BOSTON MEDICAL CENTER
HEALTHNet PLAN

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Medical Policy and InterQual® Criteria

Home Health Care

Policy Number: OCA 3.719
Version Number: 24
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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 for an adult or pediatric member or are **required EPSDT services** for a member age 20 or younger on the date of service. **The member does NOT need to be 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 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.

Prior authorization is required according to the guidelines outlined below:

1. **Home Health Aide Services:**

   All services REQUIRE Plan prior authorization, including the initial evaluation to verify that the member is receiving skilled home care services. The Plan uses **InterQual® criteria** (and EPSDT guidelines, when applicable) to determine medical necessity. When criteria are met, the Plan covers HHA services for MassHealth and SCO members with or without skilled intermittent nursing home health care services and/or skilled therapy home health care services. HHA services are NOT a replacement for personal care assistant services. When services are covered for a Plan member, personal care assistant services and HHA services must meet applicable Plan medical necessity criteria.

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. The Plan uses **InterQual® criteria** (and EPSDT guidelines, when applicable) 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. The Plan uses **InterQual® criteria** (and EPSDT guidelines, when applicable) to determine medical necessity.

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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** (and/or EPSDT guidelines, when applicable) to determine medical necessity.

5. **Personal Care Assistant Services**:

   Personal care assistant services are covered for Senior Care Options (SCO) members. All services REQUIRE prior authorization that must be obtained from the Plan's Care Management Department, including authorization for the initial evaluation.

6. **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** (and/or EPSDT guidelines, when applicable) to determine medical necessity.

7. **Postpartum Discharge and Follow-Up 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

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

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** (and EPSDT guidelines, when applicable) to determine medical necessity.

8. **Private Duty Nursing (PDN) Services**:

PDN services are ONLY covered for Plan MassHealth members who are ALSO enrolled in the Special Kids Special Care Program (SKSCP) and for SCO members, as specified below in EITHER item a or item b:

a. For Plan MassHealth members who are enrolled in the Special Kids Special Care Program (SKSCP), see the *Private Duty Nursing Services* medical policy, policy number OCA 3.715, rather than this policy for Plan's applicable guidelines; OR

b. Prior authorization is REQUIRED from the Plan's Care Management Department for ALL PDN for SCO members, including the initial evaluation; OR

9. **Skilled Intermittent Nursing Home Care Services or Psychiatric Visiting Nurse Home Health Services:**

Prior authorization is NOT required for an 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 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** (and EPSDT guidelines, when applicable) to determine medical necessity.

10. **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

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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** (and/or EPSDT guidelines, when applicable) to determine medical necessity.

For MassHealth ACO members, the Plan's medical necessity guidelines for home health care services are NOT more restrictive than the MassHealth guidelines for medical necessity determination for home health care services. The Plan will work with a member's treating provider(s) as appropriate to transition care when there is a change in the member's home health care needs. Prior authorization requests for adult day care services/adult medical day care, personal care assistant services, and/or private duty nursing services for Senior Care Options members are reviewed by the Plan's Care Management Department (rather than using criteria included in this Plan medical policy).

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 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.

Clinical Criteria

Home health care services are considered **medically necessary**, including habilitative services and/or rehabilitative services, when applicable **InterQual® criteria** are met for an adult or pediatric member or are **required EPSDT services** for a member age 20 or younger on the date of service.

Limitations and Exclusions

I. Home Health Aide Services:

   A. 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.

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B. HHA-ADL only services are services provided by a home health aide (HHA) to assist a member with hands-on assistance with activities of daily living (ADLs) when the member is NOT concurrently receiving skilled nursing home health care services and/or skilled therapy home health care services. Assisting a member with independent ADLs (IADLs) is NOT a medically necessary indication for HHA-ADL only services, but the time allotted for medically necessary HHA-ADL only services may include time to care for incidental support for HHA-ADL only services (e.g., cueing and supervision) for IADs performed by the member.

II. ANY of the following services in items A through I is NOT considered medically necessary:

A. For MassHealth enrollees, continuous skilled nursing services are considered a wrap benefit and are authorized and managed directly by MassHealth. The Plan will assist providers in accessing these services, when applicable. PDN services are ONLY covered for Plan MassHealth members who are enrolled in the Special Kids Special Care Program (SKSCP) and for SCO members when applicable Plan criteria are met.

