Home Health and In-Home Palliative Care 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)
- ☐ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)

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 Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options, 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 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.

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 website or by contacting Commercial 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.

AUTHORIZATION REQUIREMENTS

Home Health Care

Initial Evaluation

A provider's order is required for home health care services. 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.

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.

Note: Refer to the CareLink℠ Prior Authorization List for a list of procedures, services and items requiring prior authorization for CareLink members.

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[1] Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink℠ when Tufts Health Plan is the primary administrator.
[2] Per N.H. RSA 417-D-a

Post-Evaluation Visits
Prior authorization is required for all home health care services beyond the initial assessment/evaluation visit. To request prior authorization, the home care provider must fax a completed Universal Health Plan/Home Health Authorization Form (UHHA) to Tufts Health Plan's Precertification Operations Department at 617.972.9409 **within two business days** following the evaluation visit.

The home health care notification coverage period may span 30 days. Based on Tufts Health Plan data, it is anticipated that goals can usually be met in 30 days or less. Refer to the Home Health Care Services 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 mailed 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.

Maternity Visits
Prior authorization is not required for the visit; however, authorization is required for any additional visits.

In-Home Palliative Care
Prior authorization is required for in-home palliative care services. In addition to the 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. Refer to the Medical Necessity Guidelines for In-Home Palliative Care for more information.

BILLING INSTRUCTIONS

- Submit revenue codes 0550-0599 when billing in HIPAA-compliant 837I format
- Submit the procedure codes listed in the table below, as described in the provider agreement
- 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

The following procedure codes are applicable for home health services:

Code	Description
G0151	Services of physical therapist in home health setting, each 15 minutes (max. 8 units)
G0152	Services of occupational therapist in home health setting, each 15 minutes (max. 8 units)
G0153	Services of speech and language pathologist in home health setting, each 15 minutes (max. 8 units)
G0155	Services of clinical social worker in home health setting, each 15 minutes (max. 8 units)
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 (max. 8 units)
G0158	Services performed by a qualified occupational therapy assistant in the home health setting, each 15 minutes (max. 8 units)

Code	Description
G0162	Skilled services by a registered nurse (RN) in the delivery of management and evaluation of the plan care, each 15 minutes (max. 8 units)
G0299	Direct skilled nursing services of RN in the home health or hospice setting, each 15 minutes (max. 8 units)
G0300	Direct skilled nursing services of LPN in the home health or hospice setting, each 15 minutes (max. 8 units)
G0493	Skilled services of RN for the observation and assessment of the patient's condition, each 15 minutes
G0494	Skilled services of a LPN for the observation and assessment of the patient's condition, each 15 minutes
S9470	Nutritional counseling, dietitian visit
S9123	RN private duty nursing - nursing care, in the home, per hour
S9124	LPN private duty nursing- nursing care, in the home, per hour
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 E&M (up to 30 minutes)
S5130	Homemaker service, NOS; each 15 minutes[3]

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 participating DME provider and may require prior authorization by Tufts Health Plan.

ADDITIONAL RESOURCES

Durable Medical Equipment Payment Policy

DOCUMENT HISTORY

- 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
- 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
- May 2012: Added procedure codes G0157, G0158, G0162 and G0163, effective April 1, 2012.

[3] Applies to Tufts Health Freedom Plan products only, per N.H. RSA 417-D-a.
[4] Applies to palliative care services only.

- April 2012: Template updates.
- March 2012: Updated CareLink disclaimer language
- July 2010: Reviewed document for clarity
- October 2009: Updated home care prior authorization workflow effective October 1, 2009.
- 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 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 CareLink℠ 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.