

Home Health 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, as well as noncontracting providers outside of the network who have been authorized to render services to Senior Products members. For Commercial products, [click here](#). For Tufts Health Public Plans, [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.

Tufts Health Plan requires medication reconciliation documentation for all Senior Products members. Refer to the [Medication Reconciliation Guidelines](#) for more information.

REFERRALS/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.

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. Notifications must be submitted after the initial evaluation and assessment, but **before** continued services are rendered.

To submit prior notification, the home health care provider must fax a completed [Universal Health Plan/Home Health Authorization Form \(UHHA\)](#) to Tufts Health Plan 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.

² Tufts Medicare Preferred and Tufts Health Plan SCO are collectively referred to in this payment policy as Senior Products.

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. 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

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 T1502 and/or T1503 for medication administration visits for Tufts Health Plan SCO members³.
- 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 code 1111F in conjunction with G0299 in a distinct CPT procedure code field on a separate claim line to denote medication reconciliation, if applicable.

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. Refer to the [Durable Medical Equipment and Medical Supplies Payment Policy](#) for additional information.

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](#).

Home Health/Home Infusion

Tufts Health Plan does not routinely compensate for home health/home infusion procedures if the service is not billed with modifier SS (home infusion therapy in infusion suite) or if billed in any place of service other than 03, 04, 12, 13, 14, 16, 33, 54, or 55.

³ In accordance with MassHealth Transmittal Letter HHA-54.

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](#)

[Tufts Health Plan SCO Notification List](#)

DOCUMENT HISTORY

- March 2021: Reviewed by committee; removed codes and referred to provider agreements; added boiler plate language and previously communicated claim edits
- November 2019: Added MassHealth codes T1502, T1503, effective for dates of service on or after November 1, 2019 for Tufts Health Plan SCO
- 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

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.