Home Health Care
Payment Policy

Applicability

This Policy applies to the following Fallon Health products:

☒ Fallon Medicare Plus, Fallon Medicare Plus Central (Medicare Advantage)
☒ MassHealth ACO
☒ NaviCare HMO SNP
☒ NaviCare SCO (Medicaid-only)
☒ Summit ElderCare PACE
☒ Fallon Health Weinberg PACE
☒ Community Care (Commercial/Exchange)

Policy

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

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

- Services must be ordered by a licensed physician (MD, DO, DPM). The physician must sign a plan of care certifying the home health services are medically necessary.
- The member must be under a plan of treatment established and periodically reviewed by a licensed physician.
- Community Carel and Medicare Advantage members must be homebound (not able to leave the home without a taxing effort). For products with MassHealth enrollment (inclusive of dual-enrolled programs NaviCare, Summit ElderCare) there is no requirement to be homebound.
- The member must have a clinical need for part-time, intermittent skilled services, which include at least one of the following disciplines: skilled nursing (RN), physical therapy, occupational therapy, or speech therapy. In order to qualify for a medical social worker or a home health aide to assist with personal care, the member must also have the clinical need for at least one of the skilled services listed above. Summit ElderCare members are not required to need skilled services in order to qualify for a home health aide to assist with personal care.
- There must be an end point to the services based on medical necessity.

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

In accordance with MassHealth guidelines (in effect since 07/01/2019), the following additional services will be considered for coverage for MassHealth ACO and NaviCare members:

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

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

60 days in order to observe and assess each home health aide while he or she is performing care.

Other Services Furnished by Home Health Agencies
When allowed by their provider contract with the Plan, payment may be made to a home health agency that furnishes outpatient physical therapy, outpatient occupational therapy and outpatient speech-language pathology services to a Medicare member (Medicare Advantage, NaviCare and PACE) who is not homebound or otherwise receiving services under a home health plan of care (See Medicare Benefit Policy Manual, Chapter 15, Section and Medicare Claims Processing Manual, Chapter 5). Outpatient therapy services must be billed with therapy procedure codes (CPT/HCPCS) therapy revenue codes (042X, 043X, 044X), therapy modifiers (GN, GO and GP) and therapy assistant modifiers (CQ and CO), as applicable. Please refer to Physical and Occupational Payment Policy or Speech Therapy Payment Policy for detailed billing and coding guidelines for outpatient therapy services.

Definitions

Skilled Home Health Care Guidelines: Home health care services (skilled nursing, physical therapy, occupational therapy, speech therapy, medical social work, and home health aide services) are provided to members in their home by Medicare-certified home health care agencies and are considered skilled when they can only be safely and effectively provided by and/or under the supervision of a licensed clinician. Home health care services must be ordered by a licensed physician. The member must meet Medicare home health care criteria in order to qualify for these services.

Reimbursement

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

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

Referral/notification/prior authorization requirements

Home health care requires prior authorization.

Effective July 1, 2025, prior authorization requests for home health care for all members, excluding Summit ElderCare PACE and Fallon Health Weinberg PACE members, must be submitted to Integrated Home Care Services (IHCS) at FAX number: 844-215-4265. Prior authorization requests for Summit ElderCare PACE and Fallon Health Weinberg PACE members will continue to be submitted to the PACE member's interdisciplinary care team.

Each PACE plan member is assigned to an Interdisciplinary Team. PACE provides participants with all the care and services covered by Medicare and Medicaid, as authorized by the interdisciplinary team, as well as additional medically necessary care and services not covered by Medicare and Medicaid. With the exception of emergency care and out-of-area urgently needed care, all care and services provided to PACE plan members must be authorized by the interdisciplinary team.

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

HCPCS Code	Description
G0299	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes

HCPCS Code	Description
G0300	Direct skilled nursing services of a licensed practical nurse (LPN) in the home health or hospice setting, each 15 minutes

Billing/coding guidelines

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

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

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

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

HCPCS Code	Description
G0151	Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes
G0155	Services of clinical social worker in home health or hospice settings, each 15 minutes
G0156	Services of home health/hospice aide in home health or hospice settings, each 15 minutes
G0157	Services performed by a qualified physical therapist assistant in the home health or hospice setting, each 15 minutes
G0158	Services performed by a qualified occupational therapist assistant in the home health or hospice setting, each 15 minutes
G0162	Skilled services by a registered nurse (RN) for management and evaluation of the plan of care; each 15 minutes (the patient's underlying condition or complication requires an RN to ensure that essential nonskilled care achieves its purpose in the home health or hospice setting)
G0299	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes
G0300	Direct skilled nursing services of a licensed practical nurse (LPN) in the home health or hospice setting, each 15 minutes
G0493	Skilled services of a registered nurse (RN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting)
G0494	Skilled services of a licensed practical nurse (LPN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the

	patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting)

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

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

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

Code	Description
G0299	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes
G0300	Direct skilled nursing services of a licensed practical nurse (LPN) in the home health or hospice setting, each 15 minutes

MassHealth ACO's, NaviCare, Summit ElderCare utilize the below codes, prior authorization is required.

