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Medical Policy and InterQual® Criteria

Home Health Care

Policy Number: OCA 3.732
Version Number: 4
Version Effective Date: 12/01/21

Product Applicability

☐ **All Plan+ Products**

WellSense Health Plan
☐ NH Medicaid
☐ NH Medicare Advantage

Boston Medical Center HealthNet Plan
☐ MassHealth ACO
☐ MassHealth MCO
☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct
☐ Senior Care Options

+ Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan considers home health care services, including habilitative services and/or rehabilitative services, **medically necessary** when applicable **InterQual® criteria** are met and the member is confined to the home setting **(homebound)**. ALL services rendered by non-participating providers require prior authorization (including services waived for prior authorization when provided by qualified, participating providers). Home health care services must be provided within the scope of practice of the treating home health care professional and/or paraprofessional and follow all applicable state licensing and supervisory requirements. Prior authorization is required according to the guidelines outlined below.

Prior authorization is REQUIRED for hospice services after the initial evaluation and for durable medical equipment (DME) dispensed in the home setting according to the guidelines specified in the *Prior Authorization/Notification Requirements Matrix* and the *Prior Authorization Code Look-Up Tools* available at www.wellsense.org. DME providers, medical supply providers, pharmacy providers, home infusion providers, home care providers, and specialty pharmacy providers must contact Northwood at

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www.northwoodinc.com or by phone at 1-866-802-6471 (rather than the Plan) to obtain prior authorization. Behavioral health home care is managed by Beacon Health Strategies, LLC and may be contacted at 1-888-217-3501 or at www.beaconhealthstrategies.com.

Plan Prior Authorization Guidelines for Home Health Care:

1. **Home Health Aide (HHA) Services:**

   ALL services REQUIRE prior authorization PRIOR to the delivery of services (including the initial evaluation) with confirmation that the member is eligible for skilled home care services provided by an RN, LPN working under the supervision of an RN, occupational therapist, physical therapist, or speech therapist in conjunction with HHA skilled services. Applicable **InterQual® criteria** must be met.

   HHA-ADL only services are NOT covered. Homemaker, respite, and/or chore services are NOT considered home health aide services. When a home health aide (HHA) visits a member to provide health-related services, the HHA may also perform some incidental services that do NOT meet the definition of HHA services, such as light cleaning, preparing a meal, and/or removing trash. However, the purpose of the HHA visit must NOT be to provide these incidental services, since they are NOT health-related services. Personal care attendants are NOT covered.

2. **Medical Social Services Home Care**:

   Prior authorization is NOT required for an **initial evaluation** provided by a participating clinical social worker when the initial evaluation is billed with an applicable code appended with a U1 modifier in the first modifier position as the first date of service per member per benefit/Plan year per treating qualified, participating provider group (categorized by tax identification number/TIN) using the U1 modifier in the first modifier position according to the guidelines documented in the Applicable Coding section.

   Additional home-based medical social services, re-evaluations, and initial evaluations that do NOT meet criteria for waived prior authorization REQUIRE Plan prior authorization using **InterQual® criteria** to determine medical necessity.

3. **Nutrition Home Care Services:**

   Prior authorization is NOT required for an **initial evaluation** by a qualified, participating dietician when the initial evaluation is billed within the first date of service/first visit per member per benefit/Plan year per treating qualified, participating provider group (categorized by TIN) and billed with the applicable code appended with a U1 modifier in the first modifier position according to the guidelines documented in the Applicable Coding section.

Additional home-based nutrition services, re-evaluations, and initial evaluations that do NOT meet criteria for waived prior authorization REQUIRE Plan prior authorization using **InterQual® criteria** to determine medical necessity.

4. **Occupational Therapy (OT) Home Care Services:**

   Prior authorization is NOT required for an **initial evaluation** by a qualified, participating occupational therapist when the initial evaluation is billed with an applicable code appended with a U1 modifier in the first modifier position as the first date of service per member per benefit/Plan year per treating qualified, participating provider group (categorized by TIN) according to the guidelines documented in the Applicable Coding section.

   Additional OT home care services and an initial evaluation that do not meet criteria for waived prior authorization (as specified above) REQUIRE prior authorization using **InterQual® criteria** to determine medical necessity.

5. **Physical Therapy (PT) Home Care Services**:

   Prior authorization is NOT required for an **initial evaluation** by a participating physical therapist when the initial evaluation is billed with an applicable code appended with a U1 modifier in the first modifier position as the first date of service per member per benefit/Plan year per treating qualified, participating provider group (categorized by TIN) according to the guidelines documented in the Applicable Coding section.

