Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options
Home Health Care Payment Policy

The following payment policy applies to Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options (SCO) contracted home health care providers. For information on Commercial, 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 Medicare Preferred HMO covers medically necessary skilled home health care services for homebound members.

Tufts Health Plan SCO covers medically necessary home health care services for homebound and non-homebound members.

Note: This policy does not apply to home health care program services provided to members through the Aging Services Access Point (ASAP) provider network. ASAP providers should contact Provider Relations for relevant information.

**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 website or by contacting Provider Relations.

Note: There is no member responsibility for Tufts Health Plan SCO members.

**NOTIFICATION REQUIREMENTS**

Prior notification is required for all home health care services. The home health care provider is responsible for verifying a member’s eligibility and benefit coverage, and submitting the required notification to Tufts Health Plan. Notifications must be submitted after the initial evaluation and assessment, but before continued services are rendered.

Submission of notification of the continued need for home health care services beyond the initial notification period is the responsibility of the home health care provider and must be made at least two business days prior to the end of the current notification period. Refer to the home health care notification workflow below for more information.

**NOTIFICATION WORKFLOW**

**Initial Evaluation Visit**

Prior notification is not required for the initial home health care assessment and evaluation visit. Effective January 1, 2017, Tufts Health Plan requires improved comprehensive medication reconciliation documentation for all Tufts Medicare Preferred HMO and Tufts Health Plan SCO members. Refer to the Comprehensive Medication Reconciliation Guidelines for more information.

**Post Evaluation Visits**

Prior notification is required for all visits before services are rendered.

To submit prior notification, the contracting Tufts Health Plan home health care provider must complete an initial evaluation visit (provider order is required), and within two business days of the evaluation visit, must fax a completed Universal Health Plan/Home Health Authorization Form (UHHA) to the care manager. The form must include the following information:

- Initial evaluation results, evidence of homebound status (if applicable) and individualized member goals and plan of care
- Number of visits needed and duration

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1 For information on how to fill out the form, refer to the guidelines for completing the UHHA form.
Note: 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. Care managers may contact the home health care provider if additional information is needed.

Subsequent/Ongoing Visits
For ongoing notification beyond the initial coverage period, documentation must be submitted on the UHHA form with the following information:

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

Note: When any barriers to progress are identified, documentation of provider follow-up is required.

To prevent a gap in notification, all subsequent/ongoing notifications must be submitted at least two business days prior to the coverage period end date or before the last visit, whichever is sooner. Tufts Health Plan reserves the right to deny coverage of services when the provider fails to submit the required notification prior to ongoing services being rendered.

Discharge Summary
When members are being discharged from service, submit a discharge summary or UHHA form within two business days following the discharge from home health care services that includes the number of visits provided, date of last visit and patient disposition for each discipline. Include the date that the Notice of Medicare Non-Coverage (NOMNC) was delivered to the member. Tufts Health Plan reserves the right to deny payment of services when the provider fails to submit the discharge summary and required clinical information.

Lack of Information
UHHA forms that are not filled out completely will be rejected for lack of information. Tufts Health Plan must receive clinical information in a timely manner, generally no later than noon on the next business day following the notification submission. However, in rare circumstances, you may be asked to provide the information in a shorter timeframe.

DME and Supplies
All other authorized medical supplies, such as supplies for wound care or standard DME, must be obtained from a Tufts Medicare Preferred HMO or Tufts Health Plan SCO-participating DME provider, as determined by the care manager or PCP, and may require prior authorization by and/or prior notification to Tufts Health Plan.

BILLING INSTRUCTIONS

- Submit only the Home Health Care Revenue Codes 0420-0449 and 0550-0599 when billing in 837I format or on a UB-04 form only; revenue codes may not impact reimbursement and are used to determine place of service only.
- Submit CPT procedure code 1111F in conjunction with G0299 in a distinct CPT procedure code field, on a separate claim line to denote medication reconciliation
- Submit a Health Insurance Prospective Payment System (HIPPS) and treatment authorization code from the OASIS assessment on all home health care claims. The line item date of service of the line reporting the HIPPS code must match the earliest dated home health visit line. All service units on the HIPPS code lines must be greater than zero. For Tufts Health Plan SCO, this information is only required when members meet Medicare criteria for coverage.
- Submit the following HCPCS codes on home health care claims to report location where home health services were provided. These HCPCS codes will not impact reimbursement and are for informational purposes only. The line item date of service of the line reporting the Q5001, Q5002 or Q5009 must match the earliest dated home health visit line.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>Q5001</td>
<td>Hospice or home health care provided in patient’s home/residence</td>
</tr>
<tr>
<td>Q5002</td>
<td>Hospice or home health care provided in assisted living facility</td>
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</tbody>
</table>
Q5009  Hospice or home health care provided in a place not otherwise specified (NOS)

The following procedure codes are applicable for home health care services:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
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<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 licensed practical nurse (LPN) in the home health or hospice setting, each 15 minutes*</td>
</tr>
<tr>
<td>99211</td>
<td>Office or other outpatient visit for evaluation and management. A visit is up to 30 minutes.</td>
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</tbody>
</table>

Note: Asterisk (*) indicates a visit is up to two hours. An authorized visit should be billed as 8 units.

Home health aide visits should be billed in increments of 15 minutes. For example, a one-hour home health aide visit will be billed for 4 units.

Clarification of Home Health Services
All home health care services include, but are not limited to, the following incidental supplies:

- Adhesive bandage strips
- Blood pressure cuff
- Cartridge for finger stick clotting time
- Clean gowns
- Eye shields
- Nonsterile gloves
- Saline
- Scissors
- Sterile Q-Tips®
- Steri-Strips™
- Stethoscope
- Suture removal kits
- Tape
- Tongue depressors

ADDITIONAL RESOURCES
Durable Medical Equipment Payment Policy

DOCUMENT HISTORY
- January 2017: Template updates
- April 2016: Added Tufts Health Plan SCO product; replaced G0154 with G0299-G0300; clarified notification language; updated billing instructions to include additional required codes
- September 2015: Template conversion
- May 2013: Template updates
- May 2012: Added procedure codes G0157, G0158, G0162 and G0163, effective April 1, 2012
- March 2011: Reviewed document for clarity; no content changes made
- January 2010: Removed references to the Tufts Medicare Preferred PPO product
- October 2009: Removed old home care prior authorization workflow and replaced with new workflow effective October 1, 2009
- August 2009: Moved Tufts Medicare Preferred information to its own document and added a link to the revised home care prior authorization review workflow effective October 1, 2009
- February 2008: Added Home Care Prior Authorization Review Workflow
- November 2007: Added Tufts Medicare Preferred lack of information content

Revised 01/2017
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 Medicare Preferred HMO and Tufts Health Plan Senior Care Options 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, adherence to plan policies and procedures and claims editing logic.