



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 (see Section III) for the following Home Health Services provided in the member’s home: intermittent skilled nursing visits, medication-administration visits, continuous skilled nursing, physical therapy, occupational therapy, speech/language therapy, and home health-aide services. Note, however, that some members receiving Home Health Services may be eligible for a number of visits before prior authorization is required (see Section III). 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, MassHealth’s administrative and billing and home health program regulations and guidance.

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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 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.

Prior authorization determinations are made on an individual, case-by-case basis and in accordance with 130 CMR 403.000.

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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, data that would reflect relative risks and benefits of the provision of these services in the patient's home.

1. Any Home Health Service must meet all of the following:
 - a. Determination by the member's physician or podiatrist ("designated provider") that the member has a medical condition including, but not limited to, recovering from an acute illness, injury, 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/physical therapy assistant, occupational therapist/certified occupational therapy assistant, or speech/language therapist in the home.
 - b. Establishment of the designated provider's plan of care or clinical notes setting forth the designated provider's evaluation of the member's medical condition and proposed treatment and services related to the member's medical need for home health services.
 - c. Completion of a comprehensive evaluation of the member by the home health agency's relevant service professional through which the member's current medical status, disability, level of functioning, health, and psychosocial status is determined and confirms the presence of a condition requiring the need for specific services as designated under the criteria for the specific home health service as described in (3), below.
 - d. Confirmation that the designated provider for the service is certified by DPH as a provider of Medicare home health services and enrolled with MassHealth as a provider of home health services.
2. Coverage of particular services will be based on the following:
 - a. The type of professional services covered will be based on the degree of skill required for the tasks related to the member's medical need.
 - b. The plan of care demonstrates that it will significantly improve/stabilize the member's condition within a reasonable period of time, and/or 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 member's condition in (1).
 - d. Demonstration that 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(s).
3. Home Health Service Criteria
 - a. Teaching requirements for all Home Health Services

Teaching must be provided to the member, member's family, or caregiver at every visit by the nurse or therapist in order to foster independence. Teaching may include how to manage the

member's treatment regimen, any ongoing teaching required due to a change in the procedure or the member's condition, and the response to the teaching. If continued teaching is not reasonable, that assertion must be supported by sufficient documentation indicating that teaching was unsuccessful or unnecessary and why further teaching is not reasonable.

b. Intermittent Skilled Nursing Visits

Intermittent skilled nursing refers to direct skilled nursing services that are needed to provide a targeted skilled nursing assessment for a specific medical need, and/or discrete procedures and/or treatments to treat the medical need. Intermittent skilled nursing visits are typically less than two consecutive hours, are limited to the time required to perform the designated procedures/treatments, and are based on the member's needs, whether the illness or injury is acute, chronic, terminal, or expected to extend over a period of time.

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 provision of services that require the following specialized skills of a nurse:
 - a) skilled assessment and observation of signs and symptoms;
 - b) performing skilled nursing interventions including administering skilled treatments ordered by the prescribing practitioner;
 - c) assessing patient response to treatment and medications;
 - d) communicating changes in medical status to the prescribing practitioner; and
 - e) educating the member and caregiver.

Intermittent skilled nursing services can be provided when the member requires treatment that falls within the scope of nursing practice and is required in Massachusetts to be provided by a registered nurse, or by a licensed practical nurse under the supervision of a registered nurse; or when the member requires treatment at a level of complexity and sophistication that can only be safely and effectively performed by a Licensed Registered Nurse or a Licensed Practical Nurse working under the supervision of a Registered Nurse.

Medication administration may occur as part of an intermittent skilled nursing visit for the purpose of the administration of medications ordered by the prescribing practitioner that generally requires the skills of a licensed nurse to perform or teach a member or caregiver to perform independently.

Intravenous medication and infusion administrations will be treated as an intermittent skilled nursing visit due to the time required to complete these tasks.

c. Medication Administration Skilled Nursing Visits

A medication administration visit is a skilled nursing visit solely for the purpose of administering medications (other than intravenous medication or infusion administrations) ordered by the prescribing practitioner.

