

130 CMR 403.000: HOME HEALTH AGENCY

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403.401: Introduction

All home health agencies participating in MassHealth must comply with MassHealth regulations including, but not limited to, 130 CMR 403.000 and 450.000: *Administrative and Billing Regulations*.

403.402: Definitions

The following terms used in 130 CMR 403.000 have the meanings given in 130 CMR 403.402, unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 403.402 is not determined by these definitions, but by the application of regulations elsewhere in 130 CMR 403.000 and 450.000: *Administrative and Billing Regulations*.

Branch Office — a location or site from which a home health agency provides services within a portion of the total geographic area served by the parent home health agency. The branch office is located sufficiently close to the parent agency so that it shares administration, supervision, and services with the parent home health agency on a daily basis.

Calendar Week — seven consecutive days beginning Sunday at midnight and ending Saturday at 11:59 P.M.

Care Management — a function performed by the MassHealth agency or its designee that

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assesses and reassesses the medical needs of complex-care members and authorizes or coordinates long term services and supports (LTSS) that are medically necessary for such members to remain safely in the community.

Certification Period — a period of no more than 60 days in which the member's physician has certified that the plan of care is medically appropriate and necessary.

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Clinical Manager — a registered nurse employed by the MassHealth agency or its designee, who performs the in-person assessment of a member for MassHealth coverage of continuous skilled nursing (CSN) services and, if it is determined that CSN services are medically necessary, coordinates the authorization of medically necessary long term services and supports (LTSS) services for the member.

Complex-care Member — a MassHealth member whose medical needs, as determined by the MassHealth agency or its designee, are such that he or she requires a nurse visit of more than two continuous hours of nursing services to remain in the community.

Continuous Skilled Nursing (CSN) Services — a nurse visit of more than two continuous hours of nursing services for a Complex-care Member.

Co-vending — an arrangement through which a member's CSN services are provided by one or more home health agencies or independent nurses, with each provider possessing its own MassHealth prior authorization to provide nursing services to the member.

Home Health Agency — a public or private organization that provides nursing and other therapeutic services to individuals whose place of residence conforms to the requirements of 42 CFR 440.70(c). Home health agency providers are governed by 130 CMR 403.000.

Home Health Aide — a person who is employed or contracted by a MassHealth-approved home health agency and certified as a Home Health Aide to perform certain personal-care and other health-related services as described in 130 CMR 403.416(B).

Homemaker — a person who performs light housekeeping duties (for example, cooking, cleaning, laundry) for the purpose of maintaining a household.

Household — place of residence where two or more people are living that is in a group home, a residential care home, or other group living situation; at the same street address if it is a single family house that is not divided into apartments or units; or at the same apartment number or unit number if members live in a building that is divided into apartments or units.

Independent Nurse — a licensed nurse who independently enrolls as a provider in MassHealth to provide CSN services. Independent nurse providers are governed by MassHealth regulations at 130 CMR 414.000: *Independent Nurse Services*.

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 consecutive hours, and limited to the time required to perform those duties.

Long Term Services and Supports (LTSS) — certain MassHealth-covered services intended to enable a member to remain safely in the community. Such services include, but are not limited to, home health, durable medical equipment, oxygen and respiratory equipment, personal-care attendant, and other health-related services as determined by the MassHealth agency or its designee.

Maintenance Program — repetitive services, required to maintain or prevent the worsening of function, that do not require the judgment and skill of a licensed therapist for safety and effectiveness.

Medical History — a component of the member's medical record that provides a summary of all

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health-related information about the member. A history includes, but is not limited to, medical and nursing care histories.

Medical Record—documentation, maintained by the home health agency, that includes medical history, diagnoses, physician's orders, discipline-specific progress notes, member assessments, the member's plan(s) of care, and other information related to the member in accordance with 130 CMR 403.419(C).

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Medical Records Release Form — a signed authorization from the member or the member's parent or legal guardian, if the member is a minor, that allows the designated releasee to access the member's confidential health information from other health-care providers.

Medication Administration Visit — a skilled nursing visit for the purpose of administration of medications when the member is unable to perform the task due to impaired physical, cognitive, behavioral, and/or emotional issues, no able caregiver is present, the member has a history of failed medication compliance resulting in a documented exacerbation of the member's condition, and/or the task including the route of administration of medication requires a licensed nurse to provide the service. A medication administration visit may include administration of oral, intramuscular, and/or subcutaneous medication or administration of medications other than oral, intramuscular and/or subcutaneous medication, but does not include intravenous administration.

Nurse — a person licensed as a registered nurse or a licensed practical nurse by a state's board of registration in nursing.

Nursing Services — the assessment, planning, intervention, and evaluation of goal-oriented nursing care that requires specialized knowledge and skills acquired under the established curriculum of a school of nursing approved by a board of registration in nursing. Such services include only those services that require the skills of a nurse.

Occupational Therapist — a person who is licensed as an occupational therapist by the Massachusetts Board of Registration in Allied Health Professionals.

Occupational Therapy — therapy services, including diagnostic evaluation and therapeutic intervention, designed to improve, develop, correct, rehabilitate, prevent, maintain, or slow the worsening of functions that affect the activities of daily living that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Occupational therapy programs are designed to improve quality of life by recovering competence and preventing further injury or disability, and to improve the individual's ability to perform tasks required for independent functioning, so that the individual can engage in activities of daily living.

