



Home Health Care Services

Clinical Coverage Criteria

Overview

Home Health Care encompasses a wide range of health care services that are rendered in the member's home. Service may follow an acute in-patient admission or are initiated to prevent an acute admission. Services are aimed at those who can safely be transitioned to the home setting and/or have a need for continued skilled services and rehabilitation.

Policy

Home Health Care Services require authorization for initial and renewal of therapy services. Requests should outline the member's diagnosis, functional level, specific therapy needs (e.g. PT, OT, Skilled, etc.). The frequency of the therapy (days of week, hours) should be outlined in the requests. All the below criteria must be met and supported in the member's medical records.

1. Services must be ordered by a licensed physician (MD, DO, DPM) or licensed Nurse Practitioner working under the oversight of a licensed physician.
2. The member must be under a plan of treatment established and periodically reviewed by a licensed physician.
3. Commercial and Senior Plan members must be homebound (not able to leave the home without a taxing effort). For products with MassHealth enrollment (inclusive of dual-enrolled programs NaviCare, Summitt Elder Care) there is no specific requirement to be homebound.
4. The member must have a clinical need for part-time, intermittent skilled services, which include at least one of the following disciplines: Skilled nursing (RN), physical therapy, occupational therapy, or speech therapy. In order to qualify for a medical social worker or a home health aide to assist with personal care, the member must also have the clinical need for at least one of the skilled services listed above.
5. There must be an end point to the services based on medical necessity.

Home health care services (skilled nursing, physical therapy, occupational therapy, speech therapy, medical social work, and home health aide services) are provided to members in their home by certified home health care agencies and are considered skilled when they can only be safely and effectively provided by and/or under the supervision of a licensed clinician. Home health care services must be ordered by a licensed physician.

The services must be provided with a reasonable endpoint and goal towards medical stability. Services will no longer be covered when any of the following occurs:

- The member no longer meets criteria for services and services can be rendered at another less intensive level of care.

- The member's individual treatment plan and goals have been met.
- The member's support system is in agreement with an aftercare treatment plan.

An authorized plan to wean a member to limited or completely off of services may be put into place. If a request is initiated to return the member to the previous level of services then there must be detailed documentation as to why the weaning plan did not work.

Masshealth:

In addition to the above criteria being met Fallon Health will adhere to the regulations set forth by Masshealth for any members with a MassHealth enrollment, inclusive of dual-enrolled members. Services must be ordered by a physician based upon medical necessity and the service prescribe are only for medical therapy or medication management oversight and not social/respite needs.

Providers should address in their request how the services

- Provide specific, effective, and reasonable treatment of the member's diagnosis and physical condition
- Are directly and specifically related to an active treatment regimen
- Are of a level of complexity and sophistication that the judgment, knowledge, and skills of a licensed therapist are required
- Can achieve a specific diagnosis-related goal
- Are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in illness or infirmity.

Masshealth defines the below as clinical criteria for Nursing services:

1. A nursing service is a service that must be provided by a registered nurse, or by a licensed practical nurse under the supervision of a registered nurse, to be safe and effective, considering the inherent complexity of the service, the condition of the member, and accepted standards of medical and nursing practice.
2. Some services are nursing services on the basis of complexity alone (for example, intravenous and intramuscular injections, or insertion of catheters). However, in some cases, a service that is ordinarily considered unskilled may be considered a nursing service because of the patient's condition. This situation occurs when only a registered nurse or licensed practical nurse can safely and effectively provide the service.
3. When a service can be safely and effectively performed (or self-administered) by the average nonmedical person without the direct supervision of a registered or licensed practical nurse, the service is not considered a nursing service, unless there is no one trained, able, and willing to provide it.
4. Nursing services for the management and evaluation of a plan of care are medically necessary when only a registered nurse can ensure that essential care is effectively promoting the member's recovery, promoting medical safety, or avoiding deterioration.
5. Medical necessity of services is based on the condition of the member at the time the services were ordered, what was, at that time, expected to be appropriate treatment throughout the certification period, and the ongoing condition of the member throughout the course of home care.