- i. Medication administration services may be considered medically necessary when medication administration is prescribed to treat a medical condition; no able caregiver

is present; the task requires the skills of a licensed nurse; and at least one of the following conditions applies:

- a) the member is unable to perform the task due to impaired physical or cognitive issues, or behavioral and/or emotional issues;
 - b) the member has a history of failed medication compliance resulting in a documented exacerbation of the member's condition.
- ii. Medication administration of the medication, documentation of that administration, observing for medication effects both therapeutic and adverse, and reporting adverse effects to the ordering practitioner. Intramuscular, subcutaneous, and other injectable medication administrations are considered skilled nursing tasks and will be treated as medication administration visits. Visits for medication administration via routes other than intravenous, intramuscular and/or subcutaneous medication including inhalers, nebulized medications, eye drops or topical medications will be considered as a medication administration visit only when the conditions below in 3.c.iii are met.
- iii. Certain medication administration tasks are not considered skilled nursing tasks, unless the complexity of the member's condition or medication regimen requires the observation and assessment of a licensed nurse to safely perform. Such conditions include:
- a) administration of oral, aerosolized, eye, ear and topical medication, which requires the skills of a licensed nurse only when the complexity of the condition(s) and/or nature of the medication(s) require the skilled observation and assessment of a licensed nurse and/or the member/caregiver is unable to perform the task.
 - b) filling of weekly/monthly medication box organizers, which requires the skills of a licensed nurse only when the member/caregiver is unable to perform the task.
- iv. Members receiving medication administration visits should be provided, at a minimum, one skilled nursing visit every 60 days to assess the plan of care and the member's ongoing need for medication administration visits. Home health providers must request any additional skilled nursing visits along with their request for medication administration visits. The authorized number of skilled nursing visits will be determined based on medical necessity and submitted supporting documentation.
- v. Documentation of Medication Administration for Intermittent Skilled Nursing Visits and Medication Administration visits: Documentation requirements include the time of the visit; drug identification, dose, and route/ or reference to the member's medication profile as ordered by the physician; teaching as applicable; documentation indicating that teaching was unsuccessful or unnecessary and why further teaching is not reasonable; the member's response to the medication/s and the signature of the licensed nurse administering the medication. Documentation of skilled procedures performed in addition to medication administration during an intermittent skilled nursing visit should also occur.

d. 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. These Medical Necessity Criteria do not apply to Continuous Skilled Nursing. Requests for continuous skilled nursing should be directed to Community Case Management at 1-800-863-6068. See 130 CMR 403.410, and 130 CMR 403.414.

e. 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:

- i. the member presents signs and symptoms of physical deterioration, impairment, or illness 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.
- ii. 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.

MassHealth does not cover services related to activities for the general good and welfare of patients such as general exercise to promote overall fitness and flexibility and activities to provide diversion or general motivation.

While MassHealth may pay for the establishment of a physical therapy maintenance program, the MassHealth agency does not pay for the performance of a maintenance program for physical therapy, except in the limited circumstance when the specialized knowledge and judgment of a licensed therapist is required to perform services that are part of the maintenance program, to ensure safety or effectiveness that may otherwise be compromised due to the member's medical condition. At the time the decision is made that the services in a maintenance program must be performed by a licensed physical therapist, all information that supports the medical necessity for performance of such services by a licensed physical therapist, rather than a non-therapist, must be documented in the member's medical record.

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.

f. Occupational Therapy

Therapy services, including diagnostic evaluation and therapeutic intervention, designed to improve, develop, correct, rehabilitate, prevent, maintain, or slow the worsening of functions that affect the activities of daily living that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Occupational therapy programs are designed to improve quality of life by recovering competence and preventing further injury or disability, and to improve the individual's ability to perform tasks required for independent functioning, so that the individual can engage in activities of daily living.

Occupational therapy services may be considered medically necessary when:

- i. The member presents signs and symptoms of functional impairment/injury 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.
- ii. 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.

MassHealth does not cover services related to activities for the general good and welfare of patients such as general exercise to promote overall fitness and flexibility and activities to provide diversion or general motivation.

While MassHealth may pay for the establishment of an occupational therapy maintenance program, the MassHealth agency does not pay for the performance of a maintenance program for occupational therapy, except in the limited circumstance when the specialized knowledge and judgment of a licensed therapist is required to perform services that are part of the maintenance program, to ensure safety or effectiveness that may otherwise be compromised due to the member's medical condition. At the time the decision is made that the services in a maintenance program must be performed by a licensed occupational therapist, all information that supports the medical necessity for performance of such services by a licensed therapist, rather than a non-therapist, must be documented in the member's medical record.

