Medical Necessity Guidelines: Home Health 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 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.

CLINICAL COVERAGE CRITERIA

Tufts Health Plan may authorize coverage of intermittent home health care services when they are:

- Provided under a plan of care established by and periodically reviewed by a physician
- Skilled services (see definition below)
- Medically necessary and reasonable based on the Member's condition and accepted standards of clinical practice
- An integral part of treatment of the Member's medical condition and associated symptoms
- Provided to Members who are homebound (see definition below)

DEFINITIONS

Skilled services

- Services which require clinical training and must be provided or supervised by a licensed health care professional (e.g. registered nurse; licensed physical, speech, occupational therapist) in order to be delivered safely and effectively and to obtain a specified medical outcome.

Custodial Services

- Services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function, as opposed to improving that function.
- Services that do not require clinical training or supervision by licensed medical professionals in order to be delivered safely and effectively.

Homebound

- In order to be considered homebound, the Member's condition should be such that there exists a normal inability to leave the home and, consequently, leaving the home would require a considerable and taxing effort. If the Member leaves the home, he or she may be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or to receive medical treatment.

Note: For **Tufts Health Direct** plans, prior authorization is not required unless services are daily or until the Member has been receiving home care services for six months and requires continued services**.**

The initial skilled nursing (SN), and/or physical therapy (PT) home care assessment/evaluation visit does not require prior authorization for Tufts Health Plan members. Speech therapy, occupational therapy and/or social worker visit will require prior authorization for the initial evaluation when provided independently and not in conjunction with physical therapy or skilled nursing visits. Tufts Health Plan uses InterQual® criteria to determine medical necessity and to authorize home care services after the initial evaluation visit, or after six months of continuous services for Tufts Health Together and Tufts Health Direct plans. Providers requesting authorization after the initial evaluation visit must submit a thoroughly completed Universal Health Plan/Home Health Authorization Form (UHHA) along with evidence of homebound status to the appropriate fax number listed above.

Please consult the Tufts Health Plan Commercial Provider Manual or the Tufts Health Public Plans Provider Manual for authorization 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

Custodial services (see definition above)

Benefits for home care may vary by plan/group. 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 (as outlined above):

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, each 15 minutes (not applicable to Tufts Health Together)
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) in the delivery of management and evaluation of the plan 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)

CPT Code	Description
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)
G2168	Services performed by a physical therapist assistant in the home health setting in the delivery of a safe and effective physical therapy maintenance program, each 15 minutes
G2169	Services performed by an occupational therapist assistant in the home health setting in the delivery of a safe and effective occupational therapy maintenance program, each 15 minutes
S9470	Nutritional Counseling, dietitian visit
99501	Early Maternity Discharge Visit or Maternal Child Home Visit- Home visit for postnatal assessment and follow-up care (one visit only)
99211	Office or other outpatient visits for Evaluation and Management. A visit is up to 30 minutes
S5130	Homemaker service, NOS; per 15 minutes (applies to Tufts Health Freedom Plan Products only, per N.H. RSA 417-D-a.)

REFERENCES

1. 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.

APPROVAL HISTORY

September 14, 2016: Reviewed by the Integrated Medical Policy Advisory Committee (IMPAC)

Subsequent endorsement date(s) and changes made:

- December 14, 2016: Reviewed by IMPAC: Definitions added.
- December 31, 2016: Coding updated. Per AMA CPT®, effective December 31, 2016 the following code(s) deleted: G0163; and effective January 1, 2017 the following code(s) added: G0493, G0494.
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- June 14, 2017: Reviewed by IMPAC, renewed without changes
- October 10, 2018: Reviewed by IMPAC, renewed without changes
- October, 2018: Template and disclaimer updated
- December 3, 2018: 2018.2 InterQual® upgrade for Tufts Health Commercial products including Freedom. Effective December 17, 2018, InterQual® upgrade is effective for Tufts Health Direct and Tufts Health Together. Effective January 14, 2019, InterQual® upgrade for Tufts Health RITogether.
- June 19, 2019: Reviewed by IMPAC, this MNG no longer applicable to Tufts Health Together, Tufts Health RITogether, and Tufts Health Unify, there is a separate MNG for Home Care Services for those plans effective 7/1/2019; references to Tufts Health Together, Tufts Health RITogether, and Tufts Health Unify removed from this guideline.
- October 16, 2019: Reviewed by IMPAC, renewed without changes
- April 1, 2020: Coding updated. Per AMA CPT®, effective April 1, 2020 the following code(s) added: G2168, G2169.
- April 3, 2020: Fax number for Unify update
- October 21, 2020: Reviewed by IMPAC, renewed without changes

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.