Home Health and In-Home Palliative Care Payment Policy

The following payment policy applies to Tufts Health Plan contracted home health care providers including providers who render palliative care services in the home. This policy applies to Commercial\(^1\) products (including Tufts Health Freedom Plan). For Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options, click here.

In addition to the specific information contained here, providers must adhere to the policy information outlined in the professional payment policies for Commercial and Tufts Medicare Preferred HMO/Tufts Health Plan SCO products, located in the Provider Resource Center or on the Payment Policies page.

**Note:** Audit and disclaimer information is located at the end of this document.

### POLICY

Tufts Health Plan covers medically necessary home health and in-home palliative care services, as described below.

### GENERAL BENEFIT INFORMATION

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to our secure Provider website or by contacting Provider Services.

The home health care provider is responsible for verifying a member’s eligibility and benefit coverage before treatment services are rendered. If services are requested after hours, verification and authorization must be obtained on the next business day. Requests for continued authorization of services are the responsibility of the provider and must be made at least two business days prior to the end of the current authorization. Refer to the Home Care Prior Authorization Review Workflow below for more information.

### AUTHORIZATION REQUIREMENTS

Referrals are not required for home health care services. However, a provider’s order is required.

Prior authorization is required for:
- Speech therapy, occupational therapy and social work only when provided independently and not in conjunction with physical therapy or skilled nursing visits.
- Palliative care services provided in the home. Refer to the In-Home Palliative Care section below for more information.

Prior authorization is not required for the initial skilled nursing and/or physical therapy home care assessment/evaluation visit.

**CareLink\(^{SM}\):** Refer to the CareLink\(^{SM}\) Prior Authorization List for a list of procedures, services and items requiring prior authorization for CareLink members.

**Prenatal Homemaker Services – Tufts Health Freedom Plan products only**

Tufts Health Freedom Plan covers medically necessary prenatal homemaker services\(^2\) when a woman is confined to bedrest or her activities of daily living are otherwise restricted on the recommendation of her attending health care provider. Homemaker services are also covered postpartum as determined by the attending health care provider.

### HOME CARE PRIOR AUTHORIZATION REVIEW WORKFLOW

All post-evaluation visits require prior authorization.

To request prior authorization, the home care provider must complete an initial evaluation visit (provider order is required), and **within two business days** following the evaluation visit, fax a legible Universal Health Plan/Home Health Authorization Form (UHHA) form to Tufts Health Plan's Precertification Operations Department at 617.972.9409.

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\(^1\) Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink\(^{SM}\) when Tufts Health Plan is the primary administrator.

\(^2\) Per N.H. RSA 417-D-a
On the UHHA form, the home care provider must document initial evaluation results, evidence of homebound status, individualized member goals and plan of care, and each discipline and the number and duration of visits needed. Refer to the Guidelines for Completing the UHHA Form for more information. All fields must be thoroughly and accurately completed.

To find the delegated care manager (DCM) responsible for care management and authorization reviews for HMO members, refer to the Commercial Delegated Care Manager Assignment List.

Based on Tufts Health Plan data, it is anticipated that goals can usually be met in 30 or fewer days. In certain circumstances, Tufts Health Plan may authorize coverage of an initial 30 day period.

**SUBSEQUENT/ONGOING VISITS**

For ongoing requests beyond the initial coverage period, submit the UHHA form with the following information:

- Clearly identified goals that were and were not met for each discipline
- Progress made toward unmet goals
- Barriers identified that will impact the member’s ability to meet unmet goals
- The plan to address those barriers, including follow up with the attending provider
- Anticipated number of visits needed to meet goals

All subsequent/ongoing requests must be submitted at least two business days prior to the coverage period end date (or before the last visit, whichever is sooner) to prevent a gap in coverage.

The Precertification Operations Department will review the request and make a determination within two business days of receipt. Approvals are faxed to the provider within two business days of request. Pending requests are forwarded for medical director review/determination. MD denials are communicated via telephone and a letter mailed to the provider within one business day of communication.