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.

g. Speech-language Therapy

Speech-language therapy programs are designed to treat disorders that affect articulation of speech, language, cognitive communication and/or swallowing abilities that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies or injuries.

Speech-language therapy may be considered medically necessary when:

- i. The member presents with a condition described above and requires treatment from a 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.
- ii. 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.

h. Home Health Aide Services

Home-health aides (HHAs) are trained personnel who provide health-related personal care and/or assist members following an established plan of care ordered by the prescribing practitioner. HHAs provide health-related 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 assistance with personal care.

Home health aide services may be considered medically necessary when the member's medical condition requires assistance with:

- i. Health-related personal care, such as bathing, dressing, grooming, caring for hair, nail, and oral hygiene, which are needed to facilitate treatment or to prevent deterioration of the member's health, changing the bed linen, shaving, deodorant application, skin care with lotions and/or powder, foot care, ear care, feeding, assistance with elimination, routine catheter care, and routine colostomy care;

- ii. assistance with activities that are directly supportive of skilled nursing, physical, occupational or speech-language therapy as identified in the plan of care;
- iii. medication reminders for medications that are ordinarily self-administered and do not require the skills of a registered or licensed nurse;
- iv. simple dressing changes that do not require the skills of a nurse; and
- v. routine care of prosthetic and orthotic devices.

The MassHealth agency does not pay for homemaker, respite, or chore services. Accordingly, services incidental to the delivery of health-related personal care, such as light cleaning, preparing a meal, or removing trash, do not meet the definition of a home-health aide service.

Home-health aide services are provided pursuant to a member's need for intermittent skilled nursing services and/or therapy services. In situations where the health-related personal care needs of the member are met through the member's receipt of intermittent skilled nursing services and/or therapy services, such as when a member is receiving intermittent skilled nursing services solely for purpose of medication administration, home-health aide services may not be considered medically necessary.

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 or behavioral health 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 the same setting with similar treatment goals, plans, and therapeutic modalities.
4. The services are primarily educational, emotional, or psychological in nature.
5. 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.
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 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 except as covered under Section II.A.3.c.iii.b.
9. Maintenance of functional skills that do not require the level of sophistication and training of a licensed PT, OT, or SLP.
10. The treatment is for educational, vocational, or recreational purposes.

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.

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SECTION III. PRIOR AUTHORIZATION FOR HOME HEALTH SERVICES

Prior authorization (PA) is required for Home Health Services for all members. For most services, PA is required after a certain number of visits within a specific period of time. (Continuous skilled nursing and certain services provided to CarePlus members on a fee-for-service basis are subject to different prior authorization requirements.) Requests for prior authorization for Home Health Services must be submitted by an enrolled MassHealth home health agency provider.

Agencies should not wait until the service thresholds are met before submitting a prior authorization request. 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 explain the medical necessity for expediting the prior authorization request in the Provider Online Service Center (POSC) or by calling or emailing the provider support center.

Any prior authorization requests that have been deferred for missing documentation will be denied if requested documentation is not received within 5 calendar days from notification of deferral and request for missing information.

The guidelines for requesting prior authorization are as follows:

- A. Prior Authorization requests must include the following attachments:
 1. Completed applicable Request and Justification (R&J) form
 2. Signed 485 or unsigned 485 with documentation of the verbal order
 3. Initial assessment note (only for initial prior authorization requests)
 4. One week of the most recent skilled nursing or therapy notes. If home-health aide services are requested, submit one week of the most recent home-health aide notes.
- B. Home health agencies should submit prior authorizations for new home health admissions in a timely way and no less than 21 days before the prior authorization gets triggered in order to avoid claim denials. See 130 CMR 403.413. Below are the specific prior authorization criteria for each home health service.
 1. For intermittent skilled nursing services, medication administration skilled nursing visits, and home-health aide services pursuant to skilled nursing (other than for CarePlus members), PA is required whenever the services provided exceed one or more of the following PA requirements:
 - a) skilled nursing visits after 30 visits in a 90-day period; or
 - b) medication administration visits after 30 visits in a 90-day period; or
 - c) home-health aide units after 240 units in a 90-day period.

