Home Health Visits to a Blind Diabetic (NCD 290.1)

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<th>Policy Number</th>
<th>Approved By</th>
<th>Current Approval Date</th>
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<tr>
<td>290.1</td>
<td>UnitedHealthcare Medicare Reimbursement Policy Committee</td>
<td>01/22/2014</td>
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**IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY**

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare reimbursement policies use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms (CMS 1450). Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy. This information is intended to serve only as a general resource regarding UnitedHealthcare’s reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, and/or the enrollee’s benefit coverage documents. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations.

UnitedHealthcare may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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**Table of Contents**

- Application ................................................................................................................. 1
- Summary ..................................................................................................................... 2
  - Overview ................................................................................................................. 2
  - Reimbursement Guidelines ................................................................................... 2
- CPT/HPCS Codes ....................................................................................................... 3
- References Included (but not limited to): ................................................................. 3
  - CMS NCD ................................................................................................................ 3
  - CMS Benefit Policy Manual .................................................................................. 3
  - UnitedHealthcare Medicare Advantage Coverage Summaries ......................... 3
- History ....................................................................................................................... 3

**Application**

This reimbursement policy applies to services reported using the Health Insurance Claim Form CMS-1500 or its electronic equivalent or its successor form, and services reported using facility claim form CMS-1450 or its electronic equivalent or its successor form. This policy applies to all products, all network and non-network physicians, and other health care professionals.

The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This policy does not take precedence over CCI edits. Please refer to the CCI for correct coding guidelines and specific applicable code combinations prior to billing UnitedHealthcare. It is not enough to link the procedure code to a correct, payable ICD-9-CM diagnosis code. The diagnosis must be present for the procedure to be paid. Compliance with the provisions in this policy is subject to monitoring by pre-payment review and/or post-payment data analysis and subsequent medical review. The effective date of changes/additions/deletions to this policy is the

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Home Health Visits to a Blind Diabetic (NCD 290.1)

committee meeting date unless otherwise indicated. CPT codes and descriptions are copyright 2010 American Medical Association (or such other date of publication of CPT). All rights reserved. CPT is a registered trademark of the American Medical Association. Applicable FARS/DFARS restrictions apply to Government use. Fee schedules, relative value units, conversion factors, and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Current Dental Terminology (CDT), including procedure codes, nomenclature, descriptors, and other data contained therein, is copyright by the American Dental Association, 2002, 2004. All rights reserved. CPT is a registered trademark of the American Dental Association. Applicable FARS/DFARS apply.

Summary

Overview

Many individuals who are blind and require daily insulin for the control of a diabetic condition are able to administer their injections without assistance (other than possibly that which may be furnished by family members or friends). There are organizations which encourage and train blind diabetics, both to fill their own syringes and to inject themselves. There are also a number of devices available for blind individuals to fill their syringes accurately. However, the individuals who may need assistance with pre-filling their syringes may also require periodic observation and evaluation, even though their diabetes is fairly stabilized. In such cases, probably few in number, Home Health Services (HHS) may be required for this purpose.

Reimbursement Guidelines

To qualify for HH benefits, a blind diabetic must be confined to his home, under the care of a physician, and in need of either skilled nursing services on an intermittent basis or physical therapy or speech. Effective July 1, 1981, a person may qualify for HH benefits based on his or her need for skilled nursing services on an intermittent basis, physical therapy, speech, or occupational therapy. Effective December 1, 1981, occupational therapy is eliminated as a basis for entitlement to HHS. However, if a person has otherwise qualified for HHS because of the need for skilled nursing care, physical therapy or speech, the patient's eligibility for HHS may be extended solely on the basis of the continuing need for occupational therapy. (See the Medicare Benefit Policy Manual, Chapter 7, "HHS," §20.) There must be a plan of treatment, established and periodically reviewed by a physician, which indicates that there is a recurring need for HHS to supplement the physician's contacts with the patient; e.g., skilled nursing visits for observing and determining the need for changes in the level and type of care which has been prescribed. (See the Medicare Benefit Policy Manual, Chapter 7, "HHS," §30.) Once an initial regimen has been established, the frequency of need for further HHS can vary greatly from patient to patient, depending on their condition and the likelihood of its changing. Some may need visits only every 90 days, for example, while others may require them much more frequently. If a nurse makes a visit to provide skilled services, and also pre-fills syringes, the purpose of the visit, which was to provide skilled services, does not change. However, if the sole purpose of the nurse's visit is to pre-fill insulin syringes for a blind diabetic, it is not a skilled nursing visit although it may be reimbursed as such as indicated below.