   Additional PT home care services and an initial evaluation that do not meet criteria for waived prior authorization (as specified above) REQUIRE prior authorization using **InterQual® criteria** to determine medical necessity.

6. **Postpartum Home Care Visit**:

   Prior authorization is NOT required for 1 postpartum home care visit by a qualified, participating provider specialist (i.e., RN, LPN under the supervision of an RN, certified nurse midwife, physician, or nurse practitioner) following the member's discharge from a maternity stay from an acute care hospital when BOTH criteria are met in items a and b:

   a. The postpartum visit is billed as the first date of service per member per benefit/Plan year per treating qualified, participating provider group (categorized by TIN) using an applicable primary postpartum diagnosis code; AND

   b. When the postpartum visit is conducted by an RN, the applicable HCPCS code for skilled intermittent nursing home care services is billed, and when the postpartum visit is provided by a certified nurse midwife, physician, or nurse practitioner, the industry-standard,

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applicable procedure code is billed with the corresponding postpartum diagnosis code according to the guidelines documented in the Applicable Coding section.

These home visits may include parent education, assistance and training in breast or bottle feeding, and necessary tests. Additional postpartum home care visits and an initial visit that do not meet criteria for waived prior authorization (as specified above) REQUIRE prior authorization. The Plan uses **InterQual® criteria** to determine medical necessity for additional skilled intermittent nursing home care visits. For newborns, the Plan covers routine nursery charges and well newborn care. The newborn must be enrolled in the Plan within 30 days of date of birth in order for the Plan to cover other medically necessary services rendered to the newborn.

7. **Skilled Intermittent Nursing Home Care Services**:

   Prior authorization is NOT required for the initial evaluation by a participating RN or LPN under the supervision of an RN when the initial evaluation is billed with an applicable HCPCS code appended with a U1 modifier in the first modifier position as the first date of service per member per benefit/Plan year per treating qualified, participating provider group (categorized by TIN) using the U1 modifier according to the guidelines documented in the Applicable Coding section.

   Additional skilled intermittent nursing home care services, additional psychiatric visiting nurse home health care visit, and an initial evaluation or visits that do not meet criteria for waived prior authorization (as specified above) REQUIRE prior authorization. The Plan uses **InterQual® criteria** to determine medical necessity. Continuous skilled nursing services, including private duty or block nursing, are NOT covered.

8. **Speech Therapy (ST) Home Care Services:**

   Prior authorization is NOT required for an **initial evaluation** by a participating speech-language pathologist/speech therapist when the initial evaluation is billed with an applicable HCPCS code appended with a U1 modifier in the first modifier position as the first date of service per member per benefit/Plan year per treating qualified, participating provider group (categorized by TIN) using the U1 modifier according to the guidelines documented in the Applicable Coding section.

   Additional ST home care services and an initial evaluation that do not meet criteria for waived prior authorization (as specified above) REQUIRE prior authorization using **InterQual® criteria** to determine medical necessity.

The following services are NOT covered for member enrolled in the Qualified Health Plans, ConnectorCare, and Employer Choice Direct products: custodial care, home health aide services when the member is NOT concurrently receiving skilled nursing home care and/or therapy home health care

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services (HHA-ADL only services), personal care attendant services, and/or continuous skilled nursing services (including private duty or block nursing).

Clinical Criteria

Home health services are considered medically necessary when applicable InterQual® criteria are met and a physician (or a licensed independent practitioner practicing within the scope of the practitioner's license, i.e., nurse practitioner or physician assistant) has certified that the member is **homebound.**

Limitations and Exclusions

1. Limitations include home health care services that do NOT meet applicable InterQual® criteria and services NOT covered for the Plan member. The following services are NOT covered for member enrolled in the Qualified Health Plans, ConnectorCare, and Employer Choice Direct products: custodial care, home health aide services when the member is NOT concurrently receiving skilled nursing and/or therapy home health care services (HHA-ADL only services), personal care attendant services, and/or continuous skilled nursing services (including private duty or block nursing). Home care services provided in a hospital, nursing facility, intermediate care facility or any other institutional facility providing medical, nursing, rehabilitative, or related care including a licensed/certified day care center are NOT covered by the Plan.

2. Services that can be safely and effectively performed (or self-administered) by the average non-medical person without the direct supervision of an RN or licensed nurse unless there is no one able to provide it; these services are NOT considered medically necessary and include but are not limited to ANY of the services listed in items a through c:

   a. The pre-filling of syringes with insulin (or other medication that is self-injected) that do NOT require the skills of a licensed nurse; OR

   b. The administration of oral medications that do NOT require the skills of a licensed nurse; OR

   c. The administration of eye drops and topical ointments.

