Reimbursement Policy

Non-Medicare Certified Home Health Agency Services

Policy Number: SCO 4.6
Version Number: 2
Version Effective Date: 08/01/2021

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 home health services based on the provider's contractual rates with the Plan and the terms of reimbursement identified within this policy. For all services related to Hospice care, reference the Plan's Hospice Reimbursement policy, SCO 4.8. For services related to Special Care Special Kids Program, please reference the Plan's Private Duty Nursing Reimbursement Policy, SCO 4.27.

This policy only applies to Non-Medicare Certified Home Health Agencies. For Home Health Agencies that are Medicare-Certified, please refer to the Plan's Medicare Certified Home Health, SCO 4.7 policy for appropriate reimbursement guidelines.

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Medicare Certified Home Health Agencies

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.

Prior-Authorization

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

Definitions

Intermittent Skilled Nursing Visits – nursing services that are necessary to provide targeted skilled nursing assessment for a specific member medical need, and/or discrete procedures and/or treatments, typically **for less than two (2) consecutive hours**, and limited to the time required to perform those duties. (Plan note: Private duty nursing is distinct from intermittent skilled nursing care provided through home health agencies and from non-clinical caregivers who provide non-skilled care such as assistance with activities of daily living).

Activities of Daily Living (ADL) — fundamental personal care tasks performed daily as part of an individual's routine self-care. ADLs are defined as: bathing, grooming, dressing, toileting/continence, transferring/ambulation, and eating.

Instrumental Activities of Daily Living (IADLs) – specific activities that are instrumental to the care of the member's health and are performed by a home health aide, such as meal preparation and clean-up, housekeeping, laundry, shopping, maintenance of medical equipment, transportation to medical providers, and completion of paperwork required for the member to receive home health care services.

Intermittent Services - services are intermittent if up to eight hours per day of medically necessary nursing visits and home health aide services, combined, are provided seven days per calendar week for temporary periods of up to 30 days.

Part-Time Services- services are part time if the combination of medically necessary nursing visits and home health aide services does not exceed 35 hours per calendar week, and those services are provided on a less-than-daily basis.

Provider Reimbursement

Home Health Care is defined as skilled services that are necessary to help treat or rehabilitate a member in the home setting.

Services that are reimbursed under the home care benefit include:

- Intermittent and part-time home nursing services

- Home health aide, when member is receiving skilled services (nursing, PT, OT or ST) in conjunction with home health aide services
- Physical, Occupational, and Speech/Language Therapy
- Maintenance program services that require the skilled assistance of a licensed therapist
- Medical social work
- Nutritional counseling
- Home visits by a network physician
- Respiratory therapy when it is a component of skilled nursing home care services

The Plan reimburses the following services in the home setting when billed by the appropriate contracted provider:

- Durable Medical Equipment (DME), benefit limits apply
- Oxygen and Respiratory Supplies and Equipment
- Home Infusion/Total Parenteral Nutritional Therapy

Home Health Services

All physical, occupational and speech/language therapy as well as skilled nursing visits are reimbursed per visit.

Home Health Aide Services

The Plan reimburses home health aide services for nursing or therapy needs as well as personal care and Assisted Daily Living activities (ADLs).

Home Health Aide (HHA) for Nursing/Therapy Need

The Plan will reimburse providers for HHA for Nursing or Therapy Need services under the following conditions:

- There is a skilled need requiring nurse/therapist;
- Home Health Aide directly supports care provided by nurse/therapist; and
- Home Health Aide may also provide hands on assistance with personal care

Providers must bill for home health aide services for a skilled or therapy need with HCPCS G0156 and no modifier. Home health aide services for a nursing therapy need will be reimbursed per 15 minutes, represented as one unit, up to a maximum of 8 units per visit.

Home Health Aide (HHA) for Assisted Daily Living (ADL) Only Services

The Plan will reimburse providers for HHA-ADL services for acute and/or intermittent or hands-on personal care needs under the following conditions:

- There are no concurrent skilled need requirements;
- The member must require 2 or more ADLs that include hands-on assistance;
- Time allotted is inclusive of supervision throughout the completion of the ADL task and not solely for the hands-on portion of the ADL task; and

- Help with IADLs is not approved; however, time allotted for ADL support includes time to care for incidental services

Providers must bill with for the HHA-ADL Services using the code/modifier combination of G0156 UD. HHA - ADL services will be reimbursed per 15 minutes, represented as one unit. The initial assessment visit conducted by a RN or therapist should be billed with code G0493, per visit.

The Plan does not reimburse for homemaker, respite, or chore services. When a home health aide visits a member to provide a health-related service, the home health aide may also perform some incidental services that do not meet the definition of a home health aide service (for example, light cleaning, preparing a meal, removing trash). However, the purpose of a home health aide visit must not be to provide these incidental services, since they are not health-related services.

Home Health agencies may not be reimbursed for other home health services during the same time period that a member is receiving home health aide services for hands-on ADL support.

Multiple Same-Day Home Visits

When home care services are required more than once on a single date, providers must bill one visit per claim line, and must bill all visits for a day on a single claim form.

Initial Home Health Evaluation Visits

Initial home health evaluations for physical therapy, occupational therapy, speech therapy, medical social work, and nursing care visits must be appended with a U1 modifier in the first modifier position.

Postpartum Follow-up Visits

The Plan allows a participating provider to perform one visit for postpartum follow-up without a Plan pre-authorization. The postpartum follow-up visit includes services for both the mother and newborn(s).

All postpartum follow-up visits must be billed under the mother's ID number for proper payment, and must include appropriate HCPCS coding and diagnosis codes that identify the visit as related to postpartum. The following HCPCS and diagnosis codes are required when billing for a postpartum follow-up visit. Failure to use these codes when no authorization has been obtained will result in claim denials.

HCPCS Code	ICD-10 Diagnosis Coding
G0299, G0300	Z39.0 to Z39.2

Additionally, if, at the time of the postpartum visit, it is determined that the newborn or mother requires immediate services, the home health provider is required to refer the member to the Emergency Department after first rendering appropriate care in anticipation for transport. If at the time of the postpartum visit, it is determined that the newborn or mother requires physician services,

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the Home Health provider is required to refer the member to their PCP. Decision making (triage) for referral and provision of care under these circumstances is inclusive to the reimbursement for the postpartum follow-up visit.

Skilled Nursing Visits for Two or More Members Living in the Same Household

When two or more members in the same household are receiving skilled nursing visits, the home health agency must provide services to all members during a single visit. Under such circumstances, the Plan pays the full skilled nursing visit rate for one member and a reduced rate for each subsequent member in the household. When billing the Plan for the second or any additional members, the service code and modifier must reflect the visit for each subsequent member. Home health agencies must document the medical necessity in the member's medical record in those cases where two or more members living in the same household cannot be provided skilled nursing services during a single visit.

Medication Administration Visit

The Plan will reimburse a separate rate for skilled nursing visits conducted for the sole purpose of medication administration.   Medication Administration Visits must include teaching on medication management to maximize independence and the assessment of the member response to medication. If medication administration is not the sole purpose of the visit it is not separately reimbursable.

Please reference the Plan's reimbursement policy, *Modifiers, SCO 4.23* for additional billing guidance regarding multiple same day medication administration visits.

Skilled Nursing Visits for Members Receiving Home Health Services After 30 Calendar Days

The Plan reimburses providers at a reduced rate for any additional skilled nursing visit provided to the member on or after the 31st calendar day of the member's first home health service, even if some or all of those services were provided by a different home health agency. Skilled nursing visits on or after the 31st calendar day, the service code and modifier must reflect the skilled nursing visit.

Service Limitations

The following home health services are considered NOT medically necessary and therefore are not reimbursable:

- Services that can be safely and effectively performed (or self-administered) by the average non-medical person without the direct supervision of a registered or licensed nurse unless there is no one able to provide it. These services include but are not limited to:
  - The pre-filling of syringes with insulin (or other medication that is self-injected) that do not require the skills of a licensed nurse
  - The administration of oral medications
  - The administration of eye drops and topical ointments
- Venipuncture for the purpose of obtaining a blood sample is not reimbursed unless the member qualifies for other skilled home care

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- Home care services provided in a hospital, nursing facility, intermediate care facility for intellectual disabilities, or any other institutional facility providing medical, nursing, rehabilitative, or related care including a licensed/certified day care center
- Homemaker services, non-hospice related respite, chore services, or meal service
- Custodial care
- Personal care attendant services
- Continuous skilled nursing services
- All administrative costs associated with the nursing service
- All supervision associated with the nursing service
- Routine medical supplies (i.e., cotton balls, alcohol swabs, bandages, surgical sponges, gloves, masks, thermometers, tongue depressors, and specimen containers) that are considered inclusive to the home visit payment.
- Private duty nursing except for members enrolled in the Special Kids Special Care program (see the Plan's Private Duty Nursing Reimbursement Policy, SCO 4.27)

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.

Providers who bill on a UB-04 form should report the appropriate Revenue code with the appropriate HCPCS code.

Revenue Code	Description
0420-0429	Physical Therapy
0430-0439	Occupational Therapy
0440-0449	Speech Therapy
0550-0559	Skilled Nursing
0560-0569	Home Health (HH)-Medical Social Services
0570-0579	Home Health Aide
0581	Nutrition Home Visit

CPT/ HCPCS Code	Description	Coding Instructions
G0151	Services of Physical Therapist in the home health setting	Per Visit

CPT/ HCPCS Code	Description	Coding Instructions
G0152	Services of Occupational Therapist in the home health setting	Per Visit
G0153	Services of Speech/Language Therapist in the home health setting	Per Visit
G0155	Services of clinical social worker in home health or hospice settings	Per 15 Minutes
G0156	Services of home health aide in home health setting	Per 15 Minutes
G0156 UD	ADL support services of a home health aide in the home health setting	Use only for HH Aide ADL support Per 15 Minutes
G0157	Services performed by a qualified physical therapist assistant in the home health or hospice setting	*BMC HealthNet Plan Qualified Health Plans, including ConnectorCare and Commercial Only* Per Visit
G0158	Services performed by a qualified occupational therapist assistant in the home health or hospice setting	*BMC HealthNet Plan Qualified Health Plans, including ConnectorCare and Commercial Only* Per Visit
G0159	Services performed by a qualified physical therapist, in the home health setting, in the establishment or delivery of a safe and effective physical therapy maintenance program	*BMC HealthNet Plan Qualified Health Plans, including ConnectorCare and Commercial Only* Per Visit
G0160	Services performed by a qualified occupational therapist, in the home health setting, in the establishment or delivery of a safe and effective occupational therapy maintenance program	*BMC HealthNet Plan Qualified Health Plans, including ConnectorCare and Commercial Only* Per Visit
G0161	Services performed by a qualified speech-language pathologist, in the home health setting, in the establishment or delivery of a safe and effective speech-language therapy maintenance program	*BMC HealthNet Plan Qualified Health Plans, including ConnectorCare and Commercial Only* Per Visit
G0299	Services of an RN in home health setting (one through 30 calendar days)	Per Visit
G0299 UD	Services of an RN in home health setting (31+ calendar days)	Per Visit

CPT/ HCPCS Code	Description	Coding Instructions
G0299 TT	Services of an RN in home health setting – Use when billing for each subsequent member – not for the first member - when two or more members in the same household are receiving a nursing visit during the same time period (one through 30 calendar days)	Per Visit
G0299 TT UD	Services of an RN in home health setting - Use when billing for each subsequent member – not for the first member - when two or more members in the same household are receiving a nursing visit during the same time period, for members in home health services for 31 calendar days or longer	Per Visit
G0300	Services of an LPN in home health setting (one through 30 calendar days)	Per Visit
G0300 UD	Services of an LPN in home health setting (31+ calendar days)	Per Visit
G0300 TT	Services of an LPN in home health setting - Use when billing for each subsequent member – not for the first member - when two or more members in the same household are receiving a nursing visit during the same time period (one through 30 calendar days)	Per Visit
G0300 TT UD	Services of an LPN in home health setting - Use when billing for each subsequent member – not for the first member - when two or more members in the same household are receiving a nursing visit during the same time period, for members in home health services for 31 calendar days or longer	Per Visit
G0493	Skilled services of a registered nurse (RN) for the observation and assessment of the patient's condition	RN on-site 60 day assessment for home health aide services for hands-on ADL support. Per Visit
S9470	Nutritional counseling, dietitian visit	Per Visit
T1502	Administration of oral, intramuscular, and/or subcutaneous medication by health care agency/professional per visit (RN or LPN) (Use only for Medication Administration visit.)	Per Visit

CPT/ HCPCS Code	Description	Coding Instructions
T1503	Administration of medication other than oral, intramuscular, and/or subcutaneous medication by health care agency/professional per visit (RN or LPN) (Use only for Medication Administration visit.)	Per Visit
99058	Office services provided on an emergency basis	Per Visit

Policy History

Original Approval Date	Original Effective Date	Policy Owner	Approved by
04/16/2019	05/01/2019	Payment Policy	Payment Policy Committee

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
07/20/2021	Annual review, added definitions, added detail for HHA and ADLs	08/01/2021	Payment Policy Committee

Other Applicable Policies

Reimbursement Policies

- General Billing and Coding Guidelines, SCO 4.31
- General Clinical Editing and Payment Accuracy Review Guidelines, SCO 4.108
- Hospice, SCO 4.8
- Physician and Non Physician Practitioner Services, SCO 4.608
- Private Duty Nursing, SCO 4.27
- Medicare Certified Home Health Agency, SCO 4.7
- Modifiers, SCO 4.23

Medical Policies

- Home Health Care, OCA 3.719
- Tube Fed Enteral Nutrition Products Supplied and Billed by Home Infusion Providers, OCA 3.37
- Private Duty Nursing, OCA 3.715

References

- 101 CMR 350.00 – Home Health Services
- 130 CMR 403.000 – Home Health Agency Regulations
- MassHealth Home Health Agency Manual Subchapter 6
- CMS 100-02 Ch. 7 Sect. 50.4.1.2
- Contract between The Office of Health and Human Services (EOHHS), and Boston Medical Center HealthNet Plan MassHealth
- Form of Contract between the Commonwealth Health Insurance Connector Authority and Boston Medical Center HealthNet Plan
- BMC HealthNet Plan Qualified Health Plans, including ConnectorCare Evidence of Coverage
- Home Health Agency Bulletin 54: Revisions to MassHealth Coverage of Home Health Aide Services

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.