Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Medical Necessity Guidelines:

Home Health Care Services for Maine Products

Effective: July 1, 2026

Prior Authorization Required If REQUIRED, submit supporting clinical documentation (electronically recommended or by fax)	Yes ☐ No ☒
Notification Required (Concurrent review may apply after a certain number of days)	Yes ☒ No ☐

Applies to:

- Harvard Pilgrim Health Care Commercial products

We recommend submitting prior authorization electronically. If you opt to submit prior authorization requests via fax, please refer to this reference chart for the appropriate fax number (varies by product).
For details on all our products, please visit the Our Plans page on our provider website. For additional Prior Authorization and Notification details on other lines of business not listed on our Medical Necessity Guidelines page, please also reference our Prior Authorization Resources page.

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

- Notification is required for the first 30 days of service. Notification must be submitted within 2 business days from the first date of service. Concurrent review will apply to services beyond 30 days

For Harvard Pilgrim Health Care Members:

This policy utilizes InterQual® criteria and/or tools, which Harvard Pilgrim may have customized. You may request authorization and complete the automated authorization questionnaire via HPHConnect at www.harvardpilgrim.org/providerportal. In some cases, clinical documentation may be required to complete a medical necessity review. Please submit required documentation as follows:

- Clinical notes/written documentation – via HPHConnect Clinical Upload or secure fax (800-232-0816)

Providers may view and print the medical necessity criteria and questionnaire via HPHConnect for providers (Select Researched and the InterQual® link) or contact the commercial Provider Service Center at 800-708-4414. (To register for HPHConnect, follow the instructions here). Members may access materials by logging into their online account (visit www.harvardpilgrim.org, click on Member Login, then Plan Details, Prior Authorization for Care, and the link to clinical criteria) or by calling Member Services at 888-333-4742

Overview

Home health care is a wide array of health care and support services provided to a member in their home environment to help treat an illness or injury. Examples of skilled services provided in the home include skilled nursing, physical therapy, occupational therapy, and speech-language pathology services. Qualified home health aide services in conjunction with a skilled service, may also be a part of a skilled home care program that provides personal care assistance to a member in their home.

Note: The home setting may be any place the Member has established his/her place of residence for the time period when home care services are being provided.

Definitions

Skilled Services

- Services which require clinical training and must be provided or supervised by a licensed health care professional (e.g., registered nurse; licensed physical, speech, occupational therapist) in order to be delivered safely and effectively and to obtain a specified medical outcome.

Custodial Services

- Services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function, as opposed to improving that function.
- Services that do not require clinical training or supervision by licensed medical professionals in order to be delivered safely and effectively.

Homebound

- In order to be considered homebound, the Member's condition should be such that there exists the inability to leave the home, or consequently leaving the home would require a considerable and taxing effort, or the member has a condition such that leaving home is medically contraindicated. If the Member leaves the home, he or she may still be considered homebound if the absences are infrequent and for short periods of time or are for health care treatments.

Authorization

The plan uses InterQual® Home Care criteria to determine medical necessity and to authorize home care services after the initial evaluation visit.

Clinical Guideline Coverage Criteria

The plan may authorize coverage of intermittent home health care services when they are:

1. Provided under a plan of care established by and periodically reviewed by a physician
2. Skilled services (see definition above)
3. Medically necessary and reasonable based on the Member's condition and accepted standards of clinical practice
4. An integral part of treatment of the Member's medical condition and associated symptoms
5. Provided to Members who are homebound (see definition above)

Note: The initial skilled nursing (SN), and/or physical therapy (PT) home care assessment/evaluation visit does not require prior authorization for certain products. Speech therapy, occupational therapy and/or social worker visit will require prior authorization for the initial evaluation when provided independently and not in conjunction with physical therapy or skilled nursing visits. The plan uses InterQual® criteria to determine medical necessity and to authorize home care services after the initial evaluation visit. Providers requesting authorization after the initial evaluation visit must submit evidence of homebound status to the appropriate fax number listed above within 2 days of the start of care.

To review authorization requirements, please consult the applicable Provider Manual for Harvard Pilgrim Health Care. You can also find important reimbursement information in our Payment Policies, which are located on the Harvard Pilgrim Health Care provider website.

Limitations

- Custodial services (see definition above)
- Benefits for home care may vary by plan/group. Specific benefit coverage should be verified prior to initiating services by logging on to our website or by contacting Provider Services.

Codes

The following code(s) require notification for the first 30 days of service concurrent review is applied after 30 days:

Table 1: CPT/HCPCS Codes

Codes	Description
S9127	Social work visit, in the home, per diem
S9128	Speech therapy, in the home, per diem
S9129	Occupational therapy, in the home, per diem
S9131	Physical therapy; in the home, per diem
S9470	Nutritional counseling, dietitian visit
G0156	Services of Home Health Aide in home setting, each 15 minutes

Table 2: Revenue Codes

Codes	Description
0551	Skilled Nursing, visit charger (per visit up to 2 hours)
0552	Skilled Nursing, hourly charge (each additional hour after the first two hours)
0559	Skilled Nursing, other (LPN nursing, per visit)

References:

1. Centers for Medicare and Medicaid Services. Medicare Benefit Policy Manual Chapter 7 - Home Health Services, June 6, 2022. Medicare Benefit Policy Manual (cms.gov). Accessed May 6, 2026.

Approval And Revision History

May 20, 2026: Reviewed by the Medical Policy Approval Committee (MPAC) as a new Medical Necessity Guideline for Harvard Pilgrim Health Care Commercial. Reviewed for the 2026 InterQual Update; July 1, 2026

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.