Home Health and In-Home Palliative Care Services Payment Policy

Applies to the following Tufts Health Plan products:

- ☒ Tufts Health Plan Commercial (including Tufts Health Freedom Plan)¹
- ☐ Tufts Medicare Preferred HMO (a Medicare Advantage product)²
- ☐ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)²

The following payment policy applies to Tufts Health Plan contracting home health care providers, including providers who render palliative care services in the home for Commercial members. For Senior Products, click here. For Tufts Health Public Plans, click here.

In addition to the specific information contained in this policy, providers must adhere to the information outlined in the Professional Services and Facilities Payment Policy.

**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, in accordance with the member’s benefits.

**Prenatal Homemaker Services - Tufts Health Freedom Plan products**

Tufts Health Freedom Plan covers medically necessary prenatal homemaker services³ 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.

**Maternity Services**

Tufts Health Plan covers one early maternity discharge or one maternal child home visit. Visits should be made within 48 hours of discharge from the hospital and are subject to the limitations of the applicable state mandate.

### 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 the secure Provider portal or by contacting Commercial Provider Services.

Members must be homebound to receive home health care services.

If services are requested after hours, verification and authorization must be obtained on the next business day.

### REFERRAL/PRIOR AUTHORIZATION/NOTIFICATION REQUIREMENTS

Certain procedures, items and/or services may require referral and/or prior authorization. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that prior authorization has been obtained.

Speech therapy, occupational therapy and/or social worker visits require prior authorization for the initial evaluation when provided independently and not in conjunction with physical therapy or skilled nursing visits. Refer to the Habilitative and Rehabilitative: Physical, Occupational and Speech Therapy Professional Payment Policy for additional information.

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¹ Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLinkSM when Tufts Health Plan is the primary administrator.
² Tufts Medicare Preferred and Tufts Health Plan SCO are collectively referred to in this payment policy as Senior Products.
³ Per N.H. RSA 417-D-a
Refer to the CareLink™ Prior Authorization List for a list of procedures, services and items requiring prior authorization for CareLink members.

**Initial Evaluation**
A provider’s order is required for home health care services and in-home palliative care. The initial skilled nursing and/or physical therapy home care assessment/evaluation visit does not require prior authorization; however, all post-evaluation visits require prior authorization.

**Post-Evaluation Visits**
Prior authorization is required for all home health care services and in-home palliative care beyond the initial assessment/evaluation visit. Refer to the Home Health Care Services Medical Necessity Guidelines or In-Home Palliative Care Medical Necessity Guidelines for additional information.

**Subsequent/Ongoing Visits**
For ongoing requests beyond the initial coverage period, fax the UHHA form 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. Denials are communicated via telephone and a letter is faxed to the provider within one business day of communication.

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

**BILLING INSTRUCTIONS**
Unless otherwise stated, Tufts Health Plan follows industry standard coding guidelines. Refer to current industry standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules. For more information, refer to the Professional Services and Facilities Payment Policy.

Use of noncontracting labs may have the unintended consequence of subjecting the member to unnecessary services not ordered by the treating provider or other unreasonable financial exposure. In such circumstances, Tufts Health Plan may hold the ordering provider accountable for any inappropriate behavior on the part of the nonparticipating lab that has been selected.

- Submit ICD-CM code Z51.5 (encounter for palliative care) when billing palliative care services
- Early maternity discharge visits and maternal child home visits should be billed one time only under the mother’s name

**COMPENSATION/REIMBURSEMENT INFORMATION**
Providers are compensated according to the applicable contracted rates and applicable fee schedules, regardless of the address where the service is rendered. For more information, refer to the Professional Services and Facilities Payment Policy.

**Additional Home Health Services**
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 but are not limited to:

- Services requiring skilled intervention that caregivers are unable to provide
- Member is not homebound 4
- 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.

Note: All home health care services include certain commonly used incidental supplies that are not compensated separately, such as routine dressings, sterile Q-tips, and nonsterile gloves. All other medical supplies, such as for complex wound care or DME, must be obtained from a Tufts Health Plan

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4 Applies to palliative care services only.
participating DME provider and may require prior authorization by Tufts Health Plan. Refer to the Durable Medical Equipment and Medical Supplies Payment Policy for additional information.

**Nursing Care Services**
Tufts Health Plan does not routinely compensate for S9123 (nursing care, in the home; by registered nurse, per hour [general nursing care only, not to be used when CPT codes 99500-99602 can be used]) if billed with 99500-99602 (home health procedures/services).

**Physician Certification for Home Health Service**
Tufts Health Plan does not routinely compensate physician recertification for home health services (G0179) if billed more than once every two months.

**ADDITIONAL RESOURCES**
- Durable Medical Equipment and Medical Supplies Payment Policy
- Habilitative and Rehabilitative: Physical, Occupational and Speech Therapy Professional Payment Policy
- Home Health Care Services Medical Necessity Guidelines
- In-Home Palliative Care Medical Necessity Guidelines

**DOCUMENT HISTORY**
- March 2021: Reviewed by committee; streamlined prior authorization requirements; removed codes and referred to provider agreements; added boiler plate language and previously communicated edits
- April 2019: Clarified existing notification process for home care services
- June 2018: Template updates
- February 2018: Policy reviewed by committee; revised incidental supplies language; clarified member homebound status requirement for palliative care services; clarified billing instructions for palliative care
- 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, removed G0154 and replaced with G0299 and G0300; template updates

**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 a provider/facility did not comply with this payment policy, Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance. For more information about Tufts Health Plan’s audit policies, refer to the Provider website.

This policy provides information on Tufts Health Plan claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication 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 requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the Tufts Health Plan products, as identified in the checkboxes on the first page, and to CareLinkSM for providers in 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. This policy does not apply to the Private Health Care Systems (PHCS) network (also known as Multiplan). Tufts Health Plan reserves the right to amend a payment policy at its discretion.