3. Home care visits may be necessary to supervise a home health care paraprofessional (according to the Commonwealth of Massachusetts regulatory guidelines), but any visit provided solely for the purpose of supervising a home health care paraprofessional (including a home health aide) is NOT reimbursed by the Plan, as stated in the Plan's applicable reimbursement policy.

4. Venipuncture for the purpose of obtaining a blood sample is not covered unless the member qualifies for other skilled home care.

5. Home Health care services are NOT considered medically necessary for ANY of the circumstances listed in items a through k:

a. The service is for a disorder NOT associated with a medical or behavioral health condition; OR

b. The service replicates concurrent services provided in a different setting with similar treatment goals, plans, and therapeutic modalities; OR

c. The service replicates concurrent services provided by a different provider in the same setting with similar treatment goals, plans, and therapeutic modalities; OR

d. The services are primarily educational, emotional, and/or psychological in nature; OR

e. The services are more appropriately provided in a setting other than the member's home or the member's need is such that home-based services will not meet the need; OR

f. The condition(s) does NOT require the level of professional requested or the need can be met with a lower level of service; OR

g. The treatment is for a dysfunction that is self-correcting in nature and could reasonably be expected to improve without treatment; OR

h. The services of a licensed nurse to fill or assist the member in filling daily medication box organizers on a daily basis; OR

i. The treatment is for educational, vocational, and/or recreational purposes; OR

j. There is NO clinical documentation and/or treatment plan to support the need for the home health care service or continuing service; OR

k. Services are considered research or experimental in nature.

Applicable Coding

The Plan uses and adopts up-to-date Current Procedural Terminology (CPT) codes from the American Medical Association (AMA), International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes developed by the World Health Organization and adapted in the United Stated by the National Center for Health Statistics (NCHS) of the Centers for Disease Control under the U.S. Department of Health and Human Services, and the Health Care Common Procedure Coding System (HCPCS) established and maintained by the Centers for Medicare & Medicaid Services (CMS). Since the AMA, NCHS, and CMS may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes included in this Plan policy is for informational purposes only, may not be all inclusive, and is subject to change without prior notification. Whether a code is listed in the Applicable Coding section of this Plan policy does not constitute or imply member coverage or provider reimbursement. Providers are responsible for

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reporting all services using the most up-to-date industry-standard procedure and diagnosis codes as published by the AMA, NCHS, and CMS at the time of the service.

Providers are responsible for obtaining Plan prior authorization for the home health care services, as specified in the Clinical Criteria section and Limitations and Exclusions section of this policy, even if an applicable code appropriately describing the service is not included in this Applicable Coding section. Review the Plan's reimbursement policies for Plan billing guidelines. Coverage for services is subject to benefit eligibility under the member's benefit plan in effect at the time of the service. Benefit documents for BMC HealthNet Plan members are available www.bmchp.org.

ICD-10 Codes	Description: Postpartum Primary Diagnosis Codes Used for Postpartum Home Care Visit
Z39.0 to Z39.2	Encounter for maternal postpartum care and examination Plan note: One (1) postpartum home visit is considered medically necessary for a member and does NOT require prior authorization following the member's discharge from a maternity stay from an acute care hospital when billed as the first date of service per member per benefit/Plan year per treating qualified, participating provider group (categorized by provider tax identification number/TIN) with an applicable primary postpartum diagnosis code noted above. When this postpartum visit is conducted by an RN, the applicable HCPCS code for skilled intermittent nursing home care services is billed with the corresponding postpartum diagnosis code. When the postpartum visit is provided by a certified nurse midwife, physician, or nurse practitioner, the industry-standard, applicable procedure code is used for the professional home care visit with the corresponding postpartum diagnosis code.

