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Reimbursement Policy

Medicare Certified Home Health Agency Services

Policy Number: SCO 4.7
Version Number: 1
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Product Applicability	☐ **All Plan⁺ Products**
Well Sense Health Plan	**Boston Medical Center HealthNet Plan**
☐ Well Sense Health Plan	☐ MassHealth MCO ☐ MassHealth ACO ☐ Qualified Health Plans/ConnectorCare/Employer Choice Direct ☒ Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan reimburses covered services based on the provider's contractual rates with the Plan and the terms of reimbursement identified within this policy.

Non-Medicare Certified Home Health Agencies

This policy only applies to Medicare Certified Home Health Agencies. For Home Health Agencies that are NOT Medicare-Certified, please refer to the Plan's *Non-Medicare Certified Home Health, SCO 4.6* policy for appropriate reimbursement guidelines.

Prior-Authorization

Please refer to the Plan's Prior Authorization Requirements Matrix at www.bmchp.org.

⁺ *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.

Home Health Agency Reimbursement

The Plan reimburses Home Health Agencies (HHA) based on the Centers for Medicare and Medicaid Services (CMS) Home Health Prospective Payment System (HH PPS) utilizing the Home Health Patient-Driven Grouping Model (HH PDGM). Under HH PDGM, each 30-day period of care would be classified through a variety of clinical characteristics and other patient information (admission source, timing, clinical grouping, functional impairment, and comorbidity) and then placed into a clinically meaningful payment category or Home Health Resource Group (HHRG). The unit of payment is a 30-day period rate with applicable adjustments. Payment for a period includes all home health services, including routine and non-routine medical supplies.

Notice of Admission (NOA)

The NOA is a one-time submission to establish the home health period of care and covers contiguous 30-day periods of care until the individual is discharged from Medicare Home Health services. The Plan only requires one NOA for any series of Home Health Periods of Care (POC) beginning with admission to home care and ending with discharge. Once a discharge is reported to the Plan a new NOA is required before any additional claims are submitted.

Effective for dates of service on or after 01/01/2022, Home Health Agencies (HHA) are required to submit a one-time NOA to the Plan within five calendar days from the start of care date if the start of care occurred on or after 01/01/2022.

Additionally, for all members receiving Home Health services in 2021 whose services will continue in 2022, the HHA must submit a NOA with a one-time, artificial "Admission" date corresponding to the "From" date of the first period of continuing care that occurs in 2022. For example, if a period of care begins in 2021 and ends on January 10, 2022, the HHA submits a NOA with an admission date of January 11, 2022 and then submits a final claim with the same artificial admission date of January 11, 2022 when the 30-day period of care is over.

To submit an NOA to the Plan, providers must have obtained a verbal or written order from the physician that contains the services required for the initial visit and have conducted an initial visit at the start of care.

Late NOA Financial Penalty

There will be a non-timely submission reduction in payment amount tied to any late submission of NOAs when the HHA does not submit the NOA within 5 calendar days from the start of care date ("admission date" and "from date" will match the start of care date). The reduction in payment amount would be equal to a 1⁄30th reduction to the wage-adjusted 30-day payment amount, including outlier payment, for each day from the home health start of care date until the date the HHA submits the NOA. No low utilization payment adjustment (LUPA) per-visit payments shall be made for visits that occurred on days that fall within the period of care prior to the submission of the NOA. This payment reduction shall be a provider liability, and the provider shall not bill the member for it.

HHAs submit a NOA at the beginning of an admission and then submit one final claim for each 30-day of care. Claims submitted before a NOA has been received by the Plan will be denied. No payment will be made for any period of care if the NOA has not been submitted to the Plan.

Examples of Late NOA Financial Penalty:

- HHA provider submits the NOA 10 days late:
  - HHA receives a 10/30ths payment reduction to the first period of care;
  - No payment reduction for any subsequent (2nd, 3rd, 4th, etc.) periods of concurrent care.

- HHA provider submits the NOA 45 days late:
  - No payment will be made for the first 30-day period of care;
  - A financial penalty of 15/30ths (45 days late less the 30 days in the first period of care) will be incurred for the second period of care;
  - No penalty will be made for any subsequent (3rd, 4th, 5th, etc.) concurrent periods of care.