Occupational Therapy Assistant — a person who is licensed as an occupational therapy assistant by the Massachusetts Board of Registration in Allied Health Professionals.

Physical Therapist — a person who is licensed as a physical therapist by the Massachusetts Board of Registration in Allied Health Professionals.

Physical Therapy — therapy services, including diagnostic evaluation and therapeutic intervention, designed to improve, develop, correct, rehabilitate, prevent, maintain, or slow the worsening of physical functions that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. 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 functioning levels.

Physical Therapy Assistant — a person who is licensed as a physical therapy assistant by the Massachusetts Board of Registration in Allied Health Professionals.

Primary Caregiver — the individual, other than the nurse or home health aide, who is primarily

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responsible for providing ongoing care to the member.

Request and Justification for Skilled Nursing and Home Health Aide Services Form — the form describing the skilled nursing and home health aide needs of a member that a home health agency is required to submit to the MassHealth agency or its designee, when requesting prior authorization for intermittent skilled nursing services.

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Request and Justification for Therapy Services and Home Health Aide Services Form — the form describing the therapy and home health aide needs of a member that a home health agency is required to submit to the MassHealth agency or its designee, when requesting prior authorization for therapy services.

Respite Services — a range of services provided on a short-term or intermittent basis in response to the need for relief of those persons who normally provide this care.

Speech/Language Therapist (Speech/Language Pathologist) — a person who is licensed by the Massachusetts Board of Registration in Speech/Language Pathology and Audiology and who has a current Certificate of Clinical Competence from the American Speech/Language-Hearing Association (ASHA).

Speech/Language Therapy — therapy services, including diagnostic evaluation and therapeutic intervention, that are designed to improve, develop, correct, rehabilitate, prevent, maintain, or slow the worsening of speech, language, cognitive-communication, and swallowing abilities that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Speech and language disorders are those that affect articulation of speech, sounds, fluency, voice (regardless of presence of a communication disability), and swallowing, and those that impair comprehension, spoken, written, or other symbol systems used for communication.

Visit — a personal contact in the member's home or other non-institutional setting, for the purpose of providing a covered service by a registered or licensed nurse, home health aide, or physical, occupational, or speech/language therapist employed by, or contracting with, the home health agency.

403.404: Eligible Members

(A) MassHealth Members. MassHealth pays for home health services for eligible members, subject to the restrictions and limitations described in 130 CMR 450.105: *Coverage Types* which specifically states, for each MassHealth coverage type, which services are covered and which members are eligible to receive those services.

(B) Recipients of the Emergency Aid to the Elderly, Disabled and Children Program. For information on covered services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program, see 130 CMR 450.106: *Emergency Aid to the Elderly, Disabled and Children Program*.

(C) For information on verifying member eligibility and coverage type, see 130 CMR 450.107: *Eligible Members and the MassHealth Card*.

403.405: Provider Eligibility: In-state

To participate in MassHealth, a Massachusetts home health agency must

(A) be certified as a provider of home health services under the Medicare program by the Massachusetts Department of Public Health including any branch office located in Massachusetts;

(B) obtain a MassHealth provider number before providing home health services;

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(C) agree to periodic inspections, by the MassHealth agency or its designee, that assess the quality of member care and ensure compliance with 130 CMR 403.000;

(D) participate in any Home Health Agency provider orientation required by the Executive Office of Health and Human Services (EOHHS); and

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(E) notify the MassHealth agency in writing within 14 days of any change in any of the information submitted in the provider application in accordance with 130 CMR 450.223(B): *Provider Contract: Execution of Contract* including, but not limited to, change of ownership, change of address, and additional home health agency branch office.

403.406: Provider Eligibility: Out-of-State

(A) To participate in MassHealth, an out-of-state home health agency located within 50 miles of the Massachusetts border must

- (1) ensure that the agency and each branch is certified as a provider of home health services under the Medicare program;
- (2) participate in the Medicaid program in its state;
- (3) provide home health services to a member who resides in a Massachusetts community near the border of the home health agency's state;
- (4) obtain a MassHealth provider number before providing home health services; and
- (5) notify the MassHealth agency in writing within 14 days of any change in any of the information submitted in the provider application in accordance with 130 CMR 450.223(B): *Provider Contract: Execution of Contract* including, but not limited to, change of ownership, change of address, and additional branch office.

(B) To participate in MassHealth, an out-of-state home health agency located beyond 50 miles of the Massachusetts border must

- (1) be certified as a provider of home health services under the Medicare program by the Medicare-certifying agency in its state;
- (2) participate in the Medicaid program in its state;
- (3) obtain a MassHealth provider number before providing home health services; and
- (4) provide services to a member in accordance with 130 CMR 450.109: *Out-of-state Services*.

403.407: Services Provided Under Contract

(A) Introduction. A home health agency may provide home health services directly or through contractual arrangements made by the home health agency. Whether the services are provided directly or through contracts, the home health agency is responsible for submitting claims for services and for meeting the requirements in 130 CMR 403.000 and all other applicable state and federal requirements. A home health agency may provide services through contracts in the following situations:

- (1) when a home health agency, in order to be approved to participate in MassHealth, makes arrangements with another agency or organization to provide the nursing, home health aide, or other therapeutic services that it does not provide directly; or
- (2) when a home health agency, that is already approved for participation in MassHealth, makes arrangements with others to provide services it does not provide.

