Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options
Home Health 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, as well as noncontracting providers outside of the network who have been authorized to render services by the applicable care manager. For information on Commercial products, click here.

In addition to the specific information contained here, providers must adhere to the policy 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 skilled home health care services for homebound members, in accordance with the member's benefits.

Note: This policy does not apply to home health care program services provided to members through the Aging Services Access Points (ASAP) provider network. ASAP providers should contact Senior Products 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 the secure Provider website or by contacting Senior Products Provider Relations.

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

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.

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.

NOTIFICATION REQUIREMENTS

Initial Evaluation
A provider order is required for the initial home health care assessment/evaluation visit.

Post-Evaluation Visits
Prior notification is required for all home health care services beyond the initial assessment/evaluation visit. To submit prior notification, the home health care provider must fax a completed Universal Health Plan/Home Health Authorization Form (UHHA) to the care manager within two business days of the evaluation visit.

Refer to the Tufts Medicare Preferred HMO Care Management List or contact Senior Products Provider Relations for Tufts Health Plan SCO members to find the appropriate care manager.

¹ Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLinkSM when Tufts Health Plan is the primary administrator.
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.

Subsequent/Ongoing Visits
For ongoing requests beyond the initial coverage period, providers should 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.

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, including the number of visits provided, date of last visit and patient disposition for each discipline. Include the date that the Notice of Medicare Noncoverage (NOMNC) was delivered to the member. Tufts Health Plan reserves the right to deny payment of services if the provider fails to submit the discharge summary and required clinical information.

Note: 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, providers 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 the required information.

BILLING INSTRUCTIONS
- Submit a Health Insurance Prospective Payment System (HIPPS) and treatment authorization code from the Outcome and Assessment Information Set (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.
  
  Note: For Tufts Health Plan SCO, this information is only required when members meet Medicare criteria for coverage.

- 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 compensation 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, if applicable.

- Submit the following HCPCS codes on home health care claims to report location where home health services were provided. These codes do not impact compensation 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>Code</th>
<th>Description</th>
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</thead>
<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>
</tr>
<tr>
<td>Q5009</td>
<td>Hospice or home health care provided in a place not otherwise specified (NOS)</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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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>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</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>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>G0493*</td>
<td>Skilled services of a registered nurse (RN) for the observation and assessment of the patient's condition, each 15 minutes</td>
</tr>
<tr>
<td>G0494*</td>
<td>Skilled services of a licensed practical nurse (LPN) for the observation and assessment of the patient's condition, 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>
</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.

** Visit may be billed in increments of 15 minutes up to a maximum of two hours (8 units)

**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
- Tufts Health Plan SCO Notification List

**DOCUMENT HISTORY**
- June 2018: Template updates
- February 2018: Policy reviewed by committee; revised incidental supplies language; added G0493-G0494, clarified billing instructions
- 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

**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 an office/facility did not comply with this payment policy, Tufts Health Plan will expect the office/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.