B. Custodial care services are considered a wrap benefit for MassHealth members and are authorized and managed directly by MassHealth. The Plan will assist providers in accessing these services, when applicable.

C. Home care services provided in a hospital, nursing facility, intermediate care facility for members with intellectual disabilities, 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 for the MassHealth products.

D. Homemaker, respite, and/or chore services are NOT considered home health aide services.

E. Maintenance home health care services are covered by the Plan ONLY when the member is receiving medically necessary skilled home care services, including nutrition services by a dietician, skilled intermittent nursing services by an RN or LPN, respiratory therapy as a component of skilled intermittent nursing services by an RN or LPN, social work services by a clinical social worker, occupational therapy by an occupational therapist, physical therapy by a physical therapist, and/or speech therapy by a speech-language pathologist/speech therapist. The Plan does NOT cover home health care services related to activities for the general good and welfare of members such as general exercise to promote overall fitness and flexibility and activities to provide diversion or general motivation.

F. Personal care attendant services are considered a wrap benefit for MassHealth members and are authorized and managed directly by MassHealth. The Plan will assist providers in accessing these services, when applicable.

G. Services that can be safely and effectively performed (or self-administered) by the average non-medical person without the direct supervision of a registered or licensed nurse unless there is

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no one able to provide it; these services are NOT considered medically necessary for the MassHealth products and include but are not limited to ANY of the following services in items 1 through 3:

1. 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

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

3. The administration of eye drops and topical ointments.

H. 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. MassHealth does NOT pay for supervisory visits.

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

III. Home health care services are NOT considered medically necessary for ANY of circumstance listed in items A through L:

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 except as specified in the Definitions section of this policy; OR

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I. Maintenance of functional skills that do NOT require the level of sophistication and training of a licensed physical therapist, occupational therapist, and/or speech language pathologist/speech therapist; OR

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

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

L. Services are considered research in nature, experimental and investigational, or NOT medically necessary.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for Senior Care Options (SCO) members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's most recent policy review, CMS NCD 290.1 and 290.2 include covered indications for home health care services. Verify CMS guidelines in effect on the date of the prior authorization request. When there is no guidance from CMS for the requested service, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service

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 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

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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. Member benefit documents are available at www.bmchp.org for BMC HealthNet Plan members and posted at www.SeniorsGetMore.org for Senior Care Options members.

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 an RN billed with G0299 and LPN billed with HCPCS code G0300 from ALL treating providers. When this code is used for 1 postpartum home care visit provided 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). HCPCS code G0299 may also be used for additional postpartum

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	home visits when medically necessary (and may be used in combination with HCPCS code G0300), but prior authorization is REQUIRED.
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 for a Plan member includes ALL skilled intermittent nursing home health care visits provided by an RN billed with G0299 and LPN billed with HCPCS code G0300 from ALL 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). HCPCS code G0300 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.

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: Use HCPCS code G0159 rather than this code for services performed by a qualified physical therapist as a component of a home maintenance program and Plan criteria are met. When this code 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 waiver guidelines are not met and for additional services.
G0152	Services of occupational therapist in the home health setting, per visit Plan note: Use HCPCS code G0160 rather than this code for services performed by a qualified occupational therapist as a component of a home maintenance

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	program when Plan criteria are met. When 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 waiver guidelines are not met and for additional services.
G0153	Services of speech/language therapist in the home health setting, per visit Plan note: Use HCPCS code G0161 rather than this code for services performed by a qualified speech-language pathologist as a component of a home maintenance program when Plan criteria are met. When 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 waiver guidelines are not met and for additional services.
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 waiver guidelines are not met and for 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 when skilled nursing/therapeutic home health care services are concurrently provided.
G0156 UD	Services of home health/hospice aide in home health or hospice setting, per 15 minutes Plan note: Code/modifier combination used to document HHA services for assistance with only activities of daily living (ADLs) when skilled nursing/ therapeutic home health care services are NOT concurrently provided (i.e., HHA-ADL only services). All home health aide (HHA) services REQUIRE Plan prior authorization prior to the start of care. When the HHA-ADL only service is covered

