Priority Health	BILLING POLICY No. 066
HOME HEALTH	
Date of origin: Jan. 3, 2025	**Review dates: 2/2025, 8/2025, 12/2025, 6/2026, 8/2026**

POLICY OVERVIEW
This policy provides guidelines for billing, coding, and documentation for Home Health Services, and ensuring claims are processed according to contractual agreements and industry standards.

DEFINITION
Home health services involve medical and supportive services designed to assist in managing health conditions. These services are provided by licensed health care professionals such as nurses, therapists, and home health aides. These services must be prescribed by a physician.

Non-medical services such as transportation, housekeeping, meal prep, and companionship are not payable services.

Home visits by a Primary Care Physician don't require prior authorization, and any home physician visits don't require prior authorization for Medicare members.

MEDICAL POLICY
Home Care (#91023)

FOR MEDICARE
For indications that don't meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get additional details on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION
Members are eligible to receive home health services based on their status of homebound, which requires skilled nursing or therapy services. A plan of care must be established by a physician and documented in the medical record. Respite care is not a payable service.

Home visits by a Primary Care Physician do not require prior authorization, and any home physician visits do not require prior authorization for Medicare members.

Services with a CMS defined payment status indicator of E, I, X are not payable when submitted by a physician or provider group.

Below are the limits identified for home health services outlined below. This is based on a timeframe of 60 days.

All plans

Service	HCPCS code	Visits
Occupational Therapy	G0152	38
Physical Therapy	G0151	50

Skilled Nurse	G0299	100
Skilled LPN	G0300	100
Speech Therapy	G0153	25
Home Health Aide	G0156	48

Medicare only

Service	HCPCS code	Visits
Medical Social Worker	G0155	20

The referring provider must be listed on the claim in the referring provider field.

Home health agencies

Revenue codes should be reported with the appropriate CPT or HCPCS codes for information and when required. Home Health Agencies must bill using UB-04 claim form.

- **0270** – DME/Supplies – not payable to HH agency, use DME provider
- **0421-0429** - Physical Therapy
- **0431-0439** - Occupational Therapy
- **0441-0449** - Speech Therapy Language Pathology
- **0552** - Skilled Nursing-Hourly Charge
- **0551-0559** - Skilled Nursing
- **0560-0569** - Medical Social Services
- **0570-0571** - Home Health (HH) Aide
- **0589** - Other Home Health Visit

Members should have a visit with their supervising physician to certify that care is ordered and medically necessary prior to home health services occurring.

- Home health care services follow a hospital or nursing home stay
- Re-evaluation for continued care after the initial 60-day period must be documented in the medical record. Additional visits must be supported within the medical record to support extension beyond visits outlined in policy.

Physician services

All physicians should be reported on the HCFA 1500 claim form with appropriate CPT/HCPCS

- **99341** – Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
- **99342** – Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
- **99344** – Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
- **99345** – Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision

making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.
- **99347** – Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
- **99348** – Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
- **99349** – Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
- **99350** – Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. Get mor information on modifier use in our Provider Manual.

Place of service

- 12 – Home

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition.

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the provider. In addition, the provider should consult any specific documentation requirements that are necessary for any applicable defined guidelines.

Documentation that may be requested would include:

- History and physical
- Physician documentation
- Imaging results in ACR format
- Lab values
- Therapy notes
- Medication record
- Consultation notes

For additional home health agency requests, attach clinical documentation for each discipline requested:

- Wound care: Include wound measurements, wound description, drainage, dressing change procedure, frequency, how often SN and member or caregiver is doing dressing. Utilization following 60 days may require documentation, which includes current pictures of the wound.
- Catheter changes: Include ordered frequency of changes

- Therapy: Include status, progression and goal
- Home Health Aide: Demonstrate the reason the HHA is seeing the member is directly tied to the reason the skilled discipline is seeing the member – custodial care is not a covered benefit

Home Health Skilled Nursing Care: Teaching and Training for Dementia Patients with Behavioral Disturbances

POLICY SPECIFIC INFORMATION

Reimbursement rates
Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. Go to the fee schedules (login required).

Reimbursement specifics
Teaching and training that would qualify as skilled nursing services when they require the expertise of skilled nursing personnel. This includes educating patients, families, or caregivers on managing a treatment plan. Coverage depends on the skill needed to teach—not the complexity of the task. Even if the task being taught is simple, if it requires nursing knowledge to teach safely and effectively, it may be covered. Teaching is considered reasonable and necessary when it relates to the patient's illness, injury, or functional limitations.

In the home health setting, skilled education services should be discontinued when, after a reasonable period, it is evident that the patient, family, or caregiver cannot or will not be trained. At that point, more teaching is not reasonable, necessary, or considered skilled care. However, any teaching done before this decision is appropriate if it matched the patient's condition, limitations, or injury. Document the reason why the training was unsuccessful in the medical record.

Billing details
Claims for services that require a referring or ordering physician must include the physician's name and NPI. Diagnosis codes should accurately reflect the patient's condition. Claims without a valid ICD-10-CM code will be returned as incomplete under Section 1833(e) of the Social Security Act.

Coding specifics
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

Documentation requirements
Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary for any applicable defined guidelines.

Behavioral Assessment Summary

For each behavioral issue, document:

1. **Behavior Description** – What is the specific behavior?
2. **Frequency** – How often does it happen?
3. **Timing & Location** – When and where does it occur?
4. **Triggers** – What situations or activities provoke it?
5. **People Involved** – Who is present during the behavior?
6. **Possible Causes** – Consider pain, illness, meds, routine changes, etc.
7. **Impact** – What are the consequences?
8. **Past Interventions** – What has worked before?
9. **New Strategies** – What else can be tried?

Care Planning Considerations

- Tailor teaching/training the patient's impairments and the caregiver's ability.
- Factor in environmental influences (noise, lighting, routine, etc.).

REFERENCES

Article - Home Health Skilled Nursing Care: Teaching and Training for Dementia Patients with Behavioral Disturbances - Medical Policy Article (A52845)

https://www.alz.org/getmedia/ae5f74b9-1226-4ba5-b687-0926a05dc99f/alzheimers-dementia-medicare-benefit-for-caregiver-training-ts.pdf

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal, or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align with these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 14, 2025	Added "Disclaimer" section
Aug. 14, 2025	Updated with information from medical policy retirement
Dec. 2025	Addition of "Home Health Skilled Nursing Care: Teaching and Training for Dementia Patients with Behavioral Disturbances" section.
June 22, 2026	Reviewed, no changes
Aug. 18, 2026	Policy overview added