HCPCS Codes	Description: Codes Covered When Medically Necessary for Postpartum Follow-Up Home Care Visit
G0299	Services of an RN in home health setting (1 through 30 calendar days), per visit Plan notes: The number of calendar days (**1 through 30 calendar days**) includes all skilled intermittent nursing home health care visits provided to a Plan member (per home health care episode of care in a continuous treatment time period, with the frequency of services based on the Plan's medical necessity criteria and the member's treatment plan). The number of visits for this time period for a Plan member includes ALL skilled intermittent nursing home health care visits provided by a registered nurse (RN) billed with G0299 and a licensed practical nurse (LPN) billed with HCPCS code G0300 (from ALL home health care agencies/treating providers). When HCPCS code G0299 is used for one (1) postpartum home care visit provided

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	by an RN following the member's discharge from a maternity stay from an acute care hospital, prior authorization is NOT required for participating providers if BOTH of the following guidelines are met: (1) The skilled nursing service is provided by an RN; and (2) the visit is billed with HCPCS codes G0299 and an applicable postpartum diagnosis code specified above as the first date of service per member per benefit/Plan year per treating, qualified provider group (categorized by provider TIN). This code may also be used for additional postpartum home visits when medically necessary (and may be used in combination with HCPCS code G0300), but prior authorization is REQUIRED using InterQual® clinical criteria for skilled intermittent nursing home care services.
G0300	Services of an LPN in home health setting (1 through 30 calendar days), per visit Plan notes: The number of calendar days (1 through 30 calendar days) includes all skilled intermittent nursing home health care visits provided to a Plan member (per home health care episode of care in a continuous treatment time period, with the frequency of services based on applicable InterQual® clinical review criteria and the member's treatment plan). The number of visits for this time period for a Plan member includes ALL skilled intermittent nursing home health care visits provided by a registered nurse (RN) billed with G0299 and a licensed practical nurse (LPN) billed with HCPCS code G0300 (from ALL home health care agencies/treating providers). When HCPCS code G0300 is used by a participating provider for the one (1) postpartum home care visit provided by an LPN following the member's discharge from a maternity stay from an acute care hospital, prior authorization is NOT required if BOTH of the following guidelines are met: (1) The skilled nursing service is provided by an LPN; and (2) the visit is billed with HCPCS codes G0299 and an applicable postpartum diagnosis code specified above as the first date of service per member per benefit/Plan year per treating, qualified provider group (categorized by the provider TIN). This code may also be used for additional postpartum home visits when medically necessary (and may be used in combination with HCPCS code G0299), but prior authorization is REQUIRED using InterQual® criteria for skilled intermittent nursing home care services.

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HCPCS Codes/ Modifier	Description: Codes Covered When Medically Necessary for Home Care Visits (Excluding Visits Relates to Postpartum Discharge)
G0151	Services of physical therapist in the home health setting, per visit Plan note: When HCPCS code G0151 is used by a participating provider for an **initial evaluation** for physical therapy in the home setting, prior authorization is NOT required if the service is provided by a qualified physical therapist and is billed with this code appended with a **U1 modifier** in the first modifier position as the first date of service per member per benefit/Plan year per treating, qualified provider group (categorized by TIN). Prior authorization is REQUIRED when wavier guidelines are not met and for all additional services. Use HCPCS code G0159 rather than G0151 for services performed by a qualified physical therapist as a component of a home maintenance program (and applicable InterQual® criteria must be met).
G0152	Services of occupational therapist in the home health setting, per visit Plan note: When HCPCS code G0152 is used by a participating provider for an **initial evaluation** for occupational therapy in the home setting, prior authorization is NOT required if the service is provided by a qualified occupational therapist and is billed with this code appended with a **U1 modifier** in the first modifier position as the first date of service per member per benefit/Plan year per treating, qualified provider group (categorized by TIN). Prior authorization is REQUIRED when wavier guidelines are not met and for all additional services. Use HCPCS code G0160 rather than G0152 for services performed by a qualified occupational therapist as a component of a home maintenance program (and applicable InterQual® criteria must be met).
G0153	Services of speech/language therapist in the home health setting, per visit Plan note: When HCPCS code G0153 is used by a participating provider for an **initial evaluation** for speech therapy in the home setting, prior authorization is NOT required if the service is provided by qualified speech-language pathologist/speech therapist and is billed with this code appended with a **U1 modifier** in the first modifier position as the first date of service per member per benefit/Plan year per treating, qualified provider group (categorized by TIN). Prior authorization is REQUIRED when wavier guidelines are not met and for all additional services. Use HCPCS code G0161 rather than G0153 for services performed by a qualified speech-language pathologist as a component of a home maintenance program (and applicable InterQual® criteria must be met).