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	for a MassHealth member or Senior Care Options member (as stated in the member's applicable benefit document), the Plan covers HHA services for members with or without concurrent skilled nursing/therapeutic home health care services according to applicable medical necessity criteria. The MassHealth WRAP benefit may provide coverage for long-term assistance to manage chronic conditions through the services such as the MassHealth Personal Care Attendant (PCA) Program.
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 an RN billed with G0299 and LPN billed with HCPCS code G0300 from ALL treating providers. HCPCS code G0299 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 waiver guidelines are not met and for additional services.
G0299 UD	Services of an RN in home health setting (31+ calendar days), per visit Plan notes: This code/modifier combination is NOT payable for the Senior Care Options (SCO) product. 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 LPN billed with HCPCS code G0300 from ALL treating providers. HCPCS code G0299 may be billed in combination with HCPCS code G0300 and may

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	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 LPNs in the home setting. Prior authorization is required when waiver guidelines are not met and for additional services.
G0299 TT	Services of an RN in home health setting, per visit Plan notes: Code/modifier combination is NOT payable for the SCO product. 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 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),

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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 waiver guidelines are not met and for additional services.
G0299 TT UD	Services of an RN in home health setting, per visit Plan notes: This code/modifier combination is NOT payable for the SCO product. 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 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 waiver guidelines are not met and for 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 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.
G0300 UD	Services of an LPN in home health setting (31+ calendar days), per visit Plan notes: Code/modifier combination is NOT payable for the SCO product. 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 LPN billed with HCPCS code G0300 from ALL treating providers. This code may be billed in combination with HCPCS code G0299 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. Prior authorization is required when waiver guidelines are not met and for additional services.
G0300 TT	Services of an LPN in home health setting, per visit

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	Plan notes: This code/modifier combination is NOT payable for the SCO product. 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 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. Prior authorization is required when waiver guidelines are not met and for additional services.
G0300 TT UD	Services of an LPN in home health setting, per visit Plan notes: Code/modifier combination is NOT payable for the SCO product. 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

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	of visits for this time period includes ALL skilled intermittent nursing home health care visits provided by an 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 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 waiver guidelines are not met and for additional services.
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.
G2168	Services performed by a physical therapist assistant in the home health setting in the delivery of a safe and effective physical therapy maintenance program, each 15

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	minutes Plan note: Code is ONLY payable for the SCO product.
G2169	Services performed by an occupational therapist assistant in the home health setting in the delivery of a safe and effective occupational therapy maintenance program, each 15 minutes Plan note: Code is ONLY payable for the SCO product.
S9470	Nutritional counseling, dietitian visit Plan note: Code is payable for the Plan's MassHealth product. Code may or may not be payable for the SCO product based on the provider type and member type. Review the following Plan reimbursement policies posted at www.bmchp.org for payment guidelines to determine if this code is listed as payable for the requesting provider and the member's type of SCO coverage (dually eligible or MassHealth only): *Medicare Certified Home Health Agency Services* reimbursement policy, policy number SCO 4.7, and *Non-Medicare Certified Home Health Agency Services* reimbursement policy, policy number SCO 4.6. 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). Prior authorization is required when waiver guidelines are not met and for additional services.
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. Code is payable for the Plan's MassHealth product. Code may or may not be payable for the SCO product based on the provider type and member type. Review the following Plan reimbursement policies posted at www.bmchp.org for payment guidelines to determine if this code is listed as payable for the requesting provider and the member's type of SCO coverage (dually eligible or MassHealth only): *Medicare Certified Home Health Agency Services* reimbursement policy, policy number SCO 4.7, and *Non-Medicare Certified Home Health Agency Services* reimbursement policy, policy number SCO 4.6.
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

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	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. Code is payable for the Plan's MassHealth product. Code may or may not be payable for the SCO product based on the provider type and member type. Review the following Plan reimbursement policies posted at www.bmchp.org for payment guidelines to determine if this code is listed as payable for the requesting provider and the member's type of SCO coverage (dually eligible or MassHealth only): *Medicare Certified Home Health Agency Services* reimbursement policy, policy number SCO 4.7, and *Non-Medicare Certified Home Health Agency Services* reimbursement policy, policy number SCO 4.6.