NOA Billing Guidelines

Home Health providers must follow Medicare guidelines for the submission requirements for submitting a NOA including the following:

- The type of bill on the NOA claim must be "32A";
- The HHA reports the date of the first visit provided in the admission as the "from date";
- The "admission date" must equal the "from date" and the "through date" on the NOA claim;
- A HIPPS code is only required on the NOA when billing via the 837I format. When billing electronically, use a placeholder HIPPS of '1AA11'.
- Providers must report only one line item with revenue code 0023, the Health Insurance Prospective Payment System (HIPPS) code and $0.01 dollars;
- The discharge status must be reported as "30" (still a patient);
- If the NOA is for a patient transferred from another HHA, the receiving HHA includes condition code 47;
- Providers submitting claims electronically must continue to report all data elements per the EDI Companion Guidelines.

Low Utilization Payment Adjustment

The Plan applies the Low Utilization Payment Adjustment (LUPA) as a standard per-visit payment for periods of care with a low number of visits. A LUPA threshold will vary by HHRG and will be based on the 30-day period of care.

LUPA thresholds will range from two to six visits per 30-day period of care. Each of the different PDGM payment groups has a threshold that determines if the 30-day period receives this Low Utilization Payment Adjustment (LUPA). Payments for 30-day periods with a low number of visits are not case-mix adjusted, but instead paid on a per-visit basis using the national per-visit rates.

Unlike the RAP, the NOA is required prior to the submission of the LUPA claim, even though there may be circumstance when a HHA knows that a period of care will be below the LUPA threshold.

The Plan will not reimburse Low-Utilization Payment Adjustment (LUPA) per-visit payments for visits that occurred on days that fall within the service dates prior to a NOA submission.

The HIPPS, revenue code of 0023, and $0.01 dollars should be on the first line of the claim and itemized visits on subsequent claim lines.

Partial Episode Payment

The Partial Episode Payment (PEP) adjustment is applied in the following scenarios:

- A member is transferred to another HHA; or
- A member is discharged and readmitted to the same HHA during the same 30-day period of care

Patient Discharge Status Code 06 (Discharged/Transferred to Home under Care of Organized Home Health Service Organization in anticipation of covered skilled care) must be reported on the claim in these scenarios. The original 30-day period of care is proportionally adjusted to reflect the length of time the member remained under the agency's care prior to the intervening event. The PEP payment calculation is as follows:

(Total Days of Service/30) x 30 day period payment

In situations where a member is transferred to another HHA, a new 30-day period begins for the receiving HHA. The receiving HHA is required to submit a NOA with condition code 47 to indicate a transfer of care when an admission period may already be open for the same member at another HHA.

Final Claim

The Plan will pay the final claim of an initial and subsequent period the full HH PPS payment, unless there is an applicable adjustment.

Under the PDGM, each 30-day period of care is classified into one of two admission source categories – community or institutional – depending on what healthcare setting was utilized in the 14 days prior to home health admission. Late 30-day periods are always classified as a community admission unless there was an acute inpatient hospital stay in the 14 days prior to the late home health 30-day period. A post-acute stay in the 14 days prior to a late home health 30-day period would not be classified as an institutional admission unless the patient had been discharged from home health prior to a post-acute stay.

All HHAs must report the Assessment Date in Occurrence code 50 on all final claims. To facilitate accurate assignment of the claim into institutional vs. community payment groups, HHAs must report ONLY one of two occurrence codes (61 or 62) to support the admission source category of the PDGM:

- Occurrence code 61 –"Hospital Discharge Date"
    - Report the discharge date ("Through" date) of an inpatient hospital admission that ended within 14 days of the "From" date of the HH period of care

    - Report on initial periods AND subsequent periods, if applicable

- Occurrence code 62 –"Other Institutional Discharge Date"
    - Report the discharge date ("Through" date) of a skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), long term care hospital (LTCH) or inpatient psychiatric facility (IPF) stay that ended within 14 days of the "From" date of the HH period of care
    - Report ONLY on initial periods, if applicable

For a member's initial home health period, if two different types of institutional/inpatient discharges occur during the 14 day window, report the later discharge date (the most recent institutional discharge to the Home Health admission) with the appropriate occurrence code signifying the type of institution.