Filling a syringe can be safely and effectively performed by the average nonmedical person without the direct supervision of a licensed nurse. Consequently, it would not constitute a skilled nursing service even if it is performed by a nurse. (See the Medicare Benefit Policy Manual, Chapter 7, "HHS," §30.2.2.) The personal care duties normally performed by HH aides include assisting the patient with medications ordered by a physician which are ordinarily self-administered. (See the Medicare Benefit Policy Manual, Chapter 7, "HHS," §50.2.)

Performance of such a service by an aide is consistent with the Medicare conditions of participation for HH agencies. Therefore, HH aide services would be appropriate for those blind diabetics who are qualified for HH benefits and who cannot fill their syringes. An adequately trained HH aide could make intermittent visits, usually on a weekly basis, to the home for the purpose of filling that supply of insulin ordered by the physician.

If State law, however, precludes a HH aide from pre-filling insulin syringes, payment may be made for this service as part of the cost of skilled nursing services when performed by a nurse for a blind diabetic who is otherwise unable to pre-fill his or her syringes. There are no adverse consequences with respect to reimbursement to the HH agency for providing the service in this manner.

If State law does not preclude a HH aide from pre-filling insulin syringes, but the HH agency chooses to send a nurse to perform only this task, the visit is reimbursed as if made by a HH aide.
Home Health Visits to a Blind Diabetic (NCD 290.1)

**NOTE:** As indicated, to qualify for home health benefits, a patient must require skilled nursing services on an intermittent basis or physical therapy or speech-language pathology. If a beneficiary does not qualify for home health benefits but only needs someone to prefill syringes with the correct dosage of insulin, then no program payment can be made.

### CPT/HCPCS Codes

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<th>Code</th>
<th>Description</th>
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<tr>
<td>G0154</td>
<td>Direct skilled nursing services of a licensed nurse (LPN or RN) in the home health or hospice setting, each 15 minutes</td>
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<tr>
<td>G0156</td>
<td>Services of home health/hospice aide in home health or hospice settings, each 15 minutes</td>
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<tr>
<td>T1021</td>
<td>Home health aide or certified nurse assistant, per visit (Not Covered by Medicare)</td>
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### References Included (but not limited to):

**CMS NCD**
NCD 290.1 Home Health Visit to a Blind Diabetic

**CMS Benefit Policy Manual**
Chapter 7; §20 Conditions To Be Met for Coverage of Home Health Services, §30 Conditions Patient Must Meet to Qualify for Coverage of Home Health Services, §40 Covered Services Under a Qualifying Home Health Plan of Care, §50 Coverage of Other Home Health Services

Chapter 15; §60.4.1 Definition of Homebound Patient Under the Medicare Home Health (HH) Benefit

**UnitedHealthcare Medicare Advantage Coverage Summaries**
Diabetes Management, Equipment and Supplies
Home Health Services and Home Health Visits

### History

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<th>Date</th>
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<td>01/22/2014</td>
<td>Administrative updates</td>
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<tr>
<td>09/06/2013</td>
<td>Administrative updates</td>
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<tr>
<td>07/18/2013</td>
<td>MRPC Review; no changes to content or codes</td>
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<tr>
<td>03/13/2013</td>
<td>Annual review for MRP Committee presentation; approved</td>
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<tr>
<td>04/27/2011</td>
<td>Administrative updates</td>
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