Home Health Care Payment Policy

Policy

The Plan reimburses medically necessary home health care services that meet the criteria for coverage below.

Coverage of home health care services requires the member to meet all of the following criteria:

- Services must be ordered by a licensed physician (MD, DO, DPM). The physician must sign a plan of care certifying the home health services are medically necessary.
- The member must be under a plan of treatment established and periodically reviewed by a licensed physician.
- Commercial and Medicare Advantage 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.
- 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.
- There must be an end point to the services based on medical necessity.

The certifying physician must document that he or she or an allowed non-physician practitioner (NPP) had a face-to-face encounter with the patient.

Effective July 1, 2019 in accordance with MassHealth guidelines the below additional services will be considered for coverage for MassHealth ACO 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.

Updates related to coronavirus disease 2019 (COVID-19) for MassHealth ACO and NaviCare:
Effective March 10th, 2020, in response to the State of Emergency in Massachusetts due to 2019 novel coronavirus (COVID-19), Home Health agencies are permitted to provide services via telehealth in accordance with the LTSS guidance issued by EOHHS for MassHealth ACO and NaviCare members (**MassHealth LTSS Provider Information: Updates Related to the Coronavirus Disease 2019 (COVID-19))**. Those services are limited to:

- A Home Health Agency Provider may provide appropriate home health services via telehealth (including telephone and/or live video)) in accordance with the standards set forth in MassHealth All Provider Bulletin 289, as determined necessary by the Home Health Agency Provider.
- A Home Health Agency Provider may provide member/family consultative continuous skilled nursing (CSN) services via telehealth (including telephone and/or live video) in accordance with the standards set forth in MassHealth All Provider Bulletin 289, as determined necessary by the Home Health Agency Provider.

Additionally, the following administrative requirements will be waived or amended during the State of Emergency in accordance with the LTSS guidance:

- In accordance with 42 CFR 440.70(f)(6), MassHealth will permit physicians and other qualified non-physician practitioners, as appropriate, to conduct any face-to- face encounter required by 42 CFR 440.70 via telehealth (including telephone and/or live video.
- Home Health agency providers will be provided additional time to obtain the signed plan of care. The home health agency may obtain the signed plan of care either before the first claims submission or within 90 days from the first claims submission as long as the requirements outlined in 130 CMR 403.420 are met, effectively extending the physician signature timeframe from 45 days to 90 days.
- Home Health Agency Providers may request the continuation of an existing prior authorization. Extension requests may be approved for periods up to 90 days depending on the home health agency's ability to assess the member's continuing need for home health services. All approved extensions will be based off of the member's most recently authorized frequency for home health services. PA extensions will not be approved for requests to increase the frequency of services.
- Home Health Agencies may provide home health aide supervisory visits conducted by a nurse or therapist via Telehealth (including telephone and/or live video)) in accordance with the standards set forth in the All Provider Bulletin 289 located on the MassHealth website (https://www.mass.gov/doc/all-provider-bulletin-289-masshealth-coverage-and-reimbursement-policy-for-services-related-to/download). Additionally, supervisory visits shall be conducted no less than every 30 days. This is an expansion of the requirements established under 42 CFR 484.80(h), which require a supervisory visit no less than every 14 days.

Updates related to coronavirus disease 2019 (COVID-19) for Medicare Advantage:
Effective March 1, 2020 and for the duration of the public health emergency for the COVID-19 pandemic, CMS is amending the regulations at 42 CFR § 409.43(a) on an interim basis to provide home health agencies with the flexibility, in addition to remote patient monitoring, to use various types of telecommunications systems (technology) in conjunction with the provision of in-person visits. Specifically, CMS is amending the Plan of Care requirements at 42 CFR § 409.43(a) on an interim basis to state that:

(1) the use of technology must be related to the skilled services being furnished by the nurse or therapist or therapy assistant to optimize the services furnished during the home visit or when there is a home visit, and

(2) the use of technology must be included on the home health plan of care along with a description of how the use of such technology will help to achieve the goals outlined on the plan of care without substituting for an in-person visit as ordered on the plan of care.

Although home health agencies have the flexibility, in addition to remote patient monitoring, to use various types of technology, payment for home health services remains contingent on the furnishing of an in-person home visit. The use of technology may not substitute for an in-person home visit ordered as part of the plan of care and services furnished via technology (e.g., telehealth) cannot be considered a home health visit for purposes of eligibility or payment.

However, the use of such technology may result in changes to the frequency or types of visits outlined on the plan of care, especially to combat the public health emergency for the COVID-19 pandemic.

The inclusion of technology on the plan of care must be tied to the patient-specific needs as identified in the comprehensive assessment and the measurable outcomes that the home health agency anticipates will occur as a result of implementing the plan of care. For example, if a physician orders an in-person skilled nursing visit once a week to assess the patient and to monitor for worsening symptoms and a video consultation twice a week between the skilled nurse and the patient for medication management, teaching and assessment, as well as to obtain oxygen saturation readings that the patient relays to the nurse during the consult; the plan of care could specify that the goal of the video consultation is to increase patient adherence with medication regimen and oxygen use with no worsening respiratory symptoms.

Clarification of the definition of “homebound”:
The definition of “confined to the home” (that is, “homebound”) allows patients to be considered “homebound” if it is medically contraindicated for the patient to leave the home. For the COVID-19 public health emergency, this would apply for those plan members:
(1) where a physician has determined that it is medically contraindicated for a member to leave the home because he or she has a confirmed or suspected diagnosis of COVID-19; or
(2) where a physician has determined that it is medically contraindicated for a member to leave the home because the memberhas a condition that may make the member more susceptible to contracting COVID-19.

In cases where it is medically contraindicated for the member to leave the home, the medical record documentation for the patient must include information as to why the individual condition of the patient is such that leaving the home is medically contraindicated.

A member who is exercising “self-quarantine” for their own safety would not be considered “confined to the home” unless a physician certifies that it is medically contraindicated for the member to leave the home.

In addition to being considered “homebound”, the member must continue to meet all home health eligibility requirements to receive Medicare home health services. That is, the member must be under the care of a physician; receiving services under a plan of care established and periodically reviewed by a physician; be in need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology; or have a continuing need for occupational therapy.

COVID-19 diagnostic testing: If a plan member is already receiving Medicare home health services, the home health nurse, during an otherwise covered visit, can obtain the specimen to send to the laboratory for COVID-19 diagnostic testing.

Definitions

Skilled home health care guidelines: 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 Medicare-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 member must meet Medicare home health care criteria in order to qualify for these services.

Reimbursement

The Plan will conduct periodic audits of claims for home health care services to check for compliance to skilled home health care guidelines.

The Plan reimburses contracted providers for non-state supplied vaccines and the administration of both state-supplied and non-state-supplied vaccines. Reimbursement for the vaccine/toxoid and administration of the vaccine/toxoid will be made according to the contractual arrangements between the provider and the Plan. Refer to the Plan *Vaccine Payment Policy* for additional information.

Referral/notification/prior authorization requirements

Authorization requirements vary according to Plan product or Provider Contract; contact Customer Service for eligibility and benefits.

For MassHealth ACO, NaviCare and Summit ElderCare - Referral and prior authorization requirements for services delivered via telehealth are the same as services delivered on an in-person basis; as such, telehealth services to MassHealth ACO and NaviCare members may require referral or prior authorization.

If the Provider's contract requires the below code to be billed with Home Health then prior authorization is required.

Code	Description
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

Please refer to the *Hospice Payment Policy* for requirements related to hospice services.

Billing/coding guidelines

The Plan will use current industry standard procedure codes throughout our processing systems.

The Health Insurance Portability & Accountability Act (HIPAA) Transaction & Code Set Rule requires providers to use the code(s) that are valid at the time the service is provided. The Plan adheres to HIPAA standards.

Claims for skilled services provided to Fallon Medicare Plus, NaviCare, and Summit ElderCare members should include the Health Insurance Prospective Payment System (HIPPS) code. Claims should be billed using industry standard UB-04 forms. The HIPPS code should be placed in box 44, and the admission dates should be placed in box 12. Claims for members receiving only non-skilled services do not require HIPPS codes.

Additionally for NaviCare members, claims must be submitted with a corresponding HCPCS code (see below) even if the provider contract pays based on a revenue code. This is required for compliance with NaviCare's encounter data submissions to Masshealth.