**LACK OF INFORMATION**

UHHA forms that are not filled out completely (e.g., omission of defined medical goals and plan of care) are rejected for lack of information. In rare circumstances, you may be asked to provide the information in a shorter timeframe. Tufts Health Plan reserves the right to deny coverage of services when the provider fails to submit required clinical information.

**IN-HOME PALLIATIVE CARE**

Palliative care is a specialized form of medical care focused on helping members feel relief from the pain, symptoms and emotional distress caused by a serious illness or the treatment of a serious illness. The goal is to improve how a patient functions each day, and improve his or her quality of life throughout the course of a serious illness. Palliative care can offer an extra layer of support, and can be provided as the main goal of care or in conjunction with treatments meant to cure. Palliative care services can be appropriate at any age or at any time during a person's illness.

Tufts Health Plan may authorize coverage of intermittent in-home palliative care services 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

Tufts Health Plan will use InterQual® criteria to determine medical necessity and to authorize services after the initial evaluation visit. For more information on in-home palliative care services, refer to the Medical Necessity Guidelines for In-Home Palliative Care Services.

The ICD-CM diagnosis code **Z51.5** (encounter for palliative care) is used to distinguish palliative care services. Providers should use Z51.5 when billing palliative care services in accordance with the applicable financial exhibits of their provider agreements.

In addition to the Universal Health Plan/Home Health Authorization (UHHA) form, the requesting provider must provide documentation of a discussion between the member and his/her provider during which palliative care was discussed and agreed upon by the member. Documentation of a new discussion should be submitted every six months with the prior authorization request.

**Note:** Discussions with home care agency staff do not fulfill this requirement.
BILLING INSTRUCTIONS
• Submit only the home health care revenue codes 0550-0599 when billing in HIPAA-compliant 837I format.
• Submit only the procedure codes listed in the table as described in the provider agreement.

The following procedure codes are applicable for home health services:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0151*</td>
<td>Services of physical therapist in home health setting, each 15 minutes**</td>
</tr>
<tr>
<td>G0152*</td>
<td>Services of occupational therapist in home health setting, each 15 minutes**</td>
</tr>
<tr>
<td>G0153*</td>
<td>Services of speech and language pathologist in home health setting, each 15 minutes**</td>
</tr>
<tr>
<td>G0155*</td>
<td>Services of clinical social worker in home health setting, each 15 minutes **</td>
</tr>
<tr>
<td>G0156*</td>
<td>Services of home health aide in home setting, each 15 minutes</td>
</tr>
<tr>
<td>G0157*</td>
<td>Services performed by a qualified physical therapy assistant in the home health setting, each 15 minutes</td>
</tr>
<tr>
<td>G0158*</td>
<td>Services performed by a qualified occupational therapy assistant in the home health setting, each 15 minutes</td>
</tr>
<tr>
<td>G0162*</td>
<td>Skilled services by a registered nurse (RN) in the delivery of management and evaluation of the plan care, each 15 minutes</td>
</tr>
<tr>
<td>G0163*</td>
<td>Skilled services of a licensed nurse (LPN or RN) for the observation and assessment of the patient's condition, each 15 minutes</td>
</tr>
<tr>
<td>G0299*</td>
<td>Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes</td>
</tr>
<tr>
<td>G0300*</td>
<td>Direct skilled nursing services of a license practical nurse (LPN) in the home health or hospice setting, each 15 minutes</td>
</tr>
<tr>
<td>S9470</td>
<td>Nutritional counseling, dietitian visit</td>
</tr>
<tr>
<td>S9123</td>
<td>RN private duty nursing - nursing care, in the home; by a registered nurse, per hour</td>
</tr>
<tr>
<td>S9124</td>
<td>LPN private duty nursing- nursing care, in the home; by licensed practical nurse, per hour</td>
</tr>
<tr>
<td>99501</td>
<td>Early maternity discharge visit or maternal child home visit- home visit for postnatal assessment and follow-up care (one visit only)</td>
</tr>
<tr>
<td>99211</td>
<td>Office or other outpatient visits for evaluation and management. A visit is up to 30 minutes</td>
</tr>
<tr>
<td>S5130*3</td>
<td>Homemaker service, NOS; per 15 minutes</td>
</tr>
</tbody>
</table>

* Indicates a visit should be billed in increments of 15 minutes. For example, a one hour home health aide visit will be billed as four units.

