Effective: August 1, 2023

Prior Authorization Required
If REQUIRED, submit supporting clinical documentation pertinent to service request.

| Yes ☒ | No ☐ |

Applies to:

**Commercial Products**
- Harvard Pilgrim Health Care Commercial products; Fax 617-509-1147
- Tufts Health Plan Commercial products; Fax 617-972-9409
  - CareLinkSM – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

**Public Plans Products**
- Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax 888-415-9055
- Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax 888-415-9055
- Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax 857-3047-6304
- Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax 857-304-6304
  - *The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

**Senior Products**
- Harvard Pilgrim Health Care Stride Medicare Advantage; Fax 866-874-0857
- Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); Fax 617-673-0965
- Tufts Medicare Preferred HMO, (a Medicare Advantage product); Fax 617-673-0965
- Tufts Medicare Preferred PPO, (a Medicare Advantage product); Fax 617-673-0965

**Note:** While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

**Note:** This guideline does not apply to Medicare Members (includes dual eligible Members).

**Overview**

Home health care is a wide array of health care and support services provided to a member in their home environment to help treat an illness or injury. Examples of skilled services provided in the home include skilled nursing, physical therapy, occupational therapy, and speech-language pathology services. Qualified home health aide services in conjunction with a skilled service, may also be a part of a skilled home care program that provides personal care assistance to a member in their home.

**Note:** The home setting may be any place the Member has established his/her place of residence for the time period when home care services are being provided.

**Definitions**

**Skilled Services**
- Services which require clinical training and must be provided or supervised by a licensed health care professional (e.g., registered nurse; licensed physical, speech, occupational therapist) in order to be delivered safely and effectively and to obtain a specified medical outcome.

**Custodial Services**
- Services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function, as opposed to improving that function.
- Services that do not require clinical training or supervision by licensed medical professionals in order to be delivered safely and effectively.
Homebound

- In order to be considered homebound, the Member’s condition should be such that there exists the inability to leave the home, or consequently leaving the home would require a considerable and taxing effort, or the member has a condition such that leaving home is medically contraindicated. If the Member leaves the home, he or she may still be considered homebound if the absences are infrequent and for short periods of time, or are for health care treatments.

Authorization

The plan uses InterQual® Home Care criteria to determine medical necessity and to authorize home care services after the initial evaluation visit.

Clinical Guideline Coverage Criteria

The plan may authorize coverage of intermittent home health care services when they are:

1. Provided under a plan of care established by and periodically reviewed by a physician
2. Skilled services (see definition above)
3. Medically necessary and reasonable based on the Member’s condition and accepted standards of clinical practice
4. An integral part of treatment of the Member’s medical condition and associated symptoms
5. Provided to Members who are homebound (see definition above)

Note: The initial skilled nursing (SN), and/or physical therapy (PT) home care assessment/evaluation visit does not require prior authorization. Speech therapy, occupational therapy and/or social worker visit will require prior authorization for the initial evaluation when provided independently and not in conjunction with physical therapy or skilled nursing visits. The plan uses InterQual® criteria to determine medical necessity and to authorize home care services after the initial evaluation visit. Providers requesting authorization after the initial evaluation visit must submit a thoroughly completed Universal Health Plan/Home Health Authorization Form (UHHA) along with evidence of homebound status to the appropriate fax number listed above within 2 days of the start of care.

To review authorization requirements, please consult the applicable Provider Manual for Tufts Health Plan Commercial business, Tufts Health Public Plans, or Harvard Pilgrim Health Care. You can also find important reimbursement information in our Payment Policies, which are located on the Harvard Pilgrim Health Care and Tufts Health Plan provider websites.

Limitations

- Custodial services (see definition above)
- Benefits for home care may vary by plan/group. Specific benefit coverage should be verified prior to initiating services by logging on to our website or by contacting Provider Services.

Codes

The following code(s) require prior authorization after the initial evaluation (as outlined above):

Table 1: CPT Codes

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>99501</td>
<td>Early Maternity Discharge Visit or Maternal Child Home Visit- Home visit for postnatal assessment and follow-up care (one visit only)</td>
</tr>
</tbody>
</table>

Table 2: HCPCS Codes

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>S9127</td>
<td>Social work visit, in the home, per diem</td>
</tr>
<tr>
<td>S9128</td>
<td>Speech therapy, in the home, per diem</td>
</tr>
<tr>
<td>S9129</td>
<td>Occupational therapy, in the home, per diem</td>
</tr>
<tr>
<td>S9131</td>
<td>Physical therapy; in the home, per diem</td>
</tr>
<tr>
<td>S9470</td>
<td>Nutritional Counseling, dietitian visit</td>
</tr>
</tbody>
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Table 3: Revenue Codes

<table>
<thead>
<tr>
<th>Revenue Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>0551</td>
<td>Skilled Nursing, visit charger (per visit up to 2 hours)</td>
</tr>
<tr>
<td>0552</td>
<td>Skilled Nursing, hourly charge (each additional hour after the first two hours)</td>
</tr>
<tr>
<td>0559</td>
<td>Skilled Nursing, other (LPN nursing, per visit)</td>
</tr>
</tbody>
</table>

References:

Approval And Revision History
November 16, 2022: Reviewed by the Medical Policy Approval Committee (MPAC) for integration between Harvard Pilgrim Health Care and Tufts Health Plan; effective February 1, 2023
Subsequent endorsement date(s) and changes:
• June 21, 2023: Reviewed by the Medical Policy Approval Committee (MPAC), removal of codes 99601 and 99602 to no longer require PA effective August 1, 2023

Background, Product and Disclaimer Information
Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member’s benefit document, and in coordination with the Member’s physician(s) on a case-by-case basis considering the individual Member’s health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.