BOSTON MEDICAL CENTER HEALTHNet PLAN

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WELL SENSE HEALTH PLAN

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Reimbursement Policy

Medicare Certified Home Health Agency Services

Policy Number: SCO 4.7
Version Number: 5
Version Effective Date: 01/01/2020

Product Applicability

☐ **All Plan[+] Products**

Well Sense Health Plan
☐ Well Sense Health Plan

Boston Medical Center HealthNet 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.

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Home Health Agency Reimbursement

Effective for Home Health episodes of care that begin on or after January 1, 2020, 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 episode 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 episode rate with applicable adjustments. Payment for an episode includes all home health services, including routine and non-routine medical supplies.

For Home Health episodes of care that begin on or before December 31, 2019 and end on or after January 1, 2020, payment will be the CY 2020 national, standardized 60-day episode payment amount. The CY2020 rates will be used for Low Utilization Payment Adjustment (LUPA), Outlier, and Value-Based Purchasing (VBP) adjustments/payments. Please reference the Plans reimbursement policy, *Medicare Certified Home Health Agency, SCO 4.7 Retired: Episodes beginning on or before 12/31/2019*.

Request for Anticipated Payment

HHAs certified for participation in Medicare prior to January 1, 2019, must submit a request for anticipated payment (RAP) at the start of the 30-day episode. For initial and subsequent episodes, the Plan will pay the RAP claim 20 percent of the HH PPS payment.

HHAs newly enrolled in Medicare on or after January 1, 2019 will not receive split percentage payments but are still required to submit a no-pay Request for Anticipated Payment (RAP) at the beginning of each 30-day episode to establish the home health episode of care. Full payment for each episode of care will be made on the final claim.

The RAP claim must be submitted with bill type 322. The Statement From/To dates should be the same date. For an initial episode the From/To date should match the date of admission. For subsequent episodes, the admission date will remain the same as the initial episode however, the From/To date should reflect the next calendar day in the following episode (day, 31, 61, 91, etc.) Providers must report only one line item with revenue code 0023, the applicable HIPPS code and $0.01 dollars. The patient discharge status 30 (S*till a Patient)* must be reported.

Low Utilization Payment Adjustment

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

LUPA thresholds will range from two to six visits per 30-day episode. Each of the different PDGM payment groups has a threshold that determines if the 30-day episode receives this Low Utilization Payment Adjustment (LUPA). Payments for 30-day episodes 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.

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.

In the event a RAP claim was previously submitted, the provider must submit a voided RAP claim with bill type 328 or the Plan will retract payment from the RAP claim.

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 episode

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 episode 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 episode payment

In situations where a member is transferred to another HHA, a new 30-day episode begins for the receiving HHA.

Final Claim

For HHAs certified for participation in Medicare prior to January 1, 2019, the Plan will pay the final claim of an initial and subsequent episode the full HH PPS payment, unless there is an applicable adjustment. At the same time, the Plan will recoup the RAP funds paid to the provider for the applicable episode, allowing full payment on the final claim. If the Final claim is not received within timely filing requirements, the RAP payment will be canceled and recouped. In order to receive payment, the RAP must be resubmitted and a final claim billed timely.

For HHAs newly enrolled in Medicare on or after January 1, 2019, the Plan will pay the final claim of an initial and subsequent episode the full HH PPS payment.

Under the PDGM, each 30-day episode 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 episodes 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 episode of care
  - Report on initial episodes AND subsequent episodes, 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 episode of care
  - Report ONLY on initial episodes, if applicable

For a member's initial home health episode, 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 episode, 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 episode of care will be categorized as a community admission source.

The Final Claim of the 30-day episode must be submitted with bill type 329. The Statement From/To dates must be a range from the first day of the episode 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.

Outlier Payments

The Plan provides additional outlier payments to the episode payment when the cost of care exceeds the Medicare threshold dollar amount. The outlier threshold for each episode is the HH PPS payment amount plus Medicare's fixed dollar loss amount in comparison to the episode'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 episode 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
Durable Medical Equipment (DME) is excluded from the HHPPS and paid separately at the fee schedule rates.

Injectable osteoporosis drugs are paid separately from the HH PPS at a reasonable cost basis. The administration of the drug is included in the HH PPS payment.

Non-Routine Supplies (NRS) are considered part of the standard national rate and therefore no add-on payment for NRS will be made.

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
322	Initial RAP claim
327	Adjustment Claim
328	Void/Cancel Prior RAP claim
329	Final 60-day episode claim
34X	Osteoporosis Drugs

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 episode on the final claim. Each service must be reported with From/To dates within the range of the 30 day episode.

Site of Service Codes

Providers must report a site of service code with the first billable service on the final episode claim. If the location changes during the episode, 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 (e.g., $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)

Treatment Authorization Code

For episodes of care that begin prior to January 1, 2020, the Plan requires providers to submit the Medicare treatment authorization code. Claims submitted without the treatment authorization code for that time period will be denied.

The Medicare treatment authorization code is not required for episodes of care beginning on or after January 1, 2020.

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

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.

Effective for dates of service 1/1/2019 or after, 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
10/24/2017	11/01/2017	Payment Policy	Payment Policy Committee

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
05/15/2018	Added language for member ineligible for Medicare Home health benefit	08/01/2018	Payment Policy Committee
06/19/2018	Revised billing of zero dollars to $0.01 dollars with rev code 0023	09/01/2018	Payment Policy Committee
04/16/2019	Update for value code 85, RAP recoupment, and references to new SCO policy for Non-Certified HHAs	05/01/2019	Payment Policy Committee
11/19/2019	Revised policy for Medicare Home Health CY2020 revisions	01/01/2020	Payment Policy Committee

Other Applicable Policies

- General Billing and Coding Guidelines, SCO 4.31
- Non-Medicare Certified Home Health Agency Services, SCO 4.6

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 MM11081, MM11272, MM11395, MM11527, MM11536, SE19027 and SE19028

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.

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