Home Health Services
Clinical Coverage Criteria

Effective July 1, 2025, Fallon Health is delegating utilization management for home health services for all plan members, except PACE members, to Integrated Home Care Services. All prior authorization requests related to home health services should be directed to Integrated Home Care Services at FAX number: 844-215-4265, except for PACE members. Prior authorization requests for PACE members should continue to be submitted to the PACE member's interdisciplinary care team.

Overview

Home health care encompasses a wide range of health care services that are rendered in the members' home. Service may follow an acute in-patient admission or are initiated to prevent an acute admission. Services are aimed at those who can safely be transitioned to the home setting and/or have a need for continued skilled services and rehabilitation.

Policy

This Policy applies to the following Fallon Health products:

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

Effective 7/1/2025, Fallon is partnering with Integrated Home Care Services to review prior authorization requests for home health services.

Home health services require authorization for initial and renewal of skilled nursing and therapy services. Requests should outline the members' diagnosis, functional level, specific therapy needs (e.g. RN, PT, OT, ST.).

All home health requests must be accompanied by supporting clinical documentation to establish medical necessity (physician office visit and/or history and physical, hospital/skilled nursing facility discharge summary).

Recertification is required at least every 60 days when there is a need for continuous home health care after the initial 60-day certification.

Each initial or recertification requires the development of a plan of care by the home health agency. The plan of care must be reviewed and signed by the physician or allowed practitioner who established the plan of care, in consultation with the home health agency professional personnel, at least every 60 days. Recertification requires submission of signed and dated plan of care for previous certification period and re-evaluation by appropriate discipline (RN, PT, OT, ST) as supporting documentation.

Prior authorization is not a guarantee of payment from Fallon Health and is subject to eligibility at the time of service.

Fallon Health Clinical Coverage Criteria

Fallon Health Clinical Coverage Criteria apply to Community Care members. All the criteria listed below must be met and supported in the members' medical records.

Home health services may be considered medically necessary when all of the following criteria are met:

1. Services must be ordered by a licensed physician (MD, DO, DPM) or licensed Nurse Practitioner working under the oversight of a licensed physician.
2. The member must be under a plan of care established and periodically reviewed by a licensed physician. Beginning March 1, 2020, the practitioners listed below may establish and review home health plans of care:
    - A nurse practitioner (NP) collaborating with a physician
    - A clinical nurse specialist (CNS) collaborating with a physician
    - A physician assistant (PA) working in accordance with state law
3. The member must be homebound (not able to leave the home without a taxing effort).
4. 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.
5. There must be an end point to the services based on medical necessity.

Home health 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 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 or other allowed practitioner.

The services must be provided with a reasonable endpoint and goal towards medical stability Services will no longer be covered when any of the following occurs:

- The member no longer meets criteria for services and services can be rendered at another less intensive level of care.).
- The members' individual treatment plan and goals have been met.
- The member's support system is in agreement with an aftercare treatment plan.

An authorized plan to wean a member to limited or completely off of services may be put into place. If a request is initiated to return the member to the previous level of services then there must be detailed documentation as to why the weaning plan did not work.

Medicare Variation

Beneficiary qualifications for coverage of services are at 42 CFR 409.42. Medicare does not have an NCD for home health services. National Government Services, Inc. is the Home Health & Hospice Medicare Administrative Contractor with jurisdiction in the Plan's service area. National Government Services, Inc. does not have an LCD for Home Health Services (Medicare Coverage Database search 04/15/2025).

Home Health Services will be considered medically necessary for Medicare Advantage plan members when the member meets all of the requirements of 42 CFR § 409.42, as interpreted by the Medicare Benefit Policy Manual, Chapter 7 – Home Health Services. Coverage for home health services is fully established by Medicare, therefore the Plan's coverage criteria are not applicable.

All criteria must be met and supported in the members' medical records.

MassHealth Variation

MassHealth has Guidelines for Medical Necessity Determination for Home Health Services. Fallon Health will determine medical necessity for home health service for MassHealth members in accordance with MassHealth Guidelines for Medical Necessity Determination for Home Health Services. Additionally, home health services provided to MassHealth members must meet requirements in MassHealth regulations at 130 CMR 403.000: Home Health Agency.

Home health services must be ordered by a physician or ordering non-physician practitioner and must be included in the plan of care for the member and based upon medical necessity and are only for medical therapy or medication management oversight and not social/respite needs.

All criteria must be met and supported in the members' medical records.

Exclusions

- Home health services other than described as above.
- Custodial care, unless specifically covered under the member's plan.
- Services provided in the home for the members' convenience.

Coding

The following codes are included below for informational purposes only; inclusion of a code does not constitute or imply coverage or reimbursement.

Coverage of a specific HCPCS or revenue code is subject to the billing provisions outlined in the provider's contract.

Procedure Code	Description
G0156	Services of home health/hospice aide in home health or hospice settings, each 15 minutes
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)
T1502	Administration of oral, intramuscular and/or subcutaneous medication by health care agency/professional, per visit
T1503	Administration of medication, other than oral and/or injectable, by a health care agency/professional, per visit

Revenue Code	Description
0421	Physical Therapy Visit Charge
0431	Occupational Therapy Visit Charge
0441	Speech Therapy Language Pathology Visit Charge
0550	Skilled Nursing General Charge
0551	Skilled Nursing Visit Charge
0552	Skilled Nursing Hourly Charge
0559	Skilled Nursing Other Charge
0561	Home Health Medical Social Services Visit Charge
0572	Home Health Aide Hourly Charge
0579	Home Health Aide Other Charge

0581	Home Health Aide (Other Visits) Visit Charge
0582	Home Health Aide (Other Visits) Hourly Charges
0583	Home Health Other Visits Assessment
0589	Home Health Aide (Other Visits) Other
0590	Home Health Units of Service General

References

1. Medicare Benefit Policy Manual. Chapter 7 – Home Health Services (Rev. 10438, 11-06-20).
2. MassHealth Guidelines for Medical Necessity Determination for Home Health Services. Revised Policy Effective: March 26, 2024. Available at: https://www.mass.gov/guides/masshealth-guidelines-for-medical-necessity-determination-for-home-health-services. Accessed 04/15/2025.
3. MassHealth Home Health Agency Manual (130 CMR 403.000). Date 07/01/2022. Available at: https://www.mass.gov/lists/home-health-agency-manual-for-masshealth-providers#subchapter-4:-home-health-agency-providers-regulations-. Accessed 04/15/2025.

Policy history

Origination date:	09/01/2018
Approval(s):	Technology Assessment Committee: 08/22/2018 (approved as a new policy), 09/10/2019 (added additional non-skilled coverage for MassHealth, added codes), 06/25/2021 (Added clarifying language related to Medicare Advantage, NaviCare and PACE under policy section. Utilization Management Committee: 04/15/2025 (annual review; approved with no changes to coverage criteria; added new sections for Medicare and MassHealth Variation), 05/20/2025 (updated to include information about Fallon Health's partnership with Integrated Health Care Services effective 7/1/2025).

Instructions for Use

Fallon Health complies with CMS's national coverage determinations (NCDs), local coverage determinations (LCDs) of Medicare Contractors with jurisdiction for claims in the Plan's service area, and applicable Medicare statutes and regulations when making medical necessity determinations for Medicare Advantage members. When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health may create internal coverage criteria under specific circumstances described at § 422.101(b)(6)(i) and (ii).

Fallon Health follows Medical Necessity Guidelines published by MassHealth when making medical necessity determinations for MassHealth members. In the absence of Medical Necessity Guidelines published by MassHealth, Fallon Health may create clinical coverage criteria in accordance with the definition of Medical Necessity in 130 CMR 450.204.

For plan members enrolled in NaviCare, Fallon Health first follows CMS's national coverage determinations (NCDs), local coverage determinations (LCDs) of Medicare Contractors with jurisdiction for claims in the Plan's service area, and applicable Medicare statutes and regulations when making medical necessity determinations. When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, or if the NaviCare member does not meet coverage criteria in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health then follows Medical Necessity Guidelines published by MassHealth when making necessity determinations for NaviCare members.

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.

Not all services mentioned in this policy are covered for all products or employer groups. Coverage is based upon the terms of a member's particular benefit plan which may contain its own specific provisions for coverage and exclusions regardless of medical necessity. Please consult the product's Evidence of Coverage for exclusions or other benefit limitations applicable to this service or supply. If there is any discrepancy between this policy and a member's benefit plan, the provisions of the benefit plan will govern. However, applicable state mandates take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, federal mandates will apply to all plans.