6. A member's need for nursing care is based solely on his or her unique condition and individual needs, whether the illness or injury is acute, chronic, terminal, stable, or expected to extend over a long period.
7. Medication Administration Visit. A skilled nursing visit for the sole purpose of administering medication may be considered medically necessary when the member is unable to perform the task due to impaired physical, cognitive, behavioral, and/or emotional issues, no able caregiver is present, the member has a history of failed medication compliance resulting in a documented exacerbation of the member's condition, and/or the task of the administration of medication, including the route of administration, requires a licensed nurse to provide the service. A medication administration visit may include administration of oral, intramuscular, and/or subcutaneous medication or administration of medications other than oral, intramuscular and/or subcutaneous medication.

The full Masshealth regulation can be found here [Masshealth criteria](#)

Effective July 1, 2019 in accordance with MassHealth guidelines the below additional services will be considered for coverage for MassHealth and NaviCare plan members:

Pursuant to this change, a member may receive medically necessary home health aide services without having a concurrent skilled nursing or therapy need when the member requires hands-on assistance throughout the task or until completion with at least 2 activities of daily living (ADLs) defined as: bathing, grooming, dressing, toileting/continence, transferring/ambulation, and eating.

The services must continue to meet the below requirements

- The frequency and duration of the home health aide services must be ordered by the physician and must be included in the plan of care for the member
- The services are medically necessary to provide personal care to the member, to maintain the member's health, or to facilitate treatment of the member's injury or illness
- Authorization is obtained when required
- For members who are receiving home health aide services not pursuant to a skilled nursing or therapy need, a registered nurse must make an on-site visit no less frequently than every 60 days in order to observe and assess each home health aide while he or she is performing care

Exclusions

- Home health services other than described as above
- Custodial care, unless specifically covered under the member's plan
- Services provided in the home for the member's convenience

Codes

Coverage of a specific HCPCS or REV code is subject to the billing provisions outlined in the Providers contract.

Code type	Code	Description
HCPCS	G0156	Services of home health/hospice aide in home health or

		hospice settings, each 15 minutes
	G0299	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes
	G0300	Direct skilled nursing services of a licensed practical nurse (LPN) in the home health or hospice setting, each 15 minutes
	G0493	Skilled services of a registered nurse (rn) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting)
	T1502	Administration of oral, intramuscular and/or subcutaneous medication by health care agency/professional, per visit
	T1503	Administration of medication, other than oral and/or injectable, by a health care agency/professional, per visit
REV	0421	Physical Therapy Visit Charge
	0431	Occupational Therapy Visit Charge
	0441	Speech Therapy Language Pathology Visit Charge
	0550	Skilled Nursing General Charge
	0551	Skilled Nursing Visit Charge
	0552	Skilled Nursing Hourly Charge
	0559	Skilled Nursing Other Charge
	0561	Home Health Medical Social Services Visit Charge
	0572	Home Health Aide Hourly Charge
	0579	Home Health Aide Other Charge
	0581	Home Health Aide (Other Visits) Visit Charge
	0582	Home Health Aide (Other Visits) Hourly Charges
	0583	Home Health Other Visits Assessment
	0589	Home Health Aide (Other Visits) Other
	0590	Home Health Units of Service General

References

1. Commonwealth of Massachusetts Provider Manual Series: Home Health Agency Manual. Effective July 14, 2017
2. CMS Medicare Benefit Policy Manual Chapter 7: Home Health Services. Last revised March 22, 2019

Policy History

Origination date: 09/01/2018
Approval(s): Technology Assessment Committee: 08/22/2018 (approved as a new policy), 09/10/2019 (added additional non-skilled coverage for Masshealth, added codes)

Not all services mentioned in this policy are covered for all products or employer groups. Coverage is based upon the terms of a member's particular benefit plan which may

contain its own specific provisions for coverage and exclusions regardless of medical necessity. Please consult the product's Evidence of Coverage for exclusions or other benefit limitations applicable to this service or supply. If there is any discrepancy between this policy and a member's benefit plan, the provisions of the benefit plan will govern. However, applicable state mandates take precedence with respect to fully-insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, federal mandates will apply to all plans. For Medicare and Medicaid members, this policy will apply unless Medicare and Medicaid policies extend coverage beyond this policy.