** Indicates a visit is up to two hours. An authorized visit should be billed as eight units.

The ICD-CM diagnosis code Z51.5 (encounter for palliative care) is used to distinguish palliative care services. Providers should use Z51.5 when billing palliative care services in accordance with the applicable financial exhibits of their provider agreements.

Additional Home Health Services
1. Office visits are allowed at the home health care office for simple medical procedures when no other option is available. Situations that qualify for payment of office visits at the home health care agency include:
   • Services that require skilled intervention that member/caregiver are unable to provide.
   • Member is not homebound.
   • Member has no other available option for provision of skilled service.
   • No other services are being provided in the home by the home health care agency.
2. Prior authorization is not required for early maternity discharge and maternal child home visits. Coverage is for either one of the two home visits listed below. Prior authorization is required for any additional visits for these services.
   a. Early maternity discharge visits must be made within 48 hours of discharge from the hospital. This visit should be billed one time only under the mother’s name and is subject to the limitations of the applicable state mandate.
   b. Maternal child home visits must be made within 48 hours of discharge from the hospital. This visit should be billed one time only under the mother’s name. It is the responsibility of the provider to verify that a member is covered for the maternal child home visit benefit prior to performing the visit.

3. All home health care services include certain incidental supplies. Commonly used incidental supplies that are not separately reimbursed include, but are not limited to:

   - Adhesive bandage strips
   - Blood pressure cuff
   - Cartridge for finger stick clotting time
   - Clean gowns
   - Eye shields
   - Non-sterile gloves
   - Saline
   - Scissors
   - Sterile q-tips
   - Routine dressings
   - Sterile q-tips
   - Stethoscope
   - Suture removal kits
   - Tape
   - Tongue depressors

   **Note:** All other medical supplies, such as for complex wound care or DME, must be obtained from a Tufts Health Plan participating DME provider and may require prior authorization by Tufts Health Plan.

**ADDITIONAL RESOURCES**

[Durable Medical Equipment Payment Policy](#)

**DOCUMENT HISTORY**

- January 2017: Template updates
- August 2016: Added in-home palliative care services effective October 1, 2016
- July 2016: Reviewed by committee; template changes
- January 2016: Added S2130 for Tufts Health Freedom Plan products, replaced G0154 and G0299 with G0300; template updates
- September 2015: Template updates
- January 2014: Review process clarified, template updates
- September 2013: Template conversion
- May 2103: Policy reviewed, minor content changes, template updates
- January 2013: Template updates
- April 2012: Template updates.
- March 2012: Updated CareLink disclaimer language
- July 2010: Reviewed document for clarity
- August 2009: Added link to new home care prior authorization workflow, effective October 1, 2009.
- February 2008: Added Home Care Prior Authorization Review Workflow and revised general benefit information
- March 2000: Policy created

**AUDIT AND DISCLAIMER INFORMATION**

Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, Tufts Health Plan will expect your office/facility to refund all payments related to non-compliance. For more information about Tufts Health Plan’s [audit policies](#), refer to our website.

This policy provides information on Tufts Health Plan claims adjudication processing guidelines. As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.
This policy does not apply to Tufts Medicare Preferred HMO, Tufts Health Plan Senior Care Options, Tufts Health Public Plans or the Private Health Care Systems (PHCS) network (also known as Multiplan). This policy applies to CareLink for providers in the Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna’s provider agreements with respect to CareLink members.