



Kaiser Foundation Health Plan of Washington

**Clinical Review Criteria
Home Care Services Criteria**

NOTICE: Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc., provide these Clinical Review Criteria for internal use by their members and health care providers. The Clinical Review Criteria only apply to Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. Use of the Clinical Review Criteria or any Kaiser Permanente entity name, logo, trade name, trademark, or service mark for marketing or publicity purposes, including on any website, or in any press release or promotional material, is strictly prohibited.

Kaiser Permanente Clinical Review Criteria are developed to assist in administering plan benefits. These criteria neither offer medical advice nor guarantee coverage. Kaiser Permanente reserves the exclusive right to modify, revoke, suspend or change any or all of these Review Criteria, at Kaiser Permanente's sole discretion, at any time, with or without notice. **Member contracts differ in their benefits. Always consult the patient's Medical Coverage Agreement or call Kaiser Permanente Customer Service to determine coverage for a specific medical service.**

**Criteria
For Medicare Members**

Source	Policy
CMS Coverage Manuals	Medicare Benefit Policy Manual Chapter 7 Home Health Services.
National Coverage Determinations (NCD)	None
Local Coverage Determinations (LCD)	None
Local Coverage Article	None

For Non-Medicare Members

Kaiser Permanente has elected to use the MCG* Home Care Guidelines for medical necessity determinations. **

*MCG manuals are proprietary and cannot be published and/or distributed. However, on an individual member basis, Kaiser Permanente can share a copy of the specific criteria document used to make a utilization management decision. If one of your patients is being reviewed using these criteria, you may request a copy of the criteria by calling the Kaiser Permanente Clinical Review staff at 1-800-289-1363.

**note - Social Work is to be considered a secondary service and not a primary service

The following information was used in the development of this document and is provided as background only. It is provided for historical purposes and does not necessarily reflect the most current published literature. When significant new articles are published that impact treatment option, KPWA will review as needed. This information is not to be used as coverage criteria. Please only refer to the criteria listed above for coverage determinations.

Background

The criteria for admission to home health services are based on the federal regulations for the Medicare home health benefit.

Evidence and Source Documents

Kaiser Permanente Home Care Services Policy HCS-06-1008.

Date Created	Date Reviewed	Date Last Revised
02/1996	01/05/2010 ^{MDCRPC} , 11/02/2010 ^{MDCRPC} , 09/06/2011 ^{MDCRPC} , 01/03/2012 ^{MDCRPC} , 11/06/2012 ^{MDCRPC} , 09/03/2013 ^{MPC} , 07/01/2014 ^{MPC} , 08/05/2014 ^{MPC} , 06/02/2015 ^{MPC} , 04/05/2016 ^{MPC} , 02/07/2017 ^{MPC} , 12/05/2017 ^{MPC} , 10/02/2018 ^{MPC}	12/05/17

^{MDCRPC} Medical Director Clinical Review and Policy Committee
^{MPC} Medical Policy Committee

Revision History	Description
02/07/2016	MPC approved to adopt MCG 20 th edition guidelines for home health services

12/05/2017	MPC approved to adopt MCG 21 st edition guidelines for home health services
------------	--

Codes