minutes
H2032	Habilitation- Activity Therapy per 15 minutes
G0176	Habilitation- Activity Therapy per 45 min or more

HCPCS® Codes	Description
H2019	Habilitation- Behavior Support Consultation LTSS per 15 minutes
S5185	Habilitation- Medication Reminder Svc per month
G0155	HOME HEALTH WAIVER- HHCP-SVS OF CSW per 15 minutes
S9122	HOME HEALTH WAIVER- HHCP-SVS OF CSW per hour
T1004	HOME HEALTH WAIVER- HHCP-SVS OF CSW to 15 minutes
T1022	Home health waiver- Contracted HH Agency
G0156	HOME HEALTH WAIVER- Home Health Aide per 15 minutes
S9122	HOME HEALTH WAIVER- Home Health Aide per hour
T1004	HOME HEALTH WAIVER- Home Health Aide to 15 minutes
S5135	HOME HEALTH WAIVER- Adult Companion Services per 15 minutes
S5136	HOME HEALTH WAIVER- Adult Companion Services per diem
S5125	HOME HEALTH WAIVER- Attendant Care per 15 minutes
S5126	HOME HEALTH WAIVER- Attendant Care per diem
S9123	HOME HEALTH WAIVER- RN Home Care per hour
S9124	HOME HEALTH WAIVER-LPN Home Care per hour
S5108	HOME HEALTH WAIVER- Home Care Training: Client per 15 minutes
S5111	HOME HEALTH WAIVER- Home Care Training, family; per session
S5115	HOME HEALTH WAIVER- Home Care Training, nonfamily, per 15 minutes
S5110	HOME HEALTH WAIVER- Home Care Training, family, per 15 minutes
S5116	HOME HEALTH WAIVER- Home Care Training, nonfamily, per session
T1000	HOME HEALTH WAIVER- Private Duty/Independent Nursing service(s), licensed, up to 15 minutes
T1001	HOME HEALTH WAIVER- Nursing Assessment/Eval
T1002	HOME HEALTH WAIVER- RN Services up to 15 minutes
T1003	HOME HEALTH WAIVER- LPN/LVN Services up to 15 minutes
S5181	HOME HEALTH WAIVER- Respiratory Therapy HH per diem
T2025	HOME HEALTH WAIVER- Waiver Services NOS
S9110	HOME HEALTH WAIVER- Telemonitoring per month
S5170	Home Meals- Home Delivered meals (HOT), per meal
S5165	Home Modifications- Home Mod per Service
T2039	Home Modifications- Vehicle modifications, per service
S5130	Homemaker Services, nonspecific, per 15 minutes
S5131	Homemaker Services, nonspecific, per diem
S5120	Homemaker Services- Chores (Personal Care) per 15 minutes
S5175	Homemaker Services- Laundry Service per order
T1019	Personal Care Services- per 15 minutes
T1020	Personal Care Services- per diem
S5199	Personal Care Worker- Personal Care Item, each

HCPCS® Codes	Description
G9006	Personal Care Worker- Personal Care Directed Admin Fee
T1005	Respite Services up to 15 minutes
H0045	Respite Services, not in the home, per diem
S5150	Respite Services- Unskilled Respite (Not Hospice)- per 15 minutes
S5151	Respite Services- Unskilled Respite (Not Hospice)- per diem
T2027	Respite Services- Specialized Childcare (waiver) per 15 minutes
T2026	Respite Services- Specialized Childcare (waiver) per diem
T2028	Specialized Supplies
T2029	Specialized Medical Equipment

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Original approval date	3/24	06/24
Annual review. Minor edits with no impact to criteria. Codes reviewed. CPT codes 99600, 99509 removed from HCPCS code chart and placed on CPT code chart. References reviewed and updated. Sent for plan review.	03/25	03/25

References

1. Delaware First Health Person Centered Service Plan with Time Task Tool.
2. Delaware Division of Medicaid and Medical Assistance. Delaware Medical Assistance Program. Long Term Care Community Services Provider Specific Policy Manual. https://medicaidpublications.dhss.delaware.gov/docs/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core_Download&EntryId=898&language=en-US&PortalId=0&TabId=94. Published June 1, 2017 (Revised August 20, 2018). Accessed January 29, 2025.
3. Delaware Health and Social Services. Division of Substance Abuse and Mental Health: Personal centered planning. https://dhss.delaware.gov/dhss/dsamh/files/person_centered_planning.pdf. Accessed January 29, 2025.
4. Delaware Health and Social Services. State of Delaware. 1915(i) State plan home and community-based services administration and operation. https://www.dhss.delaware.gov/dhss/ddds/files/Pathways1915(i)12082021.pdf. Effective January 1, 2022. Accessed January 29, 2025.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical

policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.