G0155	Services of clinical social worker in home health or hospice setting, per 15 minutes Plan note: When this code is used by a participating provider for an **initial evaluation** for medical social services in the home setting, prior authorization is NOT required if the service provided by a qualified social worker and is billed with this code appended with a U1 modifier in the first modifier position as the first date of service per member per benefit/Plan year per treating, qualified provider group (categorized by TIN). Prior authorization is REQUIRED when wavier guidelines are not met and for all additional services.
G0156	Services of home health/hospice aide in home health or hospice setting, per 15 minutes Plan note: All home health aide (HHA) services REQUIRE Plan prior authorization. Code used to document HHA services for assistance.
G0157	Services performed by a qualified physical therapist assistant in the home health or hospice setting, per visit Plan note: This code may NOT be used to bill for an initial evaluation for home health care services. Home health care services provided by physical therapy assistants REQUIRE Plan prior authorization.
G0158	Services performed by a qualified occupational therapist assistant in the home health or hospice setting, per visit Plan note: This code may NOT be used to bill for an initial evaluation for home health care services. Home health care services provided by occupational therapy assistants REQUIRE Plan prior authorization.
G0159	Services performed by a qualified physical therapist, in the home health setting, in the establishment or delivery of a safe and effective therapy maintenance program, per visit Plan note: This code may NOT be used to bill for an initial evaluation for home health care services. Use HCPCS code G0151 rather than this code for services performed by a qualified physical therapist when not a component of a home maintenance program (and applicable InterQual® criteria are met).
G0160	Services performed by a qualified occupational therapist, in the home health setting, in the establishment or delivery of a safe and effective therapy maintenance program, per visit Plan note: This code may NOT be used to bill for an initial evaluation for home health care services. Use HCPCS code G0152 rather than this code for services performed by a qualified occupational therapist when not a component of a home maintenance program (and applicable InterQual® criteria are met).

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G0161	Services performed by a qualified speech-language pathologist, in the home health setting, in the establishment or delivery of a safe and effective speech-language pathology maintenance program, per visit Plan note: This code may NOT be used to bill for an initial evaluation. Use HCPCS code G0153 rather than this code for services performed by a qualified speech-language pathologist and/or a speech therapy assistant when not a component of a home maintenance program (and applicable InterQual® criteria are met).
G0299	Services of an RN in home health setting (1 through 30 calendar days), per visit Plan notes: The number of calendar days (**1 through 30 calendar days**) includes all skilled intermittent nursing home health care visits provided to a Plan member (per home health care episode of care in a continuous treatment time period, with the frequency of services based on the Plan's medical necessity criteria and the member's treatment plan). The number of visits for this time period for a Plan member includes ALL skilled intermittent nursing home health care visits provided by a registered nurse (RN) billed with G0299 and a licensed practical nurse (LPN) billed with HCPCS code G0300 (from ALL home health care agencies/treating providers). This code may be billed in combination with HCPCS code G0300 and may be used to bill for psychiatric visiting nurse home health services. When this code is used by a participating provider for an **initial evaluation** for skilled intermittent nursing services in the home setting, prior authorization is NOT required if the service is provided by a qualified RN and is billed with this code appended with a **U1 modifier** in the first modifier position as the FIRST date of service per member per benefit/Plan year per treating, qualified provider group (categorized by TIN), EITHER for intermittent skilled nursing services for medical home health services or for psychiatric visiting nurse home health services. Skilled intermittent nursing home care services include all nursing services provided by both RNs and LPNs in the home setting. Prior authorization is REQUIRED when wavier guidelines are not met and for all additional services.
G0299 UD	Services of an RN in home health setting (31+ calendar days), per visit Plan notes: The number of calendar days (**31 calendar days or longer**) includes all skilled intermittent nursing home health care visits provided to a Plan member (per home health care episode of care in a continuous treatment time period, with the frequency of services based on the Plan's medical necessity criteria and the member's treatment plan). The number of visits for this time period for a Plan member includes ALL skilled intermittent nursing home health care visits provided by an RN billed with G0299 and an LPN billed with HCPCS code G0300 (from ALL home health care agencies/treating providers). This code may be billed in combination with HCPCS code G0300 and may be used to bill for psychiatric visiting nurse home health services.