Code	Description
G0151	Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes
G0155	Services of clinical social worker in home health or hospice settings, each 15 minutes
G0156	Services of home health/hospice aide in home health or hospice

	settings, each 15 minutes
G0157	Services performed by a qualified physical therapist assistant in the home health or hospice setting, each 15 minutes
G0158	Services performed by a qualified occupational therapist assistant in the home health or hospice setting, each 15 minutes
G0162	Skilled services by a registered nurse (RN) for management and evaluation of the plan of care; each 15 minutes (the patient's underlying condition or complication requires an RN to ensure that essential nonskilled care achieves its purpose in the home health or hospice setting)
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)
G0494	Skilled services of a licensed practical nurse (LPN) 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)

Providers must only use industry standard code sets and must use revenue codes as stated in your contract with the Plan. If specific codes are not available, unlisted codes require Plan prior authorization.

Service	**Code**
High-tech RN visit	0550
RN skilled visit	0551
RN, hourly	0552
RN, Other	0559
Licensed Practical Nurse (LPN)	0582
LPN visit	0589
Certified HH Aide hourly	0572
Certified HH Aide, other	0579
PT visit	0421
OT visit	0431
ST visit	0441
MSW visit	0561
Nutrition home visit	0581

COVID-19 expanded telehealth billing/coding guidelines for MassHealth ACO, NaviCare and Summit ElderCare members:

Providers should bill the same revenue and or CPT/HCPCS codes for services delivered via telehealth as appropriate for services delivered face-to-face. Professional claims for telehealth services for MassHealth ACO, NaviCare and Summit ElderCare members must be billed using

Place of Service 02 to designate them as being rendered via telehealth. Facility claims must be billed with the applicable revenue code and/or HCPCS code with a telehealth modifier (95, GT, GO or GQ, as appropriate).Telehealth services should be billed in accordance with the provider contract with Fallon Health. Please contact Provider Relations with any questions related to the billing/coding for telehealth services rendered to MassHealth ACO, NaviCare or Summit ElderCare members.

Masshealth ACO's use the below codes for services, prior authorization is required.

Code	Description
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

Masshealth ACO's, NaviCare, Summit Eldercare utilize the below codes, prior authorization may be required.

Code	Description
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)
G0156 Use Modifier UD	Services of home health/hospice aide in home health or hospice settings, each 15 minutes
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

Home health services include (but are not limited to) the following incidental supplies:

- Adhesive bandage strips
- Blood pressure cuffs
- Cartridge for finger stick clotting time
- Clean gowns
- Eye shields
- Gauze
- Non-medicated wipes
- Non-sterile gloves
- Scissors
- Sterile Q-Tips®
- Steri-Strips™
- Stethoscope
- Suture removal kits
- Tape
- Tongue depressors

All other authorized supplies such as standard DME or wound care supplies must be obtained from a Plan-contracted DME provider.

Place of service

This policy applies to services rendered in the home setting.

Policy history

Origination date:	May 1, 2011
Previous revision date(s):	01/01/2013 - Clarified language to reflect the need for home health care to be ordered by a licensed physician; added statement that all non-emergency services that do not meet the homebound and/or skilled care criteria require prior authorization. 05/01/2013 – Added prior authorization requirement for Senior Plan. 11/01/2013 - Added that HIPPS codes be submitted for claims for Fallon Senior Plan members. 05/01/2014 - Removed the prior authorization requirement for Fallon Senior Plan. 11/01/2014 - Added detail in the discussion about HIPPS code billing and moved to Fallon Health template. 09/01/2015 - Moved to new Plan template and updated policy and reimbursement sections. 07/01/2016 - Annual review. 03/01/2017 - Updated the billing/coding guidelines.
Connection date & details:	July 2017 – Clarified supplies included in home health care services and updated the authorization section. January 2018 – Clarified authorization requirements April 2018 – Clarified Policy section regarding MassHealth based plans and homebound requirements. April 2019 – Clarified coding and added NaviCare billing specifics to the Billing section. October 2019 – Updated policy for new MassHealth coverage, updated reimbursement section. January 2020 – Updated definitions. June 1, 2020 – Updated Policy, Prior Authorization and Billing and Coding sections related to COVID-19 temporary telehealth coverage for MassHealth ACO, NaviCare and Medicare Advantage members. June 26, 2020 – Updated Policy, Prior Authorization and Billing and Coding sections related to COVID-19 temporary telehealth coverage for Summit ElderCare.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.