(B) Contract Requirements.

- (1) If the home health agency contracts with another provider participating in MassHealth (e.g., hospital, nursing facility, another home health agency, or hospice), a written contract must document the services to be provided and the corresponding financial arrangements.
- (2) If the home health agency contracts with a provider that does not participate in MassHealth, the written contract must include
 - (a) a description of the services to be provided;
 - (b) the duration of the agreement and how frequently it is to be reviewed;

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- (c) a description of how personnel are supervised;
- (d) a statement that the contracting organization will provide its services in accordance with the plan of care established by the member's physician in conjunction with the home health agency's staff;
- (e) a description of the contracting organization's standards for personnel, including qualifications, functions, supervision, and in-service training;
- (f) a description of the method of determining reasonable costs and payments by the home health agency for the specific services to be provided by the contracting organization; and

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(g) an assurance that the contracting organization will comply with Title VI of the *Civil Rights Act* and all relevant MassHealth provider requirements.

403.408: Administrative Requirements

Whether services are provided by the home health agency directly or through contractual arrangements made by the agency, the agency must

- (A) accept the member for treatment in accordance with its admission policies;
- (B) maintain a complete medical record as defined at 130 CMR 403.402 relating to all services provided in accordance with 130 CMR 403.419(C)(3)(b);
- (C) obtain from the physician the required certifications and recertifications of the plan of care in accordance with 130 CMR 403.420(C); and
- (D) ensure that the home health agency's staff or designated group review the medical necessity of services and the physician certification on a regular basis.

403.409: Clinical Eligibility Criteria for Home Health Services

(A) Member must Be under the Care of a Physician. The MassHealth agency pays for home health services only if the member's physician certifies the medical necessity for such services and establishes an individual plan of care in accordance with 130 CMR 403.420. A member may receive home health services only if he or she is under the care of a physician. (A podiatrist may be considered a physician for the purposes of meeting 130 CMR 403.409(A).) The physician providing the certification of medical necessity and submitting the plan of care for home health services must not be a physician on the staff of, or under contract with, the home health agency.

(B) Limitations on Covered Services. The MassHealth agency pays for home health services to a member who resides in a non-institutional setting, which may include, without limitation, a homeless shelter or other temporary residence or a community setting. In accordance with 42 CFR 440.70(c), the MassHealth agency does not pay for home health services provided in a hospital, nursing facility, intermediate care facility for the intellectually or developmentally disabled, or any other institutional facility providing medical, nursing, rehabilitative, or related care.

(C) Medical Necessity Requirement. In accordance with 130 CMR 450.204: *Medical Necessity*, and MassHealth Guidelines for Medical Necessity Determination for Home Health Services, the MassHealth agency pays for only those home health services that are medically necessary. Home health services are not to be used for homemaker, respite, or heavy cleaning or household repair.

(D) Availability of Other Caregivers. When a family member or other caregiver is providing services, including nursing services, that adequately meet the member's needs, it is not medically necessary for the home health agency to provide such services.

(E) Least Costly Form of Care. The MassHealth agency pays for home health agency services only when services are no more costly than medically comparable care in an appropriate institution and the least costly form of comparable care available in the community.

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(F) Safe Maintenance in the Community. The member's physician and home health agency must determine that the member can be maintained safely in the community.

(G) Prior Authorization. Home health services including both intermittent and continuous skilled nursing require prior authorization. *See* 130 CMR 403.413 for requirements.

(H) Continuous Skilled Nursing (CSN) Services. The MassHealth agency pays for CSN services when

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- (1) the member meets the criteria for nursing services as stated in 130 CMR 403.420;
- (2) there is a clearly identifiable specific medical need for a nursing visit of more than two continuous hours; and
- (3) prior authorization for CSN services has been obtained from the MassHealth agency or its designee, in accordance with 130 CMR 403.410.

(I) Multiple-patient Care for CSN Services.

- (1) The MassHealth agency pays for one nurse to provide CSN services simultaneously to more than one member, but not more than three members if
 - (a) the members have been determined by the MassHealth agency or its designee to meet the criteria listed at 130 CMR 403.420 and to require CSN services;
 - (b) the members receive services in the same physical location and during the same time period;
 - (c) the MassHealth agency or its designee has determined that it is appropriate for one nurse to provide nursing services to the members simultaneously; and
 - (d) the home health agency has received a separate prior authorization for each member as described in 130 CMR 403.410.
- (2) Services provided pursuant to 130 CMR 403.410(C)(1) must be billed by using the multiple-patient service code that reflects the number of members receiving the services.

403.410: Prior Authorization Requirements

(A) General Terms.