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Policy History

Original Approval Date	Original Effective Date* and Version Number	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 06/30/10: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) 07/28/10: Quality Improvement Committee (QIC)	10/01/10 Version 1	Medical Policy Manager as Chair of MPCTAC	MPCTAC and QIC

* Effective Date for the BMC HealthNet Plan Commercial Product: 01/01/12
* Effective Date for the Senior Care Options Product: 01/01/16

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* Qualified Health Plans/ConnectorCare/Employer Choice Direct products were included in this medical policy until 08/31/20; review the Plan's *Home Health Care Services* medical policy, policy number OCA 3.729 QHP, for clinical review criteria as of 09/01/20 for members enrolled in the Qualified Health Plans/ConnectorCare/ Employer Choice Direct products.

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
06/01/11	Updated coding, added language and criteria appropriate for Commercial Members: The Plan covers medically necessary nutritional consultation by a dietician, home visits by a *network* physician. Inhalation therapy, home infusion therapy and total parental nutritional therapy.	Version 2	06/29/11: MPCTAC 07/27/11: QIC
06/01/12	Updated code descriptions, updated references, and revised the introductory paragraph in Applicable Coding section. Because timeframe for clinical review may vary, deleted sentence in Clinical Guideline Statement section that stated the following: "Requests for continued coverage of home health care service require clinical review every 30 days." Removed home bound requirement for MassHealth members only. In Skilled Nursing Care definition, included "chronic subcutaneous injection" with short-term subcutaneous injections as a type of injection generally self- administered by the enrollee.	Version 3	06/20/12: MPCTAC 07/25/12: QIC
05/01/13	Review with effective date 09/01/13. Changed title from "Home Health Care Services Guidelines" to "Home Health Care" and revised Summary and Description of Item or Service sections. Reformatted and revised criteria in the Medical Policy Statement section. Updated references. Added codes to the applicable code list (and excluded codes for initial evaluations). Referenced Reimbursement Guidelines: Home Health policy and Medically Necessary policy.	09/01/13 Version 4	05/15/13: MPCTAC 06/20/13: QIC
05/01/14	Review for effective date 09/01/14. Revised Summary and Clinical Background Information and References sections. Reformatted and revised criteria so all sections included respiratory therapy as a home health care service. Clarified benefit coverage guidelines in Limitations section. Revised Definitions section to specify a calendar week. Added language in the Applicable Coding section regarding hospice care	09/01/14 Version 5	05/21/14: MPCTAC 06/11/14: QIC

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Policy Revisions History			
	without changing the applicable code list.		
05/01/15	Review for effective date 07/01/15. Removed Commonwealth Care, Commonwealth Choice, and Employer Choice from the list of applicable products because the products are no longer available. Removed references to these terminated products in the Policy Summary, Medical Policy Statement, and Limitations sections without changing criteria.	07/01/15 Version 6	05/20/15: MPCTAC 06/10/15: QIC
11/25/15	Review for effective date 01/01/16. Updated list of applicable products and corresponding notes. Administrative changes made to the Summary, Medical Policy Statement, Limitations, and Definitions sections without changing the criteria. Updated language in the Applicable Coding section.	01/01/16 Version 7	11/18/15: MPCTAC 11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
11/25/15	Review for effective date 03/01/16. Revised the list of applicable codes.	03/01/16 Version 8	11/18/15: MPCTAC 11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
05/01/16	Review for effective date 09/01/16. Updated Summary, Description of Item or Service, Definitions, Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections. Plan notes added to the Applicable Coding section and revisions made to applicable code list by product type. Criteria revisions made in the Medical Policy Statement section.	09/01/16 Version 9	05/18/16: MPCTAC 06/08/16: QIC
09/01/16 and 09/28/16	Review for effective date 11/01/16. Updated Definitions and References to Applicable Laws and Regulations sections. Administrative changes made to clarify language related to gender.	11/01/16 Version 10	09/21/16: MPCTAC 09/30/16: MPCTAC (electronic vote) 10/12/16: QIC
12/05/16	Industry-wide revisions to the applicable code list effective 01/01/17.	01/01/17 Version 11	Not applicable because industry-wide code revisions.
12/29/16	Review for effective date 04/01/17. Revisions to the criteria in the Medical Policy Statement section to coincide with established reimbursement guidelines for MassHealth, QHP, and SCO products. Updated Description of Item or Service section and revised Plan notes in the Applicable Coding section.	04/01/17 Version 12	01/04/17: MPCTAC (electronic vote) 01/11/17: QIC
03/01/17	Review for effective date 06/07/17. Updated Description of Item or Service section. Revised criteria in the Medical Policy Statement section. Updated code list and Plan notes in the Applicable Coding section.	06/07/17 Version 13	03/15/17: MPCTAC