A provider may request a combination of skilled nursing visits, medication administration, skilled nursing visits, and home-health aide visits pursuant to a skilled nursing need on one PA request.

2. For intermittent skilled nursing services, medication administration skilled nursing visits, and home-health aide services pursuant to skilled nursing provided to CarePlus members not enrolled in an MCE, services are subject to the restrictions described at 130 CMR 403.410(F). PA is required for payment of all such covered services.
3. For continuous skilled nursing services, PA is required before the provision of services. Requests should be directed to Community Case Management at 1-800-863-6068. See 130 CMR 403.410 and 130 CMR 403.414.
4. For therapy services and home-health aide services pursuant to therapy services, PA is required as follows.
 - a) physical therapy after 20 visits in a 12-month period;
 - b) occupational therapy after 20 visits in a 12-month period;
 - c) speech-language therapy after 35 visits in a 12-month period; and
 - d) Home-health aide services supportive of physical or occupational therapy after the provision of 240 units in a 90-day period.

All prior authorization requests for physical therapy, occupational therapy, and speech-language therapy must be submitted by the therapist/designee. For further guidance, please refer to the MassHealth Guidelines for Medical Necessity Determination for the specific therapy service.

- C. For members with existing PAs, home health agencies should follow the guidelines below.
 1. Submit new requests 21 days prior to the authorized end date. Services will not be approved retroactively if requests are submitted after the prior authorization expires. This guideline does not apply to requests needed because of a member transfer to a different agency.
 2. For transfers from another agency, the accepting agency needs to submit a new prior authorization that complies with the requirements of Section III.A. within one week from the start of care unless otherwise authorized by MassHealth.
- D. If authorized services need to be adjusted because the member's condition has changed, the home health agency needs to submit an adjustment request (updated Request and Justification form) and a new PA request with the provider's order requesting the adjusted services.

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SECTION IV. CLINICAL DOCUMENTATION GUIDELINES AND SUBMISSION

Requests for prior authorization for Home Health Services must be accompanied by clinical documentation, including the individual plan of care certifying the medical necessity of the service from the designated provider. Note: the provider signing off on the plan of care must not be on the staff of or under contract with the requesting home health agency.

The following are guidelines for submitting clinical documentation.

- A. Documentation of medical necessity for all home health services 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.
 - b. treatment history and documented progress with past treatment should be included, if applicable;
 - c. results of standardized assessment and/or an objective and subjective description of the member's current level of functioning;
 - d. 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
 - e. the member's rehabilitation potential, including any risk factors or comorbid conditions affecting the treatment plan.
- B. The following clinical documentation is required for the home health services specified below, in addition to the documentation required in Section IV(A).
1. If requesting medication administration skilled nursing visits, provide rationale to support the member/caregiver's inability to administer medications independently. In addition, include the number of intermittent skilled nursing visits anticipated, supported by documentation of the member's medical history and complexity of care, history of re-hospitalizations, history of frequent medication changes, and need for extensive observation and assessment.
 2. If requesting therapy services, provide a written treatment plan with recommendations for intervention and include all of the following:
 - a. specific, 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 and required to achieve goals;
 - d. types of services, supplies, and equipment ordered;
 - e. safety measures to prevent injury;
 - f. education of the member and caregivers to promote awareness and understanding of diagnosis, prognosis, and treatment;

- g. 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;
 - h. discharge plans; and,
 - i. for members receiving therapy 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 medical basis for the services, but also the goals for the additional therapy.
3. If requesting intermittent skilled nursing services, provide a licensed practitioner plan of care with recommendations for intervention, and include 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. teaching activities to be conducted by the nurse to teach the member and caregivers how to manage the member's treatment regimen or, if teaching is not reasonable, supporting documentation;
 - h. discharge plans; and
 - i. additional items the home health agency or licensed practitioner chooses to include.
- C. Clinical information submission: Clinical information must be submitted by a MassHealth Home Health provider. Providers are strongly encouraged to submit PA requests electronically. 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. Questions regarding prior authorizations should be directed to the MassHealth Customer Service Center at 1-844-368-5184.

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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 may also be updated from time to time to reflect MassHealth administrative updates.

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.

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Approved by 

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