Medical Necessity Guidelines: In-Home Palliative 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.

PALLIATIVE CARE OVERVIEW

Palliative care is a specialized form of medical care focused on helping patients feel relief from the pain, symptoms, and emotional distress caused by a serious illness or its treatment. The goal of palliative care is to improve how a patient functions each day as well as improve his or her quality of life throughout the course of a serious illness, whether that illness is curable, chronic, or life-threatening. It can offer an extra layer of support, and can be provided as the main goal of care or along with treatments meant to cure. Palliative care services can be appropriate at any age or at any time during a person's illness, and can be provided in a variety of settings, including the home.

CLINICAL COVERAGE CRITERIA

Tufts Health Plan may authorize coverage of intermittent palliative care services in the home when they are:

- Provided under a plan of care established by and periodically reviewed by a physician
- 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

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 will use InterQual criteria to determine medical necessity and to authorize services after the initial evaluation visit. Providers requesting authorization after the initial evaluation visit must submit a thoroughly completed Universal Health Plan/Home Health Authorization Form (UHHA) to the appropriate fax number listed above. Please refer to the Home Health and In-Home Palliative Care Payment Policy for further authorization requirements.

Note: For palliative care services, evidence of homebound status is not required.

In addition to the UHHA, the requesting provider must also provide documentation of a discussion between the Member and his or her provider during which palliative care was discussed and agreed to by the Member. (Discussions with home care agency staff do not fulfill this requirement.) Updated documentation of ongoing discussions regarding palliative care status will be required every 6 months.

LIMITATIONS

Benefits for home care/palliative 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
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)
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)
S9470	Nutritional counseling, dietitian visit
99211	Office or other outpatient visits for evaluation and management. A visit is up to 30 minutes

The following ICD-10 code(s) is used to distinguish palliative care services:

Code	Description
Z51.5	Encounter for palliative care

REFERENCES

1. Centers for Medicare and Medicaid Services, Internet Only Manuals, cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html; Publication 100-02, Benefit Policy Manual; Chapter 7, Home Health Services. Accessed May 23, 2016.
2. U.S. National Library of Medicine, medlineplus.gov/palliativecare.html. Accessed May 23, 2016.

APPROVAL HISTORY

July 20, 2016: Reviewed by the Integrated Medical Policy Advisory Committee (IMPAC), effective October 1, 2016.

Subsequent endorsement date(s) and changes made:

- 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
- 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