



Guidelines for Medical Necessity Determination for Home Health Services

These Guidelines for Medical Necessity Determination (Guidelines) identify the clinical information that MassHealth uses to determine medical necessity for Home Health Services. These Guidelines are based on generally accepted standards of practice, review of medical literature, and federal and state policies and laws applicable to Medicaid programs.

MassHealth Home Health Agency providers (“Providers”) should consult MassHealth regulations at 130 CMR 403.000 and 101 CMR 350.00 for information about coverage, limitations, service conditions, and prior-authorization requirements. Providers serving members enrolled in a MassHealth-contracted managed care organization (MCO) or a MassHealth-contracted integrated care organization (ICO) should refer to the MCO’s or ICO’s medical policies for covered services.

MassHealth requires prior authorization for Home Health Services defined as skilled nursing visits, continuous skilled nursing, physical therapy, occupational therapy, speech-language therapy, and home health aide services provided in the patient’s home. MassHealth reviews requests for prior authorization on the basis of medical necessity. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including member eligibility, other insurance, and program restrictions.

Section I. General Information

Home Health Services are skilled and supportive care services provided in the member’s home to meet skilled care needs and associated activities of daily living to allow the member to safely stay in their home. Home Health Services incorporate a wide variety of skilled healthcare and supportive services provided by licensed and unlicensed professionals that assist people with chronic health conditions or disabilities to carry out everyday activities. These services are designed to meet the needs of people with acute, chronic and terminal illnesses or disabilities who without this support might otherwise require services in an acute care or residential facility.

MassHealth considers approval for coverage of Home Health Services after a certain number of visits within a specific period depending on the particular service requested. Prior authorization determinations are made on an individual, case-by-case basis and in accordance with 130 CMR 403.000 and 101 CMR 350.00.

Section II. Clinical Guidelines

A. Clinical Coverage

MassHealth bases its determination of medical necessity for Home Health Services on clinical data including, but not limited to, indicators that would affect the relative risks and benefits of the provision of these services in the patient's home. General criteria for any home-based Home Health Service include, but are not limited to, the following.

1. The member has a medical condition including, but not limited to recovering from an acute illness or surgical procedure, a chronic health condition, a terminal illness or a disability that requires skilled intervention or treatment from a licensed nurse, physical therapist, occupational therapist or speech-language therapist, for which they are under the care of a licensed physician or a podiatrist under their scope of practice and that practitioner has established a care plan that is reviewed and modified on a regular basis to meet changing needs.
2. A comprehensive evaluation of the member by the relevant service professional determines the member's current medical status, disability, level of functioning, health and psychosocial status and the presence of a condition requiring the need for specific services as designated under the criteria for individual home health services below.
3. The designated provider for the service(s) must be certified and enrolled with MassHealth as a provider of home health services.
4. The member is referred to the designated provider by a licensed practitioner using written documentation for evaluation and treatment or services related to the condition in 1.
5. Coverage of particular services will be based on the following.
 - a. The level of professional services covered will be based on the degree of skill required for the tasks related to the person's condition in 1.
 - b. The plan of care is expected to significantly improve the member's condition within a reasonable and predictable period of time, and maintain, prevent, or slow the worsening of function as a result of the condition in 1.
 - c. The amount, frequency, and duration of services are appropriate based upon professionally recognized standards of practice and the length of time required to perform the needed tasks related to the person's condition in 1.
 - d. Services are provided under the care of a licensed practitioner with a written treatment plan that has been developed in consultation with the relevant professional.

The specific criteria for each type of Home Health Service include, but are not limited to, the following:

1. Intermittent Skilled Nursing Visits

- a. Intermittent skilled nursing refers to direct skilled nursing services that are needed to provide targeted skilled nursing assessment for a specific medical need, and/or discrete procedures and/or treatments, are for less than two consecutive hours, are based on the individual's needs, whether the illness or injury is acute, chronic, terminal, or expected to extend over a period of time; and are limited to the time required to perform those duties.
- b. Intermittent skilled nursing services may be considered medically necessary when the member's medical condition requires one or more of the following.
 - i. evaluation of nursing care needs;
 - ii. development and implementation of a nursing care plan; and
 - iii. provision of services that require the specialized skills of a nurse including
 1. skilled assessment and observation of signs and symptoms;
 2. performing skilled nursing interventions including administering skilled treatments ordered by the prescribing practitioner;
 3. assessing patient response to treatment and medications;
 4. communicating changes in medical status to the prescribing practitioner; and
 5. educating the member and caregiver.
- c. Medication administration is a nursing visit for the purpose of the administration of medications ordered by the prescribing practitioner when the member is unable to perform the task, no able caregiver is present and the task including the route of administration of medication requires the skills of a licensed nurse. Coverage of nursing to perform medication administration requires that the services are necessary to treat the condition and there is a medical reason that the medication must be given by those routes.
 - i. Intravenous, intramuscular, or subcutaneous injections and infusions generally require the skills of a licensed nurse to perform or teach a member or caregiver to perform independently.
 - ii. Administration of oral, eye, ear and topical medication or supervision of self-administered medication does not require the skills of a licensed nurse unless the complexity of the condition(s) and/or nature of the medication(s) require the skilled observation and assessment of a licensed nurse.
 - iii. Assisting members with or filling daily medication box organizers does not require the skills of a licensed nurse.
- d. The member's condition requires treatment of a level of complexity and sophistication that can only be safely and effectively performed by a professional licensed Registered Nurse or a Licensed Practical Nurse working under the supervision of a Registered Nurse.

2. Continuous Skilled Nursing

Continuous Skilled Nursing is the provision of direct skilled nursing services for more than two consecutive hours in duration in the home by eligible providers. Requests for continuous skilled nursing should be directed to Community Case Management at 1-

800-863-6068. See 130 CMR 403.402, 130 CMR 403.410, 130 CMR 403.412 and 130 CMR 403.413.

3. Physical Therapy

Physical therapy emphasizes a form of rehabilitation focused on treatment of dysfunctions involving neuromuscular, musculoskeletal, cardiovascular/pulmonary, or integumentary systems through the use of therapeutic interventions to optimize functional levels.

Physical therapy services may be considered medically necessary when the member presents signs and symptoms of physical deterioration or impairment and requires treatment from a physical therapist including diagnostic evaluation, therapeutic intervention, member and caregiver training in a home program and communicating changes in functional status to the prescribing practitioner. The member's condition requires treatment of a level of complexity and sophistication that can only be safely and effectively performed by a licensed physical therapist (PT) or a physical therapy assistant (PTA) under the supervision of a PT. A PT may also supervise the work of Home Health Aides (HHA) following an established plan of care providing the member has a skilled PT need. Prior authorization for HHA services supervised by PT will be required after the 20th visit by a PT or PTA. All prior authorization requests for physical therapy must be submitted by the PT. For further guidance, please refer to the MassHealth Guideline for Medical Necessity Determination for Physical Therapy.

4. Occupational Therapy

Occupational therapy programs are designed to improve quality of life by recovering competence and preventing further injury or disability, and to improve the member's ability to perform tasks required for independent functioning, so the member can engage in activities of daily living.

Occupational therapy services may be considered medically necessary when the member presents signs and symptoms of functional impairment and requires treatment from an occupational therapist including diagnostic evaluation, therapeutic intervention, member and caregiver training in a home program, and communicating changes in functional status to the prescribing physician or nurse practitioner. The member's condition requires treatment of a level of complexity and sophistication that can only be safely and effectively performed by a licensed occupational therapist (OT) or a licensed occupational therapy assistant (OTA) supervised by an OT. An OT may also supervise the work of Home Health Aides (HHA) following an established plan of care providing the member has a skilled OT need. Prior authorization for HHA services supervised by OT will be required after the 20th visit by an OT or OTA. All prior authorization requests for occupational therapy must be submitted by the OT. For further guidance, please refer to the MassHealth Guideline for Medical Necessity Determination for Occupational Therapy.

5. Speech-language Therapy

Speech-language therapy programs are designed to treat disorders that affect articulation of speech, impaired comprehension, communication and/or swallowing.

