Home Health Care Services Fee Schedule Regulations
Title 8, California Code of Regulations
Division 1, Chapter 4.5
Subchapter 1 Administrative Director – Administrative Rules

Article 5.3 Official Medical Fee Schedule

§ 9789.90 Home Health Care - Definitions.

(a) "CMS" means the Centers for Medicare and Medicaid Services, a division of the United States Department of Health and Human Services.

(b) "Home care organization" means a business entity engaged in providing non-medical home health care services to injured workers in the home, including personal care and chore services, that must comply with the Home Care Services Consumer Protection Act of 2013 and be licensed as compliant with the Home Care Services Consumer Protection Act of 2013 by the California Department of Social Services.

(c) "Home health care agency" means a business entity engaged in providing home health care services that must be licensed by the California Department of Public Health and meet one of the following requirements: be Medicare-certified by CMS, or be accredited as a home health care agency by the Community Health Accreditation Partner (CHAP) or the Joint Commission on Certification and Accreditation.

(d) "Home health care services" includes the provision of medical and other health care services, including personal care and chore services, to the injured worker, in their place of residence, pursuant to the Medical Treatment Utilization Schedule (MTUS).

(e) "IHSS" means In-Home Supportive Services, a program of the State of California, the provisions of which are set forth in California Welfare & Institutions Code sections 12300-12330 except that the maximum hours provision of this program, set forth in Welfare & Institutions Code section 12300, subdivision (h)(3), can be exceeded for an injured worker based upon a showing of medical need, if reasonably required to cure or relieve the injured employee from the effects of his or her injury and prescribed by a licensed physician or surgeon, in accordance with Labor Code section 4600, subdivision (h).

(f) "Medicare" means a program of the United States government that provides payment for health care to elderly and disabled persons. The Centers for Medicare and Medicaid Services division of the Unites States Department of Health and Human Services provides this benefit program to eligible members of the public.

Authority: Sections 133, 4603.5, 5307.1, 5307.3 and 5307.8, Labor Code. Reference: Sections 4600, 5307.1, 5307.8 and 5307.11, Labor Code.

§ 9789.91 Home Health Care – Eligibility for Services & Payment.

(a) Home health care services shall be provided as medical treatment only if reasonably required to cure or relieve the injured worker from the effects of his or her injury and prescribed by a licensed physician and surgeon, in accordance with Labor Code section 4600, subdivision (h) and the Medical Treatment Utilization Schedule.

(b) Home health care services are subject to the utilization review and independent medical review processes set forth in Labor Code sections 4610 and 4610.5, *et seq.*

(c) At the outset of care, an in-home assessment of the injured worker's need for home health care shall be performed by a qualified registered nurse. Assessments of an injured worker's need for home health care shall be performed using CMS's OASIS (Outcome and ASsessment Information Set), a group of standard data elements used by CMS to assess patients' needs for home health care services, which is incorporated by reference (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/OASIS-C1-DataSets.html). When rehabilitation therapy service (speech language pathology, physical therapy, or occupational therapy) is the only service requested by the treating physician for the injured worker, the initial assessment may be made by the appropriate rehabilitation skilled professional (speech language pathologist, physical therapist, or occupational therapist).

(d) An employer or their insurer shall not be liable for any home health care services provided by the injured worker's spouse or other member of the injured worker's household, or other entity, if those home health care services were provided to the injured worker prior to the industrial injury. In addition, an employer or their insurer shall not be liable for home health care services provided more than fourteen (14) days prior to the date of the employer's or insurer's receipt of the physician's prescription or request for authorization for home health care services, pursuant to Labor Code section 4600, subdivision (h).

(e) This fee schedule does not cover family caregivers or individuals who are not employed by a home care organization or a home health care agency. However, a claims administrator and an injured worker may agree that the injured worker may use, and the claims administrator will pay for, an unregistered provider (who is not employed by a home care organization or home health care agency and who may be a family member of the injured worker), if the individual has the necessary skills to provide the home health care services needed by the injured worker.

Authority: Sections 133, 4603.5, 5307.1, 5307.3 and 5307.8, Labor Code. Reference: Sections 4600, 5307.1, 5307.8 and 5307.11, Labor Code.

§ 9789.92 Home Health Care – Payment Methodology & Billing Rules.

(a) The maximum allowable amounts (MAA) for home health care services are set forth in section 9789.93, Table A. In no case shall the MAA be lower than the then-current state or local minimum wage. The California workers' compensation home health care fee schedule operates on a fee for service basis.

(b)(1) Services shall be billed in fifteen (15) minute increments, with one unit of time being equal to fifteen (15) minutes. Except in the case where a per diem billing code is used, a visit by a home health care provider shall be for a minimum of four units, with additional time beyond the four unit visit billed in fifteen (15) minute increments. The four units may be for different services performed within the visit. For example, if only one service is performed during the visit, the provider would bill the four minimum units to the billing code for that service. However, if two, three or four services were provided during the initial hour of the visit, the provider would bill two, three or four codes, respectively, in relative proportion to the time spent on each service. No more than four services may be billed during a one hour visit.

(2) A per diem billing code is for a period consisting of an eight (8)-hour shift and must be used whenever the incremental rate for the number of hours worked in a day providing a particular service exceeds the per diem rate. For example, if five hours of nursing care at the incremental rate exceeds the per diem rate for nursing care, providers must use the per diem code rather than the 15-minute incremental billing code.

(3) Providers shall bill using the CMS 1500 form, which can be downloaded at the following link (http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS1188854.html), or the CMS 1450/UB-04 form which can be downloaded at the following link (http://www.nubc.org/subscriber/index.dhtml).

(c) Nothing in this section precludes an agreement for payment of home health care services, made between the provider and the insurer or claims administrator, regardless of whether such payment is less than, or exceeds, the fees set forth in this section.

Authority: Sections 133, 4603.5, 5307.1, 5307.3 and 5307.8, Labor Code.
Reference: Sections 4600, 5307.1, 5307.8 and 5307.11, Labor Code.