Code	Description
G0493	Skilled services of a registered nurse (rn) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting) With revenue code 0583
G0156 Use Modifier UD	Services of home health/hospice aide in home health or hospice settings, each 15 minutes With revenue code 0572 or 0579 (based on contract)
T1502	Administration of oral, intramuscular and/or subcutaneous medication by health care agency/professional, per visit With revenue code 0590
T1503	Administration of medication, other than oral and/or injectable, by a health care agency/professional, per visit With revenue code 0590

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

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

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

Modifier EY for MassHealth ACO and NaviCare Members

In accordance with MassHealth Home Health Agency Bulletin 85 June 2023, home health agencies who are unable to have a member's plan of care signed by the physician or ordering nonphysician practitioner in accordance with 130 CMR 403.420 may bill the applicable home health service code with modifier EY: No physician or other licensed health care provider order for this item or service.

When a home health agency bills modifier EY with a home health service code, the claim will be denied and the home health agency will not be reimbursed for the services included on the claim. Home health agencies will have 12 months from the date of service to resubmit the claim without the modifier EY for payment. Please note that claims should only be amended if the home health agency successfully secures a signed plan of care applicable for the specific date of service(s) on the claim.

Home health providers who submit claims without an established, signed plan of care may be subject to recoupment by the Plan.

Universal Postpartum Home Visiting Services for Community Care Members

In accordance with, universal postpartum home visiting services are covered for Community Care members effective for dates of service on or after November 21, 2024

Universal postpartum home visiting services are defined as evidence-based, voluntary home or community-based services for birthing people and caregivers with newborns, including but not limited to: (i) screenings for unmet health needs including reproductive health services; (ii) maternal and infant nutritional needs; and (iii) emotional health supports, including postpartum depression supports.

Universal postpartum home visits are exempt from member cost-sharing, except for members in qualified high deductible plans. For members in qualified high-deductible plans, the deductible must be met, and then the universal postpartum home visits will be covered in full.

The first visit shall occur at the patient's home or a mutually agreed upon location within 8 weeks postpartum. The first visit will not require prior authorization and claims must be submitted as follows in order to ensure accurate reimbursement and waiving of member cost-sharing:

- Revenue code 0551, 0552 or 0559
- CPT code 99501
- ICD-10-CM Diagnosis code Z39.2

Additional postpartum home visits may be covered when medically necessary and will require prior authorization. Effective July 1, 2025, prior authorization requests for home health services must be submitted to Integrated Home Care Services (IHCS) at FAX number: 844-215-4265. Additional postpartum home visits must be billed as followis in order to ensure accurate reimbursement and waiving of member cost-sharing:

- Revenue code 0551, 0552 or 0559
- ICD-10-CM Diagnosis code Z39.2

Ordering/Referring Provider NPI
Effective December 1, 2020, all claims for items and services that are the result of an order or referral must include the ordering/referring provider's name, qualifier (DN/DK), and valid NPI.

On a CMS-1500 claim form (02-12) or electronic equivalent:

- Report the name of the ordering provider in Item 17 and the appropriate qualifier to the left of the dotted line on the CMS-1500 (Version 02/12) claim form: DK (ordering provider); report the name of the ordering provider in 2420E Ordering Provider Loop, segment NM1 Ordering Provider Name (Segment NM101 (Qualifier), Segment NM103-NM105 (Name)).
- No information should appear in Item 17a. Item 17a was formerly used to report the Unique Physician Identification Number (UPIN), which is no longer used -- leave this item blank.
- Report the National Provider Identifier (NPI) of the ordering provider in Item 17b or the 837P 2420E Ordering Provider Loop, segment NM109 [NPI].

Qualifier	Provider Role
DN	Referring Provider
DK	Ordering Provider

Place of service

This policy applies to services rendered in the home setting.

Policy history

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

October 2019 – Updated policy for new MassHealth coverage, updated reimbursement section.
January 2020 – Updated definitions.
June 1, 2020 – Updated Policy, Prior Authorization and Billing and Coding sections related to COVID-19 temporary telehealth coverage for MassHealth ACO, NaviCare and Medicare Advantage members.
June 26, 2020 – Updated Policy, Prior Authorization and Billing and Coding sections related to COVID-19 temporary telehealth coverage for Summit ElderCare.
October 2020 - Added requirement for ordering/referring provider's name, qualifier, and valid NPI.
July 2021 – Updated Policy section to include information on outpatient therapy services provided to Medicare plan members.
July 2025 Removed updates related to coronavirus disease 2019 (COVID-19) throughout as this information is outdated; under Billing/coding guidelines, added new section Modifier EY for MassHealth ACO and NaviCare Members; also under Billing/coding guidelines, added new section for Universal Postpartum Home Visiting Services for Community Care Members; under Referral/notification/prior authorization requirements, added new information about how to obtain prior authorizations for home health services effective July 1, 2025.

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