Medical Necessity Guidelines:

Home Health Care Services for Tufts Health Together, Tufts Health RITogether, and Tufts Health One Care

Effective: January 1, 2025

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request to the FAX numbers below	Yes ☒ No ☐
Notification Required IF REQUIRED, concurrent review may apply	Yes ☐ No ☒

Applies to:

Commercial Products

☐ Harvard Pilgrim Health Care Commercial products; 800-232-0816
☐ Tufts Health Plan Commercial products; 617-972-9409
CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Public Plans Products

☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); 888-415-9055
☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; 888-415-9055
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; 857-304-6404
☒ Tufts Health One Care-- A dual-eligible product; 857-304-6304

Senior Products

☐ Harvard Pilgrim Health Care Stride Medicare Advantage; 866-874-0857
☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-673-0965
☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-673-0965
☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-673-0965

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.

Overview

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.

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. Intermittent skilled nursing is typically less than two consecutive hours.

This policy applies to intermittent coverage of Home Health Care services (all) up to 2 hours per day. For Together members, Home Health Care services beyond 2 hours per day will be covered directly by MassHealth.

For extended home care services for Tufts Health RITogether, please reference Medical Necessity Guidelines: Extended Home Care Services.

Clinical Guideline Coverage Criteria

The Plan uses guidance from the Centers for Medicare and Medicaid Services (CMS) and MassHealth for coverage determinations for its Dual Product Eligible plan Members. CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and documentation included in the Medicare manuals and MassHealth Medical Necessity Determinations are the basis for coverage determinations where available. For **Tuft's Health One Care** plan Members, the following criteria is used: MassHealth Guidelines for Medical Necessity Determination for Home Health Services

1. Any Home Health Service must meet the following:
    a. Determination by the Member's physician or ordering non-physician practitioner 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:
        i. 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
        ii. home health aide services under the direction of nursing or rehab services for hands on assistance for the performance of activities of daily living, (ADLs) specifically bathing, grooming, dressing, toileting/continence, transferring, ambulation, and eating under the direction of nursing or rehab services
        iii. for hands-on assistance throughout the task or until completion with at least two ADLs, specifically: bathing, grooming, dressing, toileting/continence, transferring/ambulation, and eating.
    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.
2. Coverage of home health 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:
        i. improve/stabilize the Member's condition within a reasonable period of time, and/or
        ii. maintain, prevent, or slow the worsening of function as a result of the condition in
    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 (2.b.i.).
    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.

        i. 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.
        ii. For members who had teaching discontinued as a part of their home health care plan, teaching must be resumed if the following occurs:
            a) There is a break in service of at least 60 days.
            b) A new service is added to the care plan.
            c) Requested by the Member or member's caregiver when there is a change that requires new instructions.

    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) administering intravenous medications or other infusions due to the complexity of care and the time required to complete the infusion

f) educating the Member and caregiver

Intermittent skilled nursing services can be provided when the member requires treatment at 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. In addition to the regularly ordered skilled nursing services, as needed or Pro re nata (PRN) visits can be requested. PRN visits are approved, modified, or simply not authorized depending on the clinical documentation submitted.

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 require the skills of a licensed nurse to perform or teach a member or caregiver to perform independently. Again, visits solely for intravenous medication and/or infusion administrations could be an appropriate intermittent skilled nursing visit due to the time required to complete the task(s) and the skilled nature of the task(s).

Note: 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. This Medical Necessity Guideline does not apply to Continuous Skilled Nursing

c. **Medication Administration Skilled Nursing Visits**

A medication administration visit (MAV) is a nursing visit that is: 1) ordered by the prescribing practitioner; 2) where the primary purpose of the visit is the nursing intervention of administering medications and assessing the member's response to those administered medications. MAVs do not include intravenous medication or infusion administrations that, in accordance with b. above, are properly categorized as an Intermittent Skilled Nursing Visit.

i. Medication administration services may be considered medically necessary when: 1) medication administration is prescribed to treat a medical or behavioral health condition, 2) a member has no able caregiver present, 3) the task requires the skills of a licensed nurse, and 4) at least one of the following conditions apply.

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. An MAV visit includes administration of the medication, documentation of that administration, observing for medication effects both therapeutic and adverse, reporting adverse effects to the ordering practitioner and soliciting and addressing whatever questions or concerns the member may have.

iii. Intramuscular, subcutaneous, or other injectable medication administrations can be categorized on their own as medication administration visits; except for anti-psychotic injectables, that require an intermittent skilled visit due to the complexity of the members diagnosis and effects of these types of medications.

iv. Medication administration routes other than intravenous, intramuscular and/or subcutaneous, including enteral, intranasal, or topical will be considered as a medication administration visit only when the conditions below in 3.c.v are met.

v. Certain medication administration tasks do not require the skills of a licensed nurse, unless the complexity of the member's condition or medication regiment requires the observation and assessment of a licensed nurse to safely perform. Such conditions include the following.

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.

vi. Members receiving medication administration visits must be provided, at a minimum, one skilled nursing visit (separate from the MAV) 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.

vii. Documentation of Medication Administration Documentation requirements include at a minimum the following: 1) the time of the visit; 2) drug identification, dose, and route/or reference to the member's medication profile as ordered by the prescribing practitioner; 3) teaching as applicable; 4) the member's response to the medication(s) and 5) the signature of the licensed nurse administering the medication along with printed name, date and time.

d. **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.

A PT may also supervise the work of home health aides (HHA) following an established plan of care providing the member has a skilled physical therapist need.

Services are not covered that are 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.

Note: 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.

e. **Occupational Therapy**

Occupational therapy programs are designed to improve quality of life by recovering competence and preventing further injury or disability, and to improve or maintain 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:

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.

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.

Services are not covered that are 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.

Note: 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.

f. **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:

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

g. **Home Health Aide Services**

Home Health Aide Services (HHAs) are trained personnel who provide personal care and/or assist members following an established plan of care ordered by the prescribing practitioner, and member-specific home health aide care instructions created by the RN or therapist supervising the HHA.

HHA services provided concurrently with skilled nursing services or home health therapy services

HHA services may be considered medically necessary when the member's medical condition/ cognitive and/or psychological limitations prevent them from performing 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. Verbal 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

v. Routine care of prosthetic and orthotic devices

vi. IADL support services provided incidental to hands-on ADL assistance

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.

HHA Services for ADL support only

HHA services provided for ADL support only, require a skilled nursing/therapy visit for assessment of the Member and assessment and supervision of the home health aide care plan once every 60 days*. These HHA services may be considered medically necessary when the Member's medical or behavioral health condition requires any form of hands-on assistance for successful task completion, with at least two ADLs. Qualifying ADLs for this requirement are bathing, grooming, dressing, toileting/continence, transferring/ambulation, and eating.

A home health agency may request authorization for additional personal care services if the member meets medical necessity for HHA services provided for ADL support only, and

the services are medically necessary to maintain the member's health, or to facilitate treatment of the member's injury or illness; or the services are provided incidental to the member's ADL supports.

*For Tufts Health Together and Tufts Health One Care, members who are receiving home health aide services not pursuant to a skilled nursing or therapy need, a registered nurse must make an on-site visit no less frequently than every 60 days in order to observe and assess each home health aide while he or she is performing care.

Prior Authorization Requirements:

The initial skilled nursing (SN), and/or physical therapy (PT) home care assessment/evaluation visit does not require prior authorization for Members. *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.*

Providers requesting authorization must submit a thoroughly completed Universal Health Plan/Home Health Authorization

Form (UHHA) to the appropriate fax number listed above.

Home Health Aide Services for Hands-On Assistance with ADLs (without concurrent skilled service)

Prior authorization of home health aide services for hands-on assistance with ADLs is required prior to the initiation of home health aide services when the member is not receiving concurrent skilled nursing or therapy services from the home health provider. Members may be authorized to receive home health aide services for hands-on assistance with ADLs for periods of up to 90 calendar days. Home health agencies are expected to begin discharge planning during the initial assessment visit of the member.

For initial requests of home health aide services for hands-on assistance with ADLS, the following additional documentation is required:

- Documentation of the physician's verbal order
- The initial assessment visit note conducted by a RN or therapist including a list of home health aide tasks that the member needs
- Member-specific discharge plans (may be included in the initial assessment visit note)

For members requiring a renewal to the authorization of home health aide services for hands-on assistance with ADLs, the following will be required:

- Signed Plan of Care
- Member-specific discharge plans reviewed and updated as applicable
- One week of home health aide notes
- The most recent RN visit note
- Home health aide services plan of care created by the aide's supervising RN

Skilled Nursing, Skilled Therapy, and Home Health Aide Services Provided with a Concurrent Skilled Service

Prior authorization for other home care services is required when services are daily or when the Member has been receiving home care services for six months and requires continued services

Limitations

The Plan 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 replicates concurrent services provided in a different setting with similar treatment goals, plans, and therapeutic modalities.
2. The service replicates concurrent services provided by a different provider in the same setting with similar treatment goals, plans, and therapeutic modalities.
3. The services are primarily educational, emotional, or psychological in nature.
4. 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.
5. The condition(s) does not require the level of professional requested or the need can be met with a lower level of service.
6. The treatment is for a dysfunction that is self-correcting in nature and could reasonably be expected to improve without treatment.
7. 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.
8. Maintenance of functional skills that do not require the level of sophistication and training of a licensed PT, OT, or SLP.
9. The treatment is for educational, vocational, or recreational purposes.
10. There is no clinical documentation or treatment plan to support the need for the service or continuing the service.
11. Services are considered research or experimental in nature.

Codes

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes

Code	Description
G0151	Services of Physical Therapist in home health setting, each 15 minutes
G0152	Services of Occupational Therapist in home health setting, each 15 minutes
G0153	Services of Speech and Language Pathologist in home health setting, each 15 minutes
G0155	Services of Clinical Social Worker in home health setting, each 15 minutes (not applicable to Tufts Health Together)
G0156	Services of Home Health Aide in home setting, each 15 minutes
G0157	Services performed by a qualified physical therapy assistant in the home health setting, each 15

Code	Description
	minutes
G0158	Services performed by a qualified occupational therapy assistant in the home health setting, each 15 minutes
G0162	Skilled services by a registered nurse (RN) in the delivery of management and evaluation of the plan care, 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 license 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)
G0494	Skilled services of a licensed practical nurse (LPN) 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)
G2168	Services performed by a physical therapist assistant in the home health setting in the delivery of a safe and effective physical therapy maintenance program, each 15 minutes
G2169	Services performed by an occupational therapist assistant in the home health setting in the delivery of a safe and effective occupational therapy maintenance program, each 15 minutes
T1002	RN Services, up to 15 minutes
T1003	LPN/LVN Services, up to 15 minutes
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
99501	Early Maternity Discharge Visit or Maternal Child Home Visit- Home visit for postnatal assessment and follow-up care (one visit only)
99211	Office or other outpatient visits for Evaluation and Management. A visit is up to 30 minutes

References:

1. Commonwealth of Massachusetts. Division of Medical Assistance; 130 CMR 403.00. Available at 130 CMR 403.000: Home Health Agency | Mass.gov. Accessed November 6, 2024.
2. Commonwealth of Massachusetts, Executive Office of Health and Human Services. MassHealth Guidelines for Medical Necessity Determination for Home Health Services. Available at: https://www.mass.gov/doc/home-health-services-3/download. Accessed November 6, 2024.
3. Commonwealth of Massachusetts, Executive Office of Health and Human Services. MassHealth Home Health Agency Bulletin 54. Available at mass.gov/files/documents/2019/06/17/pb-hha-54.pdf. Accessed November 6, 2024.
4. State of Rhode Island, Executive Office of Health and Human Services, Home Health Coverage Guidelines. Available at eohhs.ri.gov/ProvidersPartners/ProviderManualsGuidelines/MedicaidProviderManual/HomeHealth.aspx. Accessed November 6, 2024.

Approval And Revision History

June 19, 2019: Reviewed by the Integrated Medical Policy Advisory Committee (IMPAC) for an effective date of July 1, 2019.

Subsequent endorsement date(s) and changes made:

- October 16, 2016: Reviewed by IMPAC, codes T1502 and T1503 added to Table 1, effective November 1, 2019.
- April 1, 2020: Coding updated. Per AMA CPT®, effective April 1, 2020 the following code(s) added: G2168, G2169.
- April 3, 2020: Fax number for Unify updated
- October 21, 2020: Reviewed by IMPAC, renewed without changes
- July 21, 2021: Reviewed by IMPAC, under the “Overview” section, reinforced that this policy applies to intermittent

coverage of Home Health Care services (all) up to 2 hours per day. For Together members, Home Health Care services beyond 2 hours per day will be covered directly by MassHealth. Minor changes to wording in various sections to align with RI EOHHS criteria.

- December 21, 2021: Reviewed by Medical Policy Approval Committee (MPAC), renewed without changes
- April 6, 2022: Template updated
- December 1, 2022: Reviewed by MPAC, renewed without changes
- September 20, 2023: Reviewed by MPAC, renewed without changes
- October 18, 2023: Reviewed by MPAC, renewed without changes
- November 2023: Rebranded Unify to One Care and updated One Care criteria effective January 1, 2024
- December 1, 2023: Reviewed and approved by UM Committee
- November 21, 2024: Reviewed by MPAC, updated to reflect MassHealth guidelines, effective January 1, 2025
- December 13, 2024: Reviewed and approved by the UM Committee effective, January 1, 2025

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.