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	When this code is used by a participating provider for an **initial evaluation** for skilled intermittent nursing services in the home setting, prior authorization is NOT required if the service is provided by a qualified RN and is billed with this code appended with a **U1 modifier** in the first modifier position as the first date of service per member per benefit/Plan year per treating, qualified provider group (categorized by TIN), EITHER for intermittent skilled nursing services for medical home health services or for psychiatric visiting nurse home health services. Skilled intermittent nursing home care services include all nursing services provided by both RNs LPNs in the home setting. Prior authorization is REQUIRED when wavier guidelines are not met and for all additional services.
G0299 TT	Services of an RN in home health setting, per visit Plan notes: Use when billing for **each subsequent Plan member – not for the first member** - when 2 or more members in the same household are receiving a nursing visit during the same time period; this code is used for home health care services provided to Plan members for **1 through 30 calendar days** (per home health care episode of care in a continuous treatment time period, with the frequency of services based on the Plan's medical necessity criteria and the member's treatment plan). The number of visits for this time period includes ALL skilled intermittent nursing home health care visits provided by an RN billed with G0299 and an LPN billed with HCPCS code G0300 (from ALL home health care treating providers). When billing the Plan for the **second or any additional members**, the service code and modifier must reflect the home health care visit for each subsequent member. In those cases, where 2 or more Plan members living in the same household require home health care services, the treating home health agency/provider must document the medical necessity of the home health care visit in each of the member's medical record and obtain prior authorization for each member according to the Plan's applicable medical necessity criteria. When skilled intermittent nursing services cannot be provided during a single home health care visit for 2 or more members in the same household, the provider must document the medical necessity of each additional visit (rather than rendering home health care services to 2 or more members during the same visit). This code may be billed in combination with HCPCS code G0300 and may be used to bill for psychiatric visiting nurse home health services. When this code is used by a participating provider for an **initial evaluation** for skilled intermittent nursing services in the home setting, prior authorization is NOT required if the service is provided by a qualified RN and is billed with this code appended with a U1 modifier in the first modifier position as the first date of service per member per benefit/Plan year per treating, qualified provider group (categorized by TIN),

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	EITHER for intermittent skilled nursing services for medical home health services or for psychiatric visiting nurse home health services. Skilled intermittent nursing home care services include all nursing services provided by both RNs and LPNs in the home setting. Prior authorization is REQUIRED when wavier guidelines are not met and for all additional services.
G0299 TT UD	Services of an RN in home health setting, per visit Plan notes: Use when billing for **each subsequent Plan member – not for the first member** - when 2 or more members in the same household are receiving a nursing visit during the same time period; this code is used for home health care services provided to members for **31 calendar days or longer** (per home health care episode of care in a continuous treatment time period, with the frequency of services based on the Plan's medical necessity criteria and the member's treatment plan). The number of visits for this time period for a Plan member includes ALL skilled intermittent nursing home health care visits provided by an RN billed with G0299 and an LPN billed with HCPCS code G0300 from ALL treating providers. When billing the Plan for the **second or any additional members**, the service code and modifier must reflect the home health care visit for each subsequent member. In those cases, where 2 or more Plan members living in the same household require home health care services, the treating home health agency/provider must document the medical necessity of the home health care visit in each of the member's medical record and obtain prior authorization for each member according to the Plan's applicable medical necessity criteria. When skilled intermittent nursing services cannot be provided during a single home health care visit for 2 or more members in the same household, the provider must document the medical necessity of each additional visit (rather than rendering home health care services to 2 or more members during the same visit). This code may be billed in combination with HCPCS code G0300 and may be used to bill for psychiatric visiting nurse home health services. When this code is used by a participating provider for an **initial evaluation** for skilled intermittent nursing services in the home setting, prior authorization is NOT required if the service is provided by a qualified RN and is billed with this code appended with a U1 modifier in the first modifier position as the first date of service per member per benefit/Plan year per treating, qualified provider group (categorized by TIN), EITHER for intermittent skilled nursing services for medical home health services or for psychiatric visiting nurse home health services. Skilled intermittent nursing home care services include all nursing services provided by both RNs and LPNs in the home setting. Prior authorization is REQUIRED when wavier guidelines are not met and for all additional services.

