If a conflict arises between a Clinical Payment and Coding Policy (CPCP) and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. “Plan documents” include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. BCBSTX may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSTX has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act (HIPAA) approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing (UB) Editor, American Medical Association (AMA), Current Procedural Terminology (CPT®), CPT® Assistant, Healthcare Common Procedure Coding System (HCPCS), ICD-10 CM and PCS, National Drug Codes (NDC), Diagnosis Related Group (DRG) guidelines, Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Coordinated Home Care/Private Duty Nursing Policy

Policy Number: CPCP005

Version 1.0

Clinical Payment and Coding Policy Committee Approval Date: October 8, 2021

Plan Effective Date: December 1, 2021 (Blue Cross and Blue Shield of Texas Only)

Description

The purpose of this policy is to provide guidance for various types of coordinated home health care and appropriate code sets for claim submissions. Coordinated home care services consist of skilled and unskilled (custodial) services. These services can be long-term or short-term depending on the member’s needs. The home health care services discussed in this policy may not be limited to Covered Services. References to services herein are not a guarantee or representation of coverage. Providers are urged to refer to the state and federal mandates for eligible coverage and to the member’s benefits for home health care services.

Health care providers are expected to exercise independent judgment in providing care to members. This policy is not intended to impact care decisions or medical practice.

Definitions:

Coordinated Home Care: Organized skilled intermittent patient care initiated by a hospital or other inpatient facility to facilitate in the discharge and planning of its patients into home care under the orders of a qualified physician.

Custodial or Unskilled Care: Personal care that does not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel to be safely and effectively performed and which is to support the patient's care and activities of daily living (ADLs). Services are generally non-medical.

Home Health Care: Healthcare services provided to a patient who is at home due to a sickness or injury requiring services from a skilled and licensed professional on an intermittent or part-time basis.

Intermittent home care: Part-time skilled nursing care provided in the home or inpatient facility setting for fewer than seven days a week or less than 8 hours a day for periods of twenty-one (21) days or less. A member must have a medically predictable recurring need for skilled nursing services.

Private Duty Nursing (PDN): Skilled nursing services for patients requiring more individual and continuous care than is available from a visiting nurse providing intermittent home care. Services which can be provided by a medical assistant, nurse's aide, home health aide or other non–nurse level caregiver are not considered as PDN.

Respite Care: Short-term, temporary relief to a primary or usual caregiver. The caregiver is generally a family member.

Skilled Care: Medical care provided in the home or inpatient facility setting and may only be provided by or under the supervision of a skilled or licensed medical professional. Services require the technical skills and professional training of a licensed professional nurse or rehabilitation therapist.

Reimbursement Information:

Claim reimbursement is limited to covered services which meet medical necessity and for services which do not exceed the defined member benefit for days or hours of coverage.

Services associated with home health care may include, but are not limited to, the following set of codes listed below. Coverage for these codes is dependent upon the member's benefit, provider contracts and state or federal mandates.

BlueCross BlueShield of Texas

HCPCS CODE	DESCRIPTION
S9122	Home health aide or certified nurse assistant, providing care in the home; per hour.
S9123	Nursing care, in the home; by registered nurse, per hour (use for general nursing care only, not to be used when CPT codes 99500-99602 can be used)
S9124	Nursing care, in the home; by licensed practical nurse, per hour
T1002	RN services, up to 15 minutes
T1003	LPN/LVN services, up to 15 minutes
T1031	Nursing care, in the home, by licensed practical nurse, per diem

Example*, if a member receives nursing care for one-hour on Monday, Wednesday and Friday (total of three hours in one week/seven-day period) this is considered intermittent care and should be billed for three units of HCPCS code(s) S9123 or S9124.*

Coverage for the code below is dependent upon the member's benefit, provider contracts and state or federal mandates. The following HCPCS code is associated with PDN, however additional codes may be appropriate:

HCPCS CODE	DESCRIPTION
T1000	Private duty/independent nursing service(s), licensed, up to 15 minutes

Example*, if a member needs continuous nurse care for half of a day for five days (twelve hours per day totaling sixty hours for five days) this is considered PDN and should be billed with 240 units of HCPCS code T1000.*

The plan may request additional documentation from the PDN provider to support the medical necessity of services. Upon the initial request, additional documentation, recertification or a revision request includes, but is not limited to, nurse progress notes, medication administration records, seizure logs and ventilator logs.

Custodial Care (Medical Policy ADM1001.014)

Custodial care primarily involves assisting members in ADLs and for personal comfort or convenience and is generally not a covered benefit. Some examples of custodial care may include, but are not limited to, the following:

- Assistance with meal feeding, bathing, dressing and the use of the bathroom
- Assistance with walking or moving to and from a chair or bed
- Assistance with food preparation and eating
- Supervision of distribution, preparation and administration of medication

Refer to the current AMA CPT manual and/or HCPCS book for the appropriate custodial care CPT/HCPCS codes. Coverage for these codes is dependent upon member's benefits, provider contracts and state or federal mandates.

Additional Information

- Refer to the plan's provider website for home health contract base compensation schedules
- Verify member's maximum benefits
- Appropriate revenue codes for home health services should be submitted on UB-04 form
- Claim submissions should contain the appropriate revenue code and CPT/HCPCS code combination

The Plan reserves the right to request supporting documentation. Claims that do not adhere to coding and billing guidelines may result in a denial or reassigned payment rate. Claims may be reviewed on a case by case basis.

References:

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Medical Policy ADM1001.014 Custodial Care

Policy Update History:

Approval Date	Description
10/31/2018	New policy
09/06/2019	Annual Review and Title update
09/25/2020	Annual Review, Disclaimer Update, Verbiage Update
10/08/2021	Annual Review