	Prior Authorization Guide: **Home and Domiciliary Visits**	Applies to members enrolled in the following My Choice Wisconsin health plan products: **Partnership, SSI Managed Care, Dual Advantage**

Coverage rationale

A home or domiciliary visit includes a member history, examination, problem solving and decision making in various levels depending upon a member's need and diagnosis. These visits are an extension of normal care. The beneficiaries seen may have chronic conditions, may be disabled either physically or mentally making access to a traditional office visit very difficult, or may have limited support systems. The home or domiciliary visit in turn can lead to improved medical care by identification of unmet needs, coordination of treatment with appropriate referrals and potential reduction of acute exacerbations of medical conditions.

The following are basic conditions that must always be met before services can be covered:

- The patient is an active member of My Choice Wisconsin's SSI Managed Care, Partnership, or Dual Advantage program;
- Services are provided by a physician/qualified non-physician practitioners;
- The services billed are not excluded from payment;
- The service was not solicited. The record must clearly demonstrate that the member, his/her delegate or another clinician involved in the case sought the initial service;
- The service must be provided at a frequency that consistent with that which is typically provided in the office and acceptable standards of medical practice;
- The Member is not being treated by other providers for the same diagnosis and there is documentation that the Member understands and agrees to this;
- The initial visit and subsequent visits are scheduled are supported by documentation of medical necessity and are not scheduled to coincide with multiple other visits by the provider in the same facility for convenience; and
- The service must be personally performed or ordered by the rendering/billing provider.

Service	Procedure Code	Prior Authorization Requirements
Domiciliary, Rest Home, Assisted Living and/or Nursing Facility Codes	99324 – 99337	Prior authorization is required
Home Visit Codes	99341 – 99350	Prior authorization is required

Requesting prior authorization:

- Complete the Home Health Prior Authorization Form
- Include assessment, clinical impression, diagnoses, and medical plan of care, including treatment goals and outcomes
- Fax to 608-210-4050

Exclusions:

Created: January 2018
Reviewed: 10/10/2018
Updated: 2/19/2020, 10/1/2020

- In-network, Physician/Practitioner Services, including specialty services do not require prior authorization when rendered outpatient unless the services are rendered in the home or domicile.
- The service must be of such nature that it could not be provided by a Visiting Nurse/Home Health Services Agency under the Home Health Benefit. There may be circumstances where home health services and the services of physician/qualified non-physician practitioners (NPPs) are performed on the same day. These services cannot be duplicative or overlapping.
- Physicians cannot provide home services at their convenience (for example, visiting senior independent living facilities on a routine basis). Providers must be able to prove that the home visit was based on patient's inability to come to the office either this one time, or on an ongoing basis, due to physical or mental issues and not due to financial or other personal reasons.
- Medicare and Medicaid do not provide coverage for formalized palliative care programs, but both provide coverage for some treatments and medications that provide palliative care, including visits from doctors and qualified non-physician practitioners. Home visits for the purposes of advanced care planning are subject to the coverage rationale above.

References:

Medicare Claims Processing Manual-Chapter 12

Created: January 2018
Reviewed: 10/10/2018
Updated: 2/19/2020, 10/1/2020