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G0300	Services of an LPN in home health setting (1 through 30 calendar days), per visit Plan notes: The number of calendar days (1 through 30 calendar days) includes ALL skilled intermittent nursing home health care visits provided to a Plan member (per home health care episode of care in a continuous treatment time period, with the frequency of services based on the Plan's medical necessity criteria and the member's treatment plan). The number of visits for this time period includes ALL skilled intermittent nursing home care visits provided by an RN billed with HCPCS G0299 and an LPN billed with HCPCS code G0300 from ALL treating providers. This code may be billed in combination with HCPCS code G0299 and may be used to bill for psychiatric visiting nurse home health services. When this code is used by a participating provider for an **initial evaluation** for skilled intermittent nursing services in the home setting, prior authorization is NOT required if the service is provided by a qualified LPN and is billed with this code appended with a **U1 modifier** in the first modifier position as the first date of service per member per benefit/Plan year per treating, qualified provider group (categorized by TIN), EITHER for intermittent skilled nursing services for medical home health services or for psychiatric visiting nurse home health services. Skilled intermittent nursing home care services include all nursing services provided by both RNs and LPNs in the home setting. Prior authorization is REQUIRED when wavier guidelines are not met and for all additional services.
G0300 UD	Services of an LPN in home health setting (31+ calendar days), per visit Plan notes: The number of calendar days (31 calendar days or longer) includes all skilled nursing visits provided to a Plan member (per home health care episode of care in a continuous treatment time period, with the frequency of services based on the Plan's medical necessity criteria and the member's treatment plan). The number of visits for this time period includes ALL skilled intermittent nursing home care visits provided by an RN billed with HCPCS G0299 and an LPN billed with HCPCS code G0300 (from ALL home health agencies/treating providers). This code may be billed in combination with HCPCS code G0299 and may be used to bill for psychiatric visiting nurse home health services. When this code is used by a participating provider for an **initial evaluation** for skilled intermittent nursing services in the home setting, prior authorization is NOT required if the service is provided by a qualified LPN and is billed with this code appended with a **U1 modifier** in the first modifier position as the first date of service per member per benefit/Plan year per treating, qualified provider group (categorized by TIN), EITHER for intermittent skilled nursing services for medical home health services or for psychiatric visiting nurse home health services. Skilled intermittent nursing home care services include all nursing services provided by both RNs and LPNs in

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	the home setting. Prior authorization is REQUIRED when wavier guidelines are not met and for all additional services.
G0300 TT	Services of an LPN in home health setting, per visit Plan notes: Use when billing for **each subsequent Plan member – not for the first member** - when 2 or more members in the same household are receiving a nursing visit during the same time period; this code is used for home health care services provided to Plan members for **1 through 30 calendar days** (per home health care episode of care in a continuous treatment time period, with the frequency of services based on the Plan's medical necessity criteria and the member's treatment plan). The number of visits for this time period includes ALL skilled intermittent nursing home health care visits provided by an RN billed with G0299 and an LPN billed with HCPCS code G0300 from ALL treating providers. When billing the Plan for the **second or any additional members**, the service code and modifier must reflect the home health care visit for each subsequent member. In those cases, where 2 or more Plan members living in the same household require home health care services, the treating home health agency/provider must document the medical necessity of the home health care visit in each of the member's medical record and obtain prior authorization for each member according to the Plan's applicable medical necessity criteria. When skilled intermittent nursing services cannot be provided during a single home health care visit for 2 or more members in the same household, the provider must document the medical necessity of each additional visit (rather than rendering home health care services to 2 or more members during the same visit). This code may be billed in combination with HCPCS code G0299 and may be used to bill for psychiatric visiting nurse home health services. When this code is used by a participating provider for an **initial evaluation** for skilled intermittent nursing services in the home setting, prior authorization is NOT required if the service is provided by a qualified LPN and is billed with this code appended with a **U1 modifier** in the first modifier position as the first date of service per member per benefit/Plan year per treating, qualified provider group (categorized by TIN), EITHER for intermittent skilled nursing services for medical home health services or for psychiatric visiting nurse home health services. Skilled intermittent nursing home care services include all nursing services provided by RNs and LPNs in the home setting. Prior authorization is REQUIRED when wavier guidelines are not met and for all additional services.

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G0300 TT UD	Services of an LPN in home health setting, per visit Plan notes: Use when billing for **each subsequent Plan member – not for the first member** - when 2 or more members in the same household are receiving a nursing visit during the same time period; this code is used for home health care services provided to Plan members for **31 calendar days or longer** (per home health care episode of care in a continuous treatment time period, with the frequency of services based on the Plan's medical necessity criteria and the member's treatment plan). The number of visits for this time period includes ALL skilled intermittent nursing home health care visits provided by a registered nurse (RN) billed with G0299 and a licensed practical nurse (LPN) billed with HCPCS code G0300 (from ALL home health care agencies/treating providers). When billing the Plan for the **second or any additional members**, the service code and modifier must reflect the home health care visit for each subsequent member. In those cases, where 2 or more Plan members living in the same household require home health care services, the treating home health agency/provider must document the medical necessity of the home health care visit in each of the member's medical record and obtain prior authorization for each member according to the Plan's applicable medical necessity criteria. When skilled intermittent nursing services cannot be provided during a single home health care visit for 2 or more members in the same household, the provider must document the medical necessity of each additional visit (rather than rendering home health care services to 2 or more members during the same visit). This code may be billed in combination with HCPCS code G0299 and may be used to bill for psychiatric visiting nurse home health services. When this code is used by a participating provider for an **initial evaluation** for skilled intermittent nursing services in the home setting, prior authorization is NOT required if the service is provided by a qualified LPN and is billed with this code appended with a U1 modifier in the first modifier position as the first date of service per member per benefit/Plan year per treating, qualified provider group (categorized by TIN), EITHER for intermittent skilled nursing services for medical home health services or for psychiatric visiting nurse home health services. Skilled intermittent nursing home care services include all nursing services provided by both RNs and LPNs in the home setting. Prior authorization is REQUIRED when wavier guidelines are not met and for all additional services.

