


MEDICAL POLICY	Definition: Confined to the Home
Effective Date: 7/1/2022  7/1/2022	Medical Policy Number: 183 Medical Policy Committee Approved Date: 9/14; 9/15; 5/16; 7/17; 2/18; 8/19; 5/2020; 06/2021; 6/2022
Medical Officer Date	

SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

APPLIES TO:

All lines of business

BENEFIT APPLICATION

Medicaid Members

Oregon: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Medical policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

POLICY CRITERIA

This policy is primarily based on the Centers for Medicare & Medicaid Services (CMS) definition of “confined to home.”¹ This CMS guidance was identified as of the last policy review date on 5/4/2022. Per the CMS Chapter 7 Benefits Manual, “confined to the home” is defined as the following:

- I. For a patient to be eligible to receive covered home health services under both Part A and Part B, the law requires that a physician or allowed practitioner certify in all cases that the patient is confined to his/her home. An individual shall be considered “confined to the home” (homebound) if **both** of the following criteria (1. and 2) are met:
 1. **Either** of the following criteria must be met:
 - a. Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence; **or**
 - b. Have a condition such that leaving his or her home is medically contraindicated.

And

2. **Both** of the following criteria must be met:
 - a. There must exist a normal inability to leave home; **and**
 - b. Leaving home must require a considerable and taxing effort.

Note:

If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive health care treatment. Absences attributable to the need to receive health care treatment include, but are not limited to:

- Attendance at adult day centers to receive medical care;
- Ongoing receipt of outpatient kidney dialysis; or
- The receipt of outpatient chemotherapy or radiation therapy.

Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a state, or accredited to furnish adult day-care services in a state, shall not disqualify an individual from being considered to be confined to his home. Any other absence of an individual from the home shall not so disqualify an individual if the absence is of an infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. It is expected that in most instances, absences from the home that occur will be for the purpose of receiving health care treatment. However, occasional absences from the home for nonmedical purposes, e.g., an occasional trip to the barber, a walk around the block or a drive, attendance at a family reunion, funeral, graduation, or other infrequent or unique event would not necessitate a finding that the patient is not homebound if the absences are undertaken on an infrequent basis or are of relatively short duration and do not indicate that the patient has the capacity to obtain the health care provided outside rather than in the home.

Some examples of homebound patients that illustrate the factors used to determine whether a homebound condition exists are listed below.

- A patient paralyzed from a stroke who is confined to a wheelchair or requires the aid of crutches in order to walk.
- A patient who is blind or senile and requires the assistance of another person in leaving their place of residence.
- A patient who has lost the use of their upper extremities and, therefore, is unable to open doors, use handrails on stairways, etc., and requires the assistance of another individual to leave their place of residence.
- A patient in the late stages of ALS or neurodegenerative disabilities. In determining whether the patient has the general inability to leave the home and leaves the home only infrequently or for periods of short duration, it is necessary (as is the case in determining whether skilled nursing services are intermittent) to look at the patient's

condition over a period of time rather than for short periods within the home health stay. For example, a patient may leave the home (meeting both criteria listed above) more frequently during a short period when the patient has multiple appointments with health care professionals and medical tests in 1 week. So long as the patient's overall condition and experience is such that he or she meets these qualifications, he or she should be considered confined to the home.

- A patient who has just returned from a hospital stay involving surgery, who may be suffering from resultant weakness and pain because of the surgery and; therefore, their actions may be restricted by their physician or allowed practitioner to certain specified and limited activities (such as getting out of bed only for a specified period of time, walking stairs only once a day, etc.).
- A patient with arteriosclerotic heart disease of such severity that they must avoid all stress and physical activity.
- A patient with a psychiatric illness that is manifested in part by a refusal to leave home or is of such a nature that it would not be considered safe for the patient to leave home unattended, even if they have no physical limitations.

The aged person who does not often travel from home because of frailty and insecurity brought on by advanced age would not be considered confined to the home for purposes of this reimbursement unless they meet one of the above conditions.

INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days' notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

REGULATORY STATUS

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

REFERENCES

1. Centers for Medicare & Medicaid Services. Medicare Benefit Policy Manual: Chapter 7 - Home Health Services, 30.1.1 - Patient Confined to the Home (Rev. 10738, Effective: 05-07-21). <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf>. Accessed 5/4/2022.