Clinical Policy: Home Visit by a Clinical Social Worker Expanded Benefit

Reference Number: FL.CP.MP.05
Effective Date: 11/25

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
This policy outlines the clinical criteria for home visit by a clinical social worker as an expanded benefit in home health or hospice settings for Sunshine Health's Managed Medical Assistance (MMA), HIV/AIDS, Long Term Care (LTC), and Serious Mental Illness (SMI)members.

Policy/Criteria

I. It is the policy of Sunshine Health that a home visit by a clinical social worker for members ≥ 21 years of age is considered **medically necessary** when one or more of the following criteria are met:
- A. The services are ordered by a physician and are directly related to an active treatment plan of care established by the physician;
- B. Member lives in the community and has a chronic illness and complex physical, behavioral health and/or psychosocial needs. For example, members with an active psychiatric diagnosis such as depression and anxiety, those who receive dialysis, and/or those that are homebound and isolated from typical social interactions and services;
- C. Functioning or symptom indicates risk of relapse in patient diagnosed with psychiatric disorder in partial remission, requiring assistance with linkage to community providers and other services as needed to mitigate readmission;
- D. Member has a high level of caregiver burden or has significantly limited support systems in the home and/or the community;
- E. An identified co-morbidity of a serious or chronic medical and psychiatric condition associated with home health or hospice. Member is in need of a palliative care social worker support to assist with assessment, counseling and coordination with local resources and agencies to provide relief from the symptoms, pain, and stress of a serious illness;
- F. Services are performed in the home or outside the home and/or hospice setting such as shelter, assisted living facility, group home, temporary lodging, custodial care facility.

II. It is the policy of Sunshine Health that the following documentation must be submitted with any **initial and/or subsequent** request:
- A. A problem focused history and examination including assessment of the following:
  1. Physical and behavioral health conditions and needs;
  2. Functional and cognitive deficits;
  3. Mental and emotional health;
  4. Psychosocial needs;
  5. Support systems in the home and community;
  6. Member strengths, limitations, and context.
- B. Proposed specific, measurable, achievable, relevant, and time bound (S.M.A.R.T.) initial treatment goals with expected completion dates;

C. Treatment goal updates at each concurrent review, and clinical notes from each visit;
D. A problem focused history, examination; and history of the member's medical decision making.

III. It is the policy of Sunshine Health that the member should be evaluated for discharge when one or more of the following criteria are met:
A. The member no longer meets criteria as defined above;
B. The member withdraws from treatment against advice;
C. The member is not an active participant or fails to make adequate progress toward treatment goals;
D. The member has mental health needs that are beyond the social worker's area of expertise; for example, the member requires a different level of treatment or more specialized treatment;
E. Treatment goals are achieved;
F. Lack of communication from the member.

IV. It is the policy of Sunshine Health that home visits by a clinical social worker as an expanded benefit are **not medically necessary** when one or more of the following criteria are met:
A. Member is < 21 years of age;
B. The coverage benefit limit has been exceeded (forty-eight (48) visits/fiscal year);
C. Services are custodial in nature, which are mainly to help the member with activities of daily living rather than provide therapeutic treatment.

Note: Members will have forty-eight (48) visits per fiscal year with prior authorization.

Background
A clinical social worker is a Master's level healthcare professional with expertise in addressing the member's needs through multidimensional consideration (i.e., available support systems, financial stressors, family history and ethnic/cultural beliefs). The primary goal of the clinical social worker is to assess the member and family's needs, provide available options and education, and focus on bridging care gaps by implementing a holistic approach tailored specifically to the individual and their life circumstances.

Coding Implications
This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description

HCPCS Codes	Description

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Original approval date		07/18
Annual review		05/19
Annual review; no changes		06/20
Annual review; no changes		07/21
Policy update; Added SMI product and Added Members will have Forty-eight (48) visits per year with prior authorization		11/21
Annual review; no changes		12/22
Transitioned policy to new state specific template and sent to market for approval; policy number changed from FL.UM.16.00 to FL.CP.MP.05	06/23	
Annual review; minor grammatical changes with no criteria changes		11/23
Annual review. "HIV/AIDS" to Description. References reviewed and updated.	11/25	

References

1. Agency for Health Care Administration. Statewide Medicaid Managed Care Expanded Benefits. https://ahca.myflorida.com/content/download/9113/file/Expanded-Benefits_Program_Highlight_Final_101618.pdf. Effective October 16, 2018. Accessed November 3, 2025.
2. Sterling MR, Dell N, Piantella B, et al. Understanding the Workflow of Home Health Care for Patients with Heart Failure: Challenges and Opportunities. *J Gen Intern Med*. 2020;35(6):1721 to 1729. doi:10.1007/s11606-020-05675-8
3. Singer AE, Goebel JR, Kim YS, et al. Populations and Interventions for Palliative and End-of-Life Care: A Systematic Review. *J Palliat Med*. 2016;19(9):995 to 1008. doi:10.1089/jpm.2015.0367

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.