- (1) Prior authorization must be obtained from the MassHealth agency or its designee as a prerequisite to receipt of home health services as described in 130 CMR 403.410(C) and 403.410(F). For all other home health services, prior authorization must be obtained from the MassHealth agency or its designee as a prerequisite to payment after certain limits are reached, as described in 130 CMR 403.410. Without such prior authorization, the MassHealth agency will not pay providers for these services.
- (2) Prior authorization determines only the medical necessity of the authorized service, and does not establish or waive any other prerequisites for payment such as member eligibility or resort to health insurance payment.
- (3) Approvals for prior authorization specify the number of hours, visits, or units for each service that are medically necessary and payable each calendar week and the duration of the prior authorization period. The authorization is issued in the member's name and specifies frequency and duration of care for each service approved per calendar week.
- (4) If there are unused hours of CSN services in a calendar week, they may be used at any time during the current authorized period.
- (5) The home health agency must submit all prior authorization requests in accordance with the MassHealth agency's administrative and billing regulations and instructions and must submit each such request to the appropriate addresses listed in Appendix A of the *Home Health Agency Manual*.
- (6) In conducting prior authorization review, the MassHealth agency or its designee may refer the member for an independent clinical assessment to inform the determination of medical necessity for home health services.
- (7) If authorized services need to be adjusted because the member's medical needs have changed, the home health agency must submit an adjustment request to the MassHealth agency or its designee.

(B) Skilled Nursing and Home Health Aide Services Authorized Pursuant to Skilled Nursing Services for MassHealth Members Not Enrolled in a Managed Care Entity.

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(1) The home health agency must obtain prior authorization for the provision of skilled nursing services including medication administration services beyond the amounts set forth in 130 CMR 403.410(B)(5). Prior authorization is also required for the provision of home health aide services provided pursuant to skilled nursing services beyond the amount set forth in 130 CMR 403.410(B)(5). *See* 130 CMR 403.410(C) for prior authorization requirements relative to CSN services. *See* 130 CMR 403.410(D) for prior authorization requirements relative to home health therapy services. *See* 130 CMR 403.415(C) for service limitations and 403.410(F) for prior authorization requirements of nursing provided to MassHealth CarePlus members.

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(2) Prior authorization is required for skilled nursing and related home health aide services when payment has been discontinued by any other third-party payer, including Medicare, once the member has received nursing services and related home health aide services, including such services paid by any such third-party payer, beyond the amounts set forth in 130 CMR 403.410(B)(5).

(3) To obtain prior authorization for skilled nursing services or home health aides services provided pursuant to skilled nursing services, the home health agency must submit to the MassHealth agency or its designee written physician's orders that identify the member's admitting diagnosis, frequency, and, as applicable, duration of nursing services, and a description of the intended nursing intervention, and duration and description of home health aide services pursuant to those nursing services.

(4) The home health agency must complete the *Request and Justification for Skilled Nursing and Home Health Aide Services Form* in accordance with 130 CMR 403.410(B)(1) and 403.415 and 403.416, as applicable. This form must be submitted to the MassHealth agency or its designee with all prior authorization requests for skilled nursing or home health aide services provided pursuant to such nursing services.

(5) Prior authorization for any and all home health skilled nursing services is required whenever the services provided exceed one or more of the following PA requirements:

- (a) more than 30 intermittent skilled nursing visits in a 90 day period;
- (b) more than 240 home health aide units in a 90 day period; or
- (c) more than 30 medication administration visits in a 90 day period.

(6) Any verbal request for changes in service authorization must be followed up in writing to the MassHealth agency or its designee within two weeks of the date of the verbal request.

(C) CSN Services.

(1) The home health agency must obtain prior authorization from the MassHealth agency or its designee as a prerequisite for payment for CSN services before such services are provided to the member.

(2) The MassHealth agency or its designee will conduct the assessment of need for CSN services and coordinate other MassHealth community long-term-care services for the member, as appropriate. When the MassHealth agency or its designee conducts an assessment of need for CSN services and authorizes CSN services for the member, the member will select the home health agency that will be responsible for providing CSN services. The MassHealth agency, or its designee, will provide written notification of the outcome of the assessment to the member and, when applicable, to the home health agency selected by the member.

(3) For members who have been authorized for CSN services, the home health agency must obtain prior authorization from the member's clinical manager for all other home health services as defined in 130 CMR 403.412 before such services are provided to the member. 130 CMR 403.410(C)(3) applies to therapy services only if such therapy services are otherwise subject to prior authorization under 130 CMR 403.410(D).

(4) The MassHealth agency or its designee will specify on the prior authorization for CSN services the number of CSN hours that have been determined to be medically necessary and that are authorized for the member per calendar week. Any CSN hours provided to the member by the home health agency that exceed what the MassHealth agency or its designee has authorized in a calendar week are not payable by MassHealth.

(5) If the frequency of the authorized home health services needs to be adjusted because the member's medical needs have changed, the home health agency must contact the MassHealth agency or its designee to request an adjustment to the prior authorization.

(6) Prior authorization for CSN services may be approved for more than one home health agency or independent nurse, or both, provided that

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- (a) each provider is authorized only for a specified portion of the member's total hours;
and
- (b) the sum total of the combined hours approved for co-vending providers does not exceed what the MassHealth agency or its designee has determined to be medically necessary and authorized for the member per calendar week.

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(D) Therapy Services and Home Health Aide Services Provided Pursuant to Therapy Services for All Members for Whom Therapies Are a Covered Service.

(1) The home health agency must obtain prior authorization from the MassHealth agency or its designee as a prerequisite for MassHealth payment as primary payer of the following services to eligible MassHealth members:

(a) more than 20 occupational-therapy or 20 physical-therapy visits, including any initial patient assessment or observation and evaluation or reevaluation visits, for a member within a 12-month period beginning with the first visit;

(b) more than 35 speech-language therapy visits, including any initial patient assessment or observation and evaluation or reevaluation visits, for a member within a 12-month period beginning with the first visit; and

(c) continuing therapy when payment has been discontinued by any other third-party payer, including Medicare, once the member has received therapy services, including therapy services paid by any such third-party payer, beyond the amounts set forth in 130 CMR 403.410(D)(1) in a 12-month period beginning with the first visit.