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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) Plan note: Code used for RN home health assessment visit (initial assessment visit and/or on-site visit) that must occur no less frequently that **every 60 calendar days** while HHA-ADL only services are provided to update and sign the member's home health aide services plan of care, as well as observe and assess the HHA while performing the member's care. Plan prior authorization is required for ALL HHA services prior to the start of care.
S9470	Nutritional counseling, dietitian visit Plan note: Prior authorization is NOT required for an initial evaluation for nutrition services when conducted by a qualified, participating dietician, when the code is appended with a U1 modifier in the first modifier position as the first date of service per member per benefit/Plan year per treating, qualified provider group (categorized by TIN).
T1502	Administration of oral, intramuscular, and/or subcutaneous medication by health care agency/professional (RN or LPN), per visit Plan note: Use this code only for medication administration visit. Medication administration visits must include teaching on medication management to maximize independence and the assessment of the member response to medication. If medication administration is not the sole purpose of the visit it is not separately reimbursable.
T1503	Administration of medication other than oral, intramuscular, and/or subcutaneous medication by health care agency/professional (RN or LPN), per visit Plan note: Use this code only for medication administration visit. Medication administration visits must include teaching on medication management to maximize independence and the assessment of the member response to medication. If medication administration is not the sole purpose of the visit it is not separately reimbursable.

References

Bahar-Fuchs A, Clare L, Woods B. Cognitive training and cognitive rehabilitation for persons with mild to moderate dementia of the Alzheimer's or vascular type: a review. Alzheimers Res Ther. 2013;5(4):35. doi: 10.1186/alzrt189. PMID: 23924584.

Commonwealth of Massachusetts. Board of Allied Health Professions. Athletic Trainers, Occupational Therapists, Occupational Therapist Assistants, Physical Therapists, Physical Therapist Assistants.

Commonwealth of Massachusetts. Bureau of Health Professions Licensure

Commonwealth of Massachusetts. Division of Insurance (DOI) Bulletins.

Slomine B, Locascio G. Cognitive rehabilitation for children with acquired brain injury. Dev Disabil Res Rev. 2009;15(2):133-43. doi: 10.1002/ddrr.56. PMID: 9489085.

Policy History

Original Approval Date	Original Effective Date* and Version Number	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 06/17/20: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC)	09/01/20 Version 1	Medical Policy Manager as Chair of MPCTAC	MPCTAC

* Prior to 09/01/20 the clinical review criteria used for the Qualified Health Plans/ConnectorCare/Employer Choice Direct products were the medical necessity guidelines included in the *Home Health Care* medical policy, policy number OCA 3.719. Policy title was *Home Health Care Services*, policy number OCA 3.719 from 09/01/20 to 11/31/21. As of 12/01/21, revised policy title and reassigned policy number to: *Home Health Care* medical policy, policy number OCA 3.732.

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
04/01/21	Review for effective date 07/01/21. Revised Plan notes and added HCPCS code S9470 to the Applicable Coding section.	07/01/21 Version 2 (Version 2 not implemented; replaced with Version 3 effective 07/01/21)	04/21/21: MPCTAC
05/01/21	Review for effective date 07/01/21. Administrative changes made to the Description of Item or Service, Definitions, and References sections.	07/01/21 Version 3	05/19/21: MPCTAC
11/01/21	Review for Review for effective date 12/01/21. Adopted new medical policy template; removed	12/01/21 Version 4	11/17/21: MPCTAC

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Policy Revisions History			
	administrative sections, the Medical Policy Statement section renamed the Clinical Criteria section, and the Limitations section renamed the Limitations and Exclusions section. Administrative changes made to the Policy Summary, Clinical Criteria, Limitations and Exclusions, Applicable Coding, and References sections. Revised the policy title and reassigned policy number.		

Next Review Date

05/01/22

Authorizing Entity

MPCTAC

Disclaimer Information: +

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

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