Speech-language therapy may be considered medically necessary when the member presents with a communication disorder with functional difficulty and/or swallowing disorder and requires treatment from speech-language therapist, including diagnostic evaluation, therapeutic intervention, member and caregiver training in a home program, and communicating changes in functional status to the prescribing physician or nurse practitioner. The member's condition requires treatment of a level of complexity and sophistication that can only be safely and effectively performed by a licensed speech-language pathologist (SLP). An SLP may also supervise the work of Home Health Aides (HHA) following an established plan of care providing the member has a skilled speech-language need. Prior authorization for HHA services supervised by an SLP will be required after the 35th visit by an SLP. For further guidance, please refer to the MassHealth Guideline for Medical Necessity Determination for Speech-Language Therapy.

6. Home Health Aide Services

Home Health Aides (HHAs) are trained personnel who provide personal care and/or assist members following an established plan of care ordered by the prescribing practitioner. HHAs provide personal care in the home when the member has a concurrent specific skilled need for which the home health agency registered nurse or physical, occupational or speech-language therapist is treating the member and there is a subsequent need for personal care assistance. Home Health Aide Services may be considered medically necessary when:

- a. The member's medical condition requires assistance with one or more of the following.
 - i. activities of daily living and/or personal care services;
 - ii. activities that are directly supportive of skilled nursing, physical, occupational or speech-language therapy as identified in the plan of care;
 - iii. assistance with self-administered medications ordered by the prescribing practitioner;
 - iv. simple dressing changes that do not require the skills of a nurse; and
 - v. routine care of prosthetic and orthotic devices.
- b. The tasks performed by a home health aide for the member must not require treatment of a level of complexity and sophistication that can only be safely and effectively performed by a licensed professional.

B. Noncoverage

MassHealth does not consider Home Health Services to be medically necessary under certain circumstances. Examples of such circumstances include, but are not limited to, the following.

1. The service is for a disorder not associated with a medical condition.
2. The service replicates concurrent services provided in a different setting with similar treatment goals, plans, and therapeutic modalities.
3. The service replicates concurrent services provided by a different provider in a same setting with similar treatment goals, plans, and therapeutic modalities.
4. The services are primarily educational, emotional, or psychological in nature and provided in a school or behavioral health setting.
5. The services are more appropriately provided in a setting other than the person's home or the person's need is such that home-based services will not meet the need.
6. The condition(s) does not require the level of professional requested or the need can be met with a lower level of service.
7. The treatment is for a dysfunction that is self-correcting or developmental in nature and could reasonably be expected to improve without treatment.
8. The services of a licensed nurse to fill or assist the member in filling daily medication box organizers on a daily basis.
9. Maintenance of functional skills that do not require the level of sophistication and training of a licensed PT, OT, or SLP.
10. The purpose of the treatment is educationally, vocationally or recreationally based.
11. There is no clinical documentation or treatment plan to support the need for the service or continuing the service.
12. Services are considered research or experimental in nature.

Section III. Submitting Clinical Documentation

Prior authorization (PA) is required for Home Health Services for all members after a certain number of visits within a specific period depending on the service requested. See 130 CMR 403.413. Requests for prior authorization for Home Health Services beyond the specified number of visits must be submitted by an enrolled MassHealth home health agency provider and accompanied by clinical documentation including the individual plan of care certifying the medical necessity for the service from the referring practitioner, who must not be on the staff of or under contract with the requesting home health agency.

A. For intermittent skilled nursing services, PA is required whenever the services provided exceed one or more of the following PA requirements.

1. skilled nursing visits after 30 visits in a 90 day period; or
2. home health aide units after 240 units in a 90 day period.

- B.** For continuous skilled nursing services, PA is required before the provision of services. Requests for continuous skilled nursing should be directed to Community Case Management at 1-800-863-6068. See 130 CMR 403.402, 130 CMR 403.410, 130 CMR 403.412 and 130 CMR 403.413.
- C.** For therapy services, PA is required as follows.
1. physical therapy after 20 visits in a 12 month period;
 2. occupational therapy after 20 visits in a 12 month period;
 3. speech-language therapy after 35 visits in a 12 month period; and
 4. home Health Aide services supportive of physical or occupational therapy after 20 physical or occupational therapy visits or 35 speech-language therapy visits.