(d) Prior authorization for home health aide services supervised by a physical, occupational, or speech/language therapist will be required after the provision of 240 units in a 90-day period. The prior authorization request for home health aide services will need to include the request for physical, occupational, or speech/language therapy services.

(2) The home health agency must complete the *Request and Justification for Therapy Services Form* in accordance with 130 CMR 403.410(D)(1) and 403.417. This form must be submitted to the MassHealth agency or its designee with all prior authorization requests for therapy.

(E) Managed Care Entity (MCE) Members. For those members who are enrolled in a MassHealth-approved MCE, the home health agency must follow the authorization procedures of the MCE where applicable for home health services. For those MCE members whose nursing service needs are more than two hours in duration and are not covered by the MCE, the home health agency must comply with 130 CMR 403.410(C).

(F) MassHealth CarePlus Members Not Enrolled in a MCE.

(1) The home health agency must obtain from the MassHealth agency or its designee, as a prerequisite to payment, prior authorization for all nursing services and home health aide services pursuant to skilled nursing or therapy services for MassHealth CarePlus members who are not enrolled in a MCE. *See* 130 CMR 403.415(C) for service limitations of nursing care provided to MassHealth CarePlus members.

(2) The home health agency must submit to the MassHealth agency or its designee written physician's orders that identify the member's admitting diagnosis, frequency, and duration of nursing services, and a description of the intended nursing intervention.

(3) If authorized services need to be adjusted because the member's medical needs have changed, the home health agency must contact the MassHealth agency or its designee by telephone to request an adjustment to the prior authorization. Any verbal request for change in service authorization must be followed up in writing to the MassHealth agency or its designee within two weeks of the date of the verbal request.

403.411: Notice of Approval or Denial of Prior Authorization

(A) Notice of Approval. For all approved prior authorization requests for home health services, the MassHealth agency or its designee sends written notice to the member and the home health agency about the frequency, duration, and intensity of care authorized, and the effective date of

the authorization.

(B) Notice of Denial or Modification and Right of Appeal.

(1) For all denied or modified prior authorization requests, the MassHealth agency or its designee notifies both the member and the home health agency of the denial or modification, and the reason. In addition, the member will receive information about the member's right to appeal, and appeal procedure.

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(2) A member may request a fair hearing if the MassHealth agency or its designee denies or modifies a prior authorization request. The member must request a fair hearing in writing within 30 days after the date of receipt of the notice of denial or modification. The Office of Medicaid Board of Hearings conducts the hearing in accordance with 130 CMR 610.000: *MassHealth: Fair Hearing Rules*.

403.412: Scope of Home Health Services

The MassHealth agency pays for the following home health services for eligible MassHealth members, subject to the restrictions and limitations described in 130 CMR 403.000 and 450.000: *Administrative and Billing Regulations*:

- (A) nursing;
- (B) home health aide; and
- (C) physical, occupational, and speech/language therapy.

403.413: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

The MassHealth agency pays for all medically necessary home health agency services for EPSDT-eligible members in accordance with 130 CMR 450.140: *Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services: Introduction*, without regard to service limitations described in 130 CMR 403.415(C), and with prior authorization.

403.414: Complex Community Care Management Services

For complex-care members, as defined in 130 CMR 403.402, the MassHealth agency or its designee provides care management that includes service coordination with home health agencies as appropriate. The purpose of care management is to ensure that complex-care members are provided with a coordinated LTSS service plan that meets such members' individual needs, avoids duplicative services, and ensures that the MassHealth agency pays for home health and other LTSS only if they are medically necessary in accordance with 130 CMR 403.409(C). The MassHealth member eligibility verification system identifies complex-care members.

(A) Care Management Activities.

(1) Enrollment. The MassHealth agency or its designee automatically assigns a clinical manager to members whom it has determined require a nurse visit of more than two continuous hours of nursing, and informs such members of the name, telephone number, and role of the assigned clinical manager.

(2) Comprehensive Needs Assessment. The clinical manager performs an in-person visit with the member to evaluate whether the member meets the criteria to be a complex-care member as described in 130 CMR 403.402. If the member is determined to meet the criteria for a complex-care member, the clinical manager will complete a comprehensive needs assessment. The comprehensive needs assessment identifies

- (a) services that are medically necessary, covered by MassHealth, and required by the member to remain safely in the community;
- (b) services the member is currently receiving; and
- (c) any other case management activities in which the member participates.

(3) Service Record. The clinical manager

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- (a) develops a service record, in consultation with the member, the primary caregiver, and where appropriate, the home health agency and the member's physician, that
1. lists those MassHealth-covered services to be authorized by the clinical manager;
 2. describes the scope and duration of each service;
 3. lists service arrangements approved by the member or the member's primary caregiver; and
 4. informs the member of his or her right to a hearing, as described in 130 CMR 403.411;

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- (b) provides to the member copies of the service record, one copy of which the member or the member's primary caregiver must sign and return to the clinical manager. On the copy being returned, the member must indicate whether he or she accepts or rejects each service as offered and that he or she has been notified of the right to appeal and provided an appeal form; and
 - (c) provides to the home health agency information from the service record that is applicable to the home health agency.
 - (4) Service Authorizations. The clinical manager authorizes those LTSS in the service record, including home health, that require prior authorization (PA) as provided in 130 CMR 403.410, and that are medically necessary, and coordinates all home health services and any subsequent changes with the home health agency.
 - (5) Discharge Planning. The clinical manager may participate in member hospital discharge planning meetings as necessary to ensure that LTSS medically necessary to discharge the member from the hospital to the community are authorized and to provide coordination with all other identified third-party payers.
 - (6) Service Coordination. The clinical manager works collaboratively with any identified case managers assigned to the member.
 - (7) Clinical Manager Follow-up and Reassessment. The clinical manager provides ongoing care management for members, and in coordination with the home health agency, to
 - (a) determine whether the member continues to be a complex-care member; and
 - (b) reassess whether services in the service record are appropriate to meet the member's needs.
- (B) Home Health Agency - Case Management Activities.
- (1) Plan of Care. The home health agency participates in the development of the plan of care for each complex-care member as described in 130 CMR 403.420, in consultation with the physician, the clinical manager, the member, and the primary caregiver, or some combination, that
 - (a) includes the appropriate assignment of home health services; and
 - (b) incorporates full consideration of the member's and the caregiver's preferences for service arrangements.
 - (2) Coordination and Communication. The home health agency closely communicates and coordinates with MassHealth's or its designee's clinical manager about the status of the member's home health needs.

403.415: Nursing Services

- (A) Conditions of Payment. Nursing services are payable only if all of the following conditions are met:
- (1) there is a clearly identifiable, specific medical need for nursing services;
 - (2) the services are ordered by the physician for the member and are included in the plan of care;
 - (3) the services require the skills of a registered nurse or of a licensed practical nurse under the supervision of a registered nurse, in accordance with 130 CMR 403.415(B);
 - (4) the services are medically necessary to treat an illness or injury in accordance with 130 CMR 403.409(C); and
 - (5) prior authorization is obtained where required in compliance with 130 CMR 403.410.
- (B) Clinical Criteria.
- (1) A nursing service is a service that must be provided by a registered nurse, or by a licensed practical nurse under the supervision of a registered nurse, to be safe and effective,

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considering the inherent complexity of the service, the condition of the member, and accepted standards of medical and nursing practice.

(2) Some services are nursing services on the basis of complexity alone (for example, intravenous and intramuscular injections, or insertion of catheters). However, in some cases, a service that is ordinarily considered unskilled may be considered a nursing service because of the patient's condition. This situation occurs when only a registered nurse or licensed practical nurse can safely and effectively provide the service.

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(3) When a service can be safely and effectively performed (or self-administered) by the average nonmedical person without the direct supervision of a registered or licensed practical nurse, the service is not considered a nursing service, unless there is no one trained, able, and willing to provide it.

(4) Nursing services for the management and evaluation of a plan of care are medically necessary when only a registered nurse can ensure that essential care is effectively promoting the member's recovery, promoting medical safety, or avoiding deterioration.

(5) Medical necessity of services is based on the condition of the member at the time the services were ordered, what was, at that time, expected to be appropriate treatment throughout the certification period, and the ongoing condition of the member throughout the course of home care.

(6) A member's need for nursing care is based solely on his or her unique condition and individual needs, whether the illness or injury is acute, chronic, terminal, stable, or expected to extend over a long period.

(7) Medication Administration Visit. A skilled nursing visit for the sole purpose of administering medication may be considered medically necessary when the member is unable to perform the task due to impaired physical, cognitive, behavioral, and/or emotional issues, no able caregiver is present, the member has a history of failed medication compliance resulting in a documented exacerbation of the member's condition, and/or the task of the administration of medication, including the route of administration, requires a licensed nurse to provide the service. A medication administration visit may include administration of oral, intramuscular, and/or subcutaneous medication or administration of medications other than oral, intramuscular and/or subcutaneous medication.

(C) Service Limitations for MassHealth CarePlus Members. Nursing visits provided by a home health agency are covered for a MassHealth CarePlus member only when the following conditions and all other requirements of 130 CMR 403.000 are met:

- (1) such care is provided following an overnight hospital or skilled nursing facility stay;
- (2) such care is intended to help resolve an identified skilled-nursing need directly related to the member's hospital or skilled nursing facility stay; and
- (3) for members other than those enrolled in an MCE, the home health agency obtains prior authorization as a prerequisite to payment for nursing visits following a referral from the hospital or skilled nursing facility. *See* 130 CMR 403.410(F) for prior authorization for MassHealth CarePlus members, other than those enrolled in an MCE.

403.416: Home Health Aide Services

(A) Conditions of Payment. Home health aide services are payable only if all of the following conditions are met:

- (1) home health aide services are medically necessary and are provided pursuant to skilled nursing or therapy services;
- (2) the frequency and duration of the home health aide services must be ordered by the physician and must be included in the plan of care for the member;
- (3) the services are medically necessary to provide personal care to the member, to maintain the member's health, or to facilitate treatment of the member's injury or illness;
- (4) prior authorization, where applicable, has been obtained where required in compliance with 130 CMR 403.410; and
- (5) the home health aide is supervised by a registered nurse or therapist for skilled nursing services or therapy services respectively, employed or contracted by the same home health agency as the home health aide. In the event that the home health agency contracts for, rather than directly employs, home health aides, such aides must be supervised in accordance with

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42 CFR § 484.80(h).

(B) Payable Home Health Aide Services. Payable home health aide services include, but are not limited to

(1) personal-care services; such as bathing, dressing, grooming, caring for hair, nail, and oral hygiene, which are needed to facilitate treatment or to prevent deterioration of the member's health, changing the bed linen, shaving, deodorant application, skin care with lotions and/or powder, foot care, ear care, feeding, assistance with elimination, routine catheter care, and routine colostomy care;

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- (2) simple dressing changes that do not require the skills of a registered or licensed nurse;
- (3) medication reminders for medications that are ordinarily self-administered and that do not require the skills of a registered or licensed nurse;
- (4) assistance with activities that are directly supportive of skilled therapy services; and
- (5) routine care of prosthetic and orthotic devices.

(C) Nonpayable Home Health Aide Services. The MassHealth agency does not pay for homemaker, respite, or chore services provided to any MassHealth member.

(D) Incidental 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.

403.417: Physical, Occupational, and Speech/Language Therapy

(A) Physical Therapy. The MassHealth agency pays for up to 20 visits within a 12-month period beginning with the first visit for physical therapy without prior authorization when provided to an eligible MassHealth member, if the services are

- (1) prescribed by a physician;
- (2) directly and specifically related to an active treatment regimen;
- (3) of such a level of complexity and sophistication that the judgment, knowledge, and skills of a licensed physical therapist are required;
- (4) performed by a licensed physical therapist, or by a licensed physical therapy assistant under the supervision of a licensed physical therapist;
- (5) considered under accepted standards of medical practice to be a specific and effective treatment for the member's condition;
- (6) medically necessary for treatment of the member's condition. Services related to activities for the general good and welfare of members (for example, general exercises to promote overall fitness and flexibility, and activities to provide diversion or general motivation) do not constitute physical therapy services for purposes of MassHealth payment; and
- (7) certified by the physician every 60 days.

(B) Occupational Therapy. The MassHealth agency pays for up to 20 visits within a 12-month period beginning with the first visit for occupational therapy without prior authorization when provided to an eligible MassHealth member, if the services are

- (1) prescribed by a physician;
- (2) performed by a licensed occupational therapist, or by a licensed occupational therapy assistant under the supervision of a licensed occupational therapist;
- (3) considered under accepted standards of medical practice to be a specific and effective treatment for the member's condition;
- (4) medically necessary for treatment of the member's illness or injury. Services related to activities for the general good and welfare of the member (for example, general exercises to promote overall fitness and flexibility, and activities to provide diversion or general motivation) do not constitute occupational therapy services for purposes of MassHealth payment; and
- (5) certified by the physician every 60 days.

(C) Speech/Language Therapy. The MassHealth agency pays for up to 35 visits within a

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12-month period beginning with the first visit for speech and language therapy without prior authorization when provided to an eligible MassHealth member, if the services are

- (1) prescribed by a physician;
- (2) performed by a licensed speech and language therapist;
- (3) medically necessary for treatment of the member's illness or injury; and
- (4) certified by the physician every 60 days.

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(D) Maintenance Program.

(1) The MassHealth agency pays for the establishment of a maintenance program and the training of the member, member's family, or other persons to carry it out, as part of a regular treatment visit, not as a separate service. The MassHealth agency does not pay for performance of a maintenance program, except as provided in 130 CMR 403.423(D)(2).

(2) In certain instances, the specialized knowledge and judgment of a licensed therapist may be required to perform services that are part of a 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 must be performed by a licensed 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 medical record.

403.418: Medical Supplies

Home health agencies must submit prescriptions and orders for medical supplies only to vendors who are participating in MassHealth. Medical supplies, equipment, and appliances must be prescribed or ordered by the member's physician and must be provided and claimed directly by appropriate vendors in accordance with MassHealth regulations governing drugs, restorative therapy services, rehabilitative services, and durable medical equipment.

403.419: Provider Responsibilities

In addition to meeting all of the qualifications set forth in 130 CMR 403.000 and 450.000: *Administrative and Billing Regulations*, home health agencies must meet all of the following requirements.

(A) Policies and Procedures. Each home health agency must develop, maintain, review, and update comprehensive policies and procedures governing the delivery of home health services which, at a minimum, must contain the following:

(1) administrative policies and procedures including, but not limited to:

- (a) human resource and personnel;
- (b) staff and staffing requirements;
- (c) backup staff in the event coverage is required due to illness, vacation, or other reasons;
- (d) staff education and training;
- (e) home health agency staff evaluation and supervision;
- (f) emergencies including fire, safety and disasters, including notifying the fire department and police in emergencies;
- (g) member rights;
- (h) human rights and nondiscrimination;
- (i) incident and accident reporting;
- (j) staff and member grievances;
- (k) staff cultural competency;
- (l) quality assurance and improvement;
- (m) home health aide training;
- (n) emergency services and plans;
- (o) recognizing and reporting abuse (physical, sexual, emotional, psychological), neglect, self-neglect and financial exploitation;
- (p) Health Insurance Portability and Accountability Act (HIPAA); and
- (q) procedures to be followed if a member is missing or lost.

(2) clinical policies and procedures including, but not limited to:

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- (a) clinical evaluations;
- (b) privacy and confidentiality;
- (c) documentation of visits and progress notes;
- (d) medication management;
- (e) infection control and communicable disease;
- (f) discharge criteria;
- (g) coordination of home health with other services the member is receiving and
- (h) first aid and cardiopulmonary resuscitation requirements.

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(B) Teaching Activities. During a home health nursing or therapy treatment visit, the nurse or therapist must teach the member, family member, or caregivers how to manage the member's treatment regimen as applicable. Ongoing teaching is required when there is a change in the procedure or the member's condition.

(C) Recordkeeping.

(1) Administrative Records. Home health agencies must maintain administrative records in compliance with the record retention requirements set forth in 130 CMR 450.205: *Recordkeeping and Disclosure*. All records including, but not limited to the following, must be accessible and made available on site for inspection by the MassHealth agency:

- (a) payroll and staff records, including evidence of completed staff orientation and training;
- (b) financial records;
- (c) staffing levels;
- (d) complaints and grievances;
- (e) contracts for subcontracted services;
- (f) contracts for independent contractor services; and
- (g) job descriptions that include titles, reporting authority, qualifications and responsibilities.

(2) Incident and Accident Records. Home health agencies must maintain an easily accessible record of member and staff incidents and accidents. The record may be kept within the individual member medical record or employee record or within a separate, accessible file.

(3) Member Records. In order for a medical record to completely document a service to a member, the record must describe fully the nature, extent, quality, and necessity of the care furnished to the member. When the information contained in a member's record does not provide sufficient documentation for the service, the MassHealth agency may disallow payment (*see* 130 CMR 450.205: *Recordkeeping and Disclosure*).

(a) The record maintained by a home health agency for each member must conform to 130 CMR 450.000: *Administrative and Billing Regulations*. Payment for any service listed in 130 CMR 403.000 requires complete documentation in the member's medical record. The home health agency must maintain records for each member to whom services are provided.

(b) The home health agency must maintain an up-to-date medical record of services provided to each member. The medical record must contain at least the following in addition to the information defined at 130 CMR 403.402:

- 1. the member's name, address, phone number, date of birth, and MassHealth ID number;
- 2. the name and phone number of the member's primary care physician;
- 3. the primary caregiver's name, phone number, and relationship to the member;
- 4. the name and phone number of the member's emergency contact person;
- 5. if applicable, a copy of the approved prior authorization decision, including any *Request and Justification for Therapy Services Forms* and any *Request and Justification for Skilled Nursing and Home Health Aide Services Forms*;
- 6. a copy of all verbal orders, properly authenticated;
- 7. accessible and legible progress notes for each visit, signed by the person providing the service and that include the following information:
 - a. the full date of service and time that each visit began and ended;
 - b. any treatment or service and the member's response, including documentation of medication administration as described in 130 CMR 403.419(3)(b)8.;

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- c. the member's vital signs and any other required measurements as appropriate;
- d. progress toward achievement of goals as specified in the plan of care, including, when applicable, an explanation of why goals are not achieved as expected;
- e. a pain assessment, as appropriate;
- f. the status of any equipment maintenance and management, as appropriate; and
- g. any contacts with physicians or other health-care providers about the member's needs or change in plan of care, as applicable;

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8. a current medication-administration list or other documentation that includes the timing of administration as ordered, drug identification and dose, route of administration, the member's response to the medication being administered, and the signature of the person administering the medication;
9. documentation on the teaching provided to the member, member's family, or caregiver by the nurse or therapist on 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; or as applicable, documentation indicating that teaching was unsuccessful or unnecessary and why further teaching is not reasonable;
10. any clinical tests and their results, as applicable; and
11. a signed medical records release form, as applicable.

(4) Copies of Records.

- (a) For Members. Upon the request of the member or the member's representative, the home health agency must provide a copy of the medical record to the person or entity that the member or the member's representative designates.
- (b) CSN Services. When providing CSN services, the home health agency and, if co-vending, other providers must leave a copy of the member's medical record, including current progress notes, medication administration sheet, prior authorization form, plan of care, and physician orders in the member's home for the purpose of ensuring continuity of care.
- (c) CSN Services Documentation in the Member's Home. The home health agency and other nursing providers must maintain a copy of the member's medical record in the member's home. The record must include the total number of approved nursing hours per calendar week for the member, the names and telephone numbers of all the providers involved in co-vending care, the number of nursing hours approved for each provider by the MassHealth agency or its designee, and all other recordkeeping requirements as described in 130 CMR 403.419(C).

403.420: Plan-of-care Requirements

All home health services must be provided under a plan of care established individually for the member.

(A) Providers Qualified to Establish a Plan of Care.

- (1) The member's physician must establish a written plan of care in consultation with the home health agency. The physician must review, sign and date the plan of care and revise as applicable:
 - (a) no less than every 60 days from the start of home health services;
 - (b) more frequently as the member's condition or needs require. The plan of care or other medical notes in the member record must document that a face-to-face encounter related to the primary reason the member requires home health services occurred no more than 90 days before or 30 days after the start of home health services. *See* 130 CMR 403.420(E).
- (2) A home health agency nurse or skilled therapist may establish an additional discipline-oriented plan of care, when appropriate. These plans of care may be incorporated into the plan of care, or be prepared separately, but do not