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Policy Revisions History			
04/01/17	Review for effective date 07/08/17. Revised criteria in Medical Policy Statement section. Revised code list and updated Plan notes in the Applicable Coding section. Updated Definitions section. Changed authorization waiver guidelines from calendar year to benefit/Plan year.	07/08/17 Version 14	04/19/17: MPCTAC
02/01/18	Review for effective date 03/01/18. Administrative changes made to the Policy Summary, Medical Policy Statement, Limitations, Definitions, and Other Applicable Policies sections. Added documentation stating that medically necessary private duty nursing services are covered for BMC HealthNet Plan MassHealth members who are also enrolled in the Special Kids Special Care Program.	03/01/18 Version 15	02/21/18: MPCTAC
04/01/18	Review for effective date 07/01/18. Administrative changes made to the Policy Summary, Description of Item or Service, Definitions, References, Other Applicable Policies, and Reference to Applicable Laws and Regulations sections. Revised the criteria in the Medical Policy Statement and Limitations sections. Updated the code list and Plan notes in the Applicable Coding section.	07/01/18 Version 16	04/18/18: MPCTAC
06/01/18	Review for effective date 09/01/18. Administrative changes made to the Policy Summary, Description of Item or Service, Applicable Coding, and Other Applicable Policies sections. Criteria revised in the Medical Policy Statement and Limitations sections.	09/01/18 Version 17	06/20/18: MPCTAC
05/01/19	Review for effective date 07/01/19. Administrative changes made to the Policy Summary, Description of Item or Service, Definitions, Applicable Coding, Clinical Background Information, References, Other Applicable Policies, and Reference to Applicable Laws and Regulations sections. Criteria added to the Medical Policy Statement section for the enhanced benefit coverage for home health aide services for ADL support without skilled nursing/skill therapeutic home health care services, and the effective date of these additional criteria will be consistent with the benefit implementation date.	07/01/19 Version 18	05/15/19: MPCTAC
11/01/19	Review for effective date 02/01/20. Revised code list in the Applicable Coding section to be consistent with the Plan's reimbursement guidelines; HCPCS code S9470 removed because it is not payable for any of the Plan's products.	02/01/20 Version 19	11/20/19: MPCTAC

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Policy Revisions History			
05/01/20	Review for effective date 06/01/20. Administrative changes made to the Policy Summary, Description of Item or Service, Medical Policy Statement, Limitations, and Applicable Coding sections to clarify the existing prior authorization guidelines. Industry-wide code additions made in the Applicable Coding section.	06/01/20 Version 20	05/20/20: MPCTAC
06/01/20	Review for effective date 09/01/20. Removed Qualified Health Plans/ConnectorCare/Employer Choice Direct as applicable products for this medical policy. Updated the Policy Summary, Description of Item or Service, Medical Policy Statement, Limitations, Definitions, and Other Applicable Policies sections.	09/01/20 Version 21	06/17/20: MPCTAC
04/01/21	Review for effective date 07/01/21. Revised Plan notes and added HCPCS code S9470 to the Applicable Coding section. Updated References section.	07/01/21 Version 22 (Version 22 not implemented; replaced with Version 23 effective 07/01/21)	04/21/21: MPCTAC
05/01/21	Review for effective date 07/01/21. Administrative changes made to the Medical Policy Statement, Definitions, and References sections.	07/01/21 Version 23	05/19/21: MPCTAC
11/01/21	Review for effective date 02/01/22. Adopted new medical policy template; removed 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, Limitations and Exclusions, Applicable Coding, and References sections. InterQual criteria adopted to determine the medical necessity of home health care services.	02/01/22 Version 24	11/17/21: MPCTAC

Next Review Date

05/01/22

Authorizing Entity

MPCTAC

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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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