Requests for prior authorization for Home Health Services must be accompanied by clinical documentation that supports the medical necessity for this procedure. Agencies do not need to wait until the service thresholds are met before submitting a prior authorization request for continuing services. The MassHealth agency may take up to 14 days to act on a request for prior authorization for continuous skilled nursing services, and up to 21 days to act on a request for prior authorization for all other services. See 130 CMR 450.303(A). If there is an urgent need for prior authorization, the provider should contact the MassHealth Customer Service Center at information on how to submit a request for an expedited prior authorization.

- D.** Documentation of medical necessity must include the applicable Request and Justification form, completed in its entirety, as well as the following.
1. The primary diagnosis name and ICD-CM code for which service is being requested;
 2. The secondary diagnosis name and ICD-CM code specific to the medical condition if different from above;
 3. The severity of the signs and symptoms pertinent to the primary diagnosis or medical condition;
 4. A written comprehensive assessment of the member's condition containing the following:
 - a. medical history including underlying medical diagnosis, description of the medical condition including date of onset or exacerbation, medical status, disability, previous functional level (if relevant) and psychosocial status. Treatment history and documented progress with past treatment should be included;
 - b. results of standardized assessment and/or an objective and subjective description of the member's current level of functioning;
 - c. identified need for treatment and plan of care including need for further assessment or referral, prognosis, and expectation for change in level of functioning with and without intervention; and
 - d. the member's rehabilitation potential, including any risk factors or comorbid conditions affecting the treatment plan.
 5. For therapies, a written treatment plan with recommendations for intervention, if indicated, including all of the following.

- a. specific short and long term measurable functional treatment goals;
 - b. treatment types, techniques and interventions to be used to achieve goals;
 - c. amount, frequency and duration of treatment that is consistent with the member's current medical and functional needs;
 - d. the types of services, supplies, and equipment ordered;
 - e. estimated duration of treatment required to achieve goals;
 - f. safety measures to prevent injury;
 - g. education of the member and caregivers to promote awareness and understanding of diagnosis, prognosis, and treatment (ongoing teaching may be necessary where there is a change in the procedure or the member's condition as part of a treatment session);
 - h. a summary of all treatment provided and results achieved (response to treatment, changes in the member's condition, documentation of measurable progress toward previously defined goals, problems encountered, and goals met) during previous periods of therapy;
 - i. discharge plans; and
 - j. for members receiving services in another setting, requests for additional services must be for substantially different treatment from that currently being received. Justification for additional services must include not only the medically basis for the services, but also the goals for the additional therapy.
6. For skilled nursing services, a licensed practitioner plan of care with recommendation for intervention, if indicated, including all of the following.
- a. all pertinent diagnoses, including the member's mental status;
 - b. types of services, supplies, and equipment ordered;
 - c. the amount, frequency and duration of the visits to be made;
 - d. the prognosis, rehabilitation potential, functional limitations, permitted activities,
 - e. nutritional requirements, medications, and treatments;
 - f. safety measures to prevent injury;
 - g. any teaching activities to be conducted by the nurse to teach the member and caregivers how to manage the member's treatment regimen (ongoing teaching may be necessary where there is a change in the procedure or the member's condition);
 - h. discharge plans; and
 - i. additional items the home health agency or licensed practitioner chooses to include.
- E.** Clinical information must be submitted by a MassHealth Home Health provider. Providers must submit all information pertinent to the diagnosis using the appropriate Request and Justification form through the Provider Online Service Center (POSC) or by completing a [MassHealth Prior Authorization Request form](#) (using the PA-1 paper form and the Request and Justification form) and attaching pertinent documentation. The PA-1 form, the Request and Justification form, and documentation should be mailed to the address on the back of the PA-1 form. Questions regarding POSC access should be directed to the MassHealth Customer Service Center at 1-800-841-2900.



These Guidelines are based on review of the medical literature and current practice in Home Health Services. MassHealth reserves the right to review and update the contents of these Guidelines and cited references as new clinical evidence and medical technology emerge.

This document was prepared for medical professionals to assist them in submitting documentation supporting the medical necessity of the proposed treatment, products or services. Some language used in this communication may be unfamiliar to other readers; in this case, contact your health-care provider for guidance or explanation.

Policy Effective Date: _____ Approved by: _____
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