For a member's subsequent home health period, if two different types of institutional/inpatient discharges occur during the 14 day window, report the hospital stay discharge date with occurrence code 61.

If the HHA does not include an occurrence code on the HH claim to indicate that that the home health patient had a previous acute or post-acute care stay, the period of care will be categorized as a community admission source.

The Final Claim of the 30-day period must be submitted with bill type 329. The Statement From/To dates must be a range from the first day of the period plus 29 days. The HIPPS, revenue code of 0023, and $0.01 dollars should be on the first line of the claim and itemized visits on subsequent claim lines.

As an indicator that an HHA requests an exception to the late NOA penalty, the Plan will accept the KX modifier when reported with the HIPPS code on the revenue code 0023 line. The HHA should provide sufficient information in the Remarks section of its claim to allow the Plan to research the exception request. If the remarks are not sufficient, the Plan may request documentation from the HHA.
The four circumstances that may qualify the HHA for an exception to the consequences of filing the NOA more than 5 calendar days after the Home Health period of care "From" date are as follows:

1. Fires, floods, earthquakes, or other unusual events that inflict extensive damage to the HHA's ability to operate
2. An event that produces a data filing problem due to a Plan systems issue that is beyond the control of the HHA
3. A newly Medicare-certified HHA that is notified of that certification after the Medicare certification date, or which is awaiting its user ID from CMS
4. Other circumstances determined by the Plan to be beyond the control of the HHA.

CY2021 Home Care continuing into CY2022
Since providers are required to submit a NOA with a one-time, artificial "admission" date corresponding to the "From" date of the first period of continuing care that occurs in 2022, providers

should report the same artificial "admission" date reported on the NOA on their first final claim for the period of care that occur on or after January 1, 2022. On subsequent periods of care, the HHA continues to submit the artificial "admission" date reported on the first period of care in that occurred on or after January 1, 2022.

The guidance to bill an artificial admission date that corresponds to the "From" date of the first period of care with dates of service on or after January 1, 2022 in essence changes the admission date for the 30 day periods of care going forward until discharge from that period of care.

Outlier Payments

The Plan provides additional outlier payments to the period of care payment when the cost of care exceeds the Medicare threshold dollar amount. The outlier threshold for each period of care is the HH PPS payment amount plus Medicare's fixed dollar loss amount in comparison to the period's estimated cost. A HHA is eligible for an outlier payment if the estimated cost is greater than the outlier threshold.

Change in Eligibility

If a member's enrollment becomes effective or termed mid episode, the 30-day period of care payment will be proportionally adjusted with a PEP adjustment.

Medicare Home Health Ineligible

If a member does not meet Medicare Home Health eligibility requirements, but is eligible for MassHealth home health services, providers should include condition code "21"on their claim as an attestation of the member's Medicare Home Health ineligibility. With the inclusion of condition code "21", the provider should bill in accordance with MassHealth Home Health guidelines. Please see the Plan's *Non-Medicare Certified Home Health Agency, SCO 4.6* for appropriate reimbursement guidelines.

Excluded Services

The following services are reimbursed outside of the HH PPS payment methodology for members under a Home Health Plan of Care:

- Any durable medical equipment, oxygen or prosthetics, and orthotics provided may be billed on a HH PPS claim, and this equipment will be paid in addition to the period of care payment. If DME is not provided under a HH plan of care it should be billed on a type of bill 34X.
- Injectable osteoporosis drugs are paid separately at a reasonable cost basis. The administration of the drug is included in the HH PPS payment. Claims for this service should be billed on a TOB 34x using revenue code 0636.
- The Plan makes a separate payment for instances where the sole purpose for an HHA visit is to perform Negative Pressure Wound Therapy (NPWT) using a disposable device. Payment is equal to the amount of the payment that would otherwise be made under the Outpatient Prospective Payment System (OPPS). Claims for this service should be billed on a TOB 34x. This visit is not reported on the HH PPS claim (TOB 032x).

- Influenza, pneumococcal, hepatitis B and COVID-19 vaccines (the administration is included in the HH PPS payment). Claims for this service should be billed on a TOB 34x.
- Laboratory services provided by the HHA only if issued a CLIA number and/or having a CLIA certificate of waiver, as well as a professional billing number (excluding the cost of the blood draw that is included in the HH PPS payment) must bill on CMS-1500 professional claim.

Applicable Coding and Billing Guidelines

Applicable coding is listed below, subject to codes being active on the date of service. Because the American Medical Association (AMA), Centers for Medicare & Medicaid Services (CMS), and the U.S. Department of Health and Human Services may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes may not be all inclusive. These codes are not intended to be used for coverage determinations.

Bill Type

HHAs must bill services on a UB-04 claim or 837I with one of the following bill types:

Bill Type	Description
32A	Admission/Election Notice
327	Adjustment Claim
328	Void/Cancel Prior HH PPS Claim
329	Final Claim for an HH PPS Period of Care
34X	Medical and Other Health Services

Revenue Codes

Revenue code 0023 must be billed along with the applicable HIPPS code. Revenue code 0023 should be reported with $0.01 charges. Additional revenue codes and corresponding HCPCS code are reported to indicate all services provided to the member within the period on the final claim. Each service must be reported with From/To dates within the range of the 30 day period of care.

Site of Service Codes

Providers must report a site of service code with the first billable service on the final period claim. If the location changes during the period, report the new site of service code with the first visit in the new location. The revenue code for the site of service code must be the same revenue code and date of service as the first billable service, reported with one unit, and a nominal charge of $0.01.

HCPCS Code	Definition
Q5001	Hospice or Home Health Care Provided in Patient's Home/Residence
Q5002	Hospice or Home Health Care Provided in Assisted Living Facility
Q5009	Hospice or Home Health Care Provided in Place Not Otherwise Specified (NOS)

Taxonomy

The Plan requires providers to submit the Medicare approved taxonomy in field locator 81 for paper claims, or the electronic equivalent. Claims submitted without the taxonomy code will be denied.

Location

On all final claims, HHAs are required to submit the location where services are rendered using value code 61 and the corresponding value code amount reported with the Core Based Statistical Area (CBSA) code in the dollar amount column.

Providers are required to submit the state county where the services are rendered using value code 85 and the corresponding value code amount reported with the Federal Information Processing Standards (FIPS) County Code in the dollar amount column.

Policy History

Original Approval Date	Original Effective Date	Policy Owner	Approved by
12/14/2021	01/01/2022	Payment Policy	Payment Policy Committee

Other Applicable Policies

- General Billing and Coding Guidelines, SCO 4.31
- General Clinical Editing and Payment Accuracy Review Guidelines. SCO 4.108
- Non-Medicare Certified Home Health Agency Services, SCO 4.6
- Medicare Certified Home Health Agency Services, Medicare-Certified SCO 4.7, Effective 01/01/2021: Episodes beginning on or after 01/01/2021

References

- Medicare Claims Processing Manual 100-04, Chapter 10 Home Health Agency Billing
- Medicare Benefit Policy Manual 100-02, Chapter 7 Home Health Services
- U.S. Census Bureau, FIPS Codes
- Medicare Home Health Patient-Driven Groupings Model (PDGM) Webpage
- Medicare Learning Network: Overview of the Patient-Driven Groupings Model February 12, 2019
- Medicare Learning Network: Overview of the Patient-Driven Groupings Model August 21, 2019
- MLN Matters articles MM12256 Revised, MM12017, MM11855, MM11081, MM11272, MM11395, MM11527, MM11536, SE19027 and SE19028
- CMS 837I NOA Companion Guide

Disclaimer Information

This Policy provides information about the Plan's reimbursement/claims adjudication processing guidelines. The use of this Policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement. Member cost-sharing (deductibles, coinsurance and copayments) may apply – depending on the member's benefit plan. Unless otherwise specified in writing, reimbursement will be made at the lesser of billed charges or the contractual rate of payment. Plan policies may be amended from time to time, at Plan's discretion. Plan policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization guidelines (including NCQA). The Plan reserves the right to conduct Provider audits to ensure compliance with this Policy. If an audit determines that the Provider did not comply with this Policy, the Plan will expect the Provider to refund all payments related to non-compliance. For more information about the Plan's audit policies, refer to the Provider Manual.