Medical Necessity Guidelines: Extended Home Care Services

Effective: October 21, 2020

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	**Yes ☒ No ☐**

Applies to:

COMMERCIAL Products

☐ Tufts Health Plan Commercial products; Fax: 617.972.9409

☐ Tufts Health Freedom Plan products; Fax: 617.972.9409

- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

TUFTS HEALTH PUBLIC PLANS Products

☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax:888.415.9055

☐ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055

☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404

☐ Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304

*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

SENIOR Products

- Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan SCO Prior Authorization List
- Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

HOME HEALTH CARE OVERVIEW

Home health care is a wide range of health care services that can be provided in a Member's home to help treat an illness or injury. Examples of skilled services provided in the home are skilled nursing, physical therapy, occupational therapy, and speech-language pathology services. Home health aide (HHA) services can also be included, in conjunction with a skilled service, to provide hands-on personal care of the Member or care needed to maintain his or her health or to facilitate treatment of the Member's illness or injury.

For those patients whose medical condition requires more skilled care than can be provided during standard intermittent home care visits, extended home care services are utilized to deliver these medically necessary services and are provided in blocks (hours) as opposed to visits. They are intended for very medically fragile children and for members who have complex medical conditions or disabilities, and are used for the following purposes:

- Ongoing evaluation and assessment, with recommendations for care in the home
- Teaching and demonstration in the home, and
- Supplemental support to provide care to fulfill the medical care plan

In addition to the skilled services listed above, they may also include personal care services and homemaking services that are incidental to the Member's health care needs.

CLINICAL COVERAGE CRITERIA

Tufts Health Plan may authorize coverage of extended home care services when all of the following criteria are met:

- The services are ordered and directed by the treating practitioner or specialist (M.D., D.O., P.A., or N.P.), after a face-to-face evaluation by the physician, licensed or certified P.A. or N.P. *that has occurred within the last year*

- A letter of medical necessity and a written treatment plan must be submitted by the treating practitioner or specialist (M.D., D.O., P.A. or N.P.) along with *the request for specific services and equipment.*
- The member has complex medical condition(s) that significantly impact multiple body systems

Skilled Nursing Hours:
- Services are required on a continuous rather than intermittent basis (greater than 4 hours per day)
- Frequent reassessments and changes in treatment are required
- Private duty nursing (greater than 4 hours per day) must be clinically appropriate and not more costly than alternative health services
- Continuation of services require updated documentation *every 60 days* to support the need for ongoing care and treatment

The following categories are evaluated for care required and time required to complete the care, based on documentation submitted:
- Respiratory/cardiovascular status
- Medications/intravenous fluids/medications
- Nutritional needs
- Neurological status
- Elimination
- Skin care/wound care

Home Health Aid Hours:
- Scheduled in block hours and utilized to deliver medically necessary care which cannot be performed in a standard home health aid home care visit
- Authorization is based on medical necessity, which allows for personal care services to be performed by a licensed HHA to assist the member and/or caregiver in achieving a certain level of independence with activities of daily living (ADLs).

The following categories are evaluated for care required and time required to complete the care, based on documentation submitted:
- Member's weight, height and age
- Level of assistance needed with activities of daily living (eating, bathing, dressing, grooming)
- Mobility
- Number of hours primary caretaker is available
- Number of hours a day member attends school
- Elimination-continence status

The initial evaluation/assessment visit does not require prior authorization. Providers requesting authorization after the initial evaluation visit must submit a thoroughly completed Universal Health Plan Home Assessment (UHHA) Form to the appropriate fax number listed above.

Subsequent Requests
Requests for services beyond the initial authorization period must include the following:
- An updated Universal Health Plan Home Assessment (UHHA) Form
- Documentation of the member's current clinical status (to include the most current clinical notes), functional status, and the current plan of care
- The current level of services being requested

Refer to the Authorizations chapter of the Tufts Health Public Plans Provider Manual for specific authorization and notification requirements. Information on authorization and notification requirements is also available in the appropriate payment policies; these policies are available in the Provider Resource Center on the Tufts Health Plan website.

LIMITATIONS
- Respite care, relief care, and day care services are not covered
- Homemaking services are covered only if personal care services are covered for the Member
- Benefits for home care may vary by plan. Specific benefit coverage should be verified prior to initiating services by logging on to our website or by contacting Provider Services.

CODES
The following CPT code(s) require prior authorization after the initial evaluation visit:

Table 1: CPT Codes

CPT Code	Description
G0151	Services of physical therapist in home health setting, each 15 minutes
G0152	Services of occupational therapist in home health setting, each 15 minutes
G0153	Services of speech and language pathologist in home health setting, each 15 minutes
G0155	Services of clinical social worker in home health setting
G0156	Services of home health aide in home setting, each 15 minutes
G0157	Services performed by a qualified physical therapy assistant in the home health setting, each 15 minutes
G0158	Services performed by a qualified occupational therapy assistant in the home health setting, each 15 minutes
G0162	Skilled services by a registered nurse (RN) for management and evaluation of the plan of care; each 15 minutes
G0299	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes
G0300	Direct skilled nursing services of a license practical nurse (LPN) in the home health or hospice setting, each 15 minutes
G0493	Skilled services of a registered nurse (RN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting)
G0494	Skilled services of a licensed practical nurse (LPN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting)
G0495	Skilled services of a registered nurse (RN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes
G0496	Skilled services of a licensed practical nurse (LPN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes
T1000	Private duty/independent nursing service(s), licensed, up to 15 minutes
T1001	Nursing assessment/evaluation
T1002	RN services, up to 15 minutes
T1003	LPN/LVN services, up to 15 minutes
T1004	Services of a qualified nursing aide, up to 15 minutes
X0043	Home health nursing and therapy visits

REFERENCES

- Centers for Medicare and Medicaid Services, Internet Only Manuals, cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals; Publication 100-02, Benefit Policy Manual; Chapter 7, Home Health Services. Accessed May 23, 2016.
- Executive Office of Health and Human Services, State of Rhode Island. Medicaid Provider Manuals, Home Health Manual. Accessed December 15, 2016 at eohhs.ri.gov/ProvidersPartners/ProviderManualsGuidelines/MedicaidProviderManual/HomeHealth.aspx

APPROVAL HISTORY

January 11, 2017: Reviewed by the Integrated Medical Policy Advisory Committee (IMPAC), for an effective date of August 1, 2017.

Subsequent endorsement date(s) and changes made:

- July 20, 2017: Reviewed by IMPAC, renewed without changes
- October 10, 2018: Reviewed by IMPAC, renewed without changes
- October 2018: Template and disclaimer updated
- October 16, 2019: Reviewed by IMPAC, renewed without changes

- October 21, 2020: Reviewed by IMPAC, renewed without changes
- December 4, 2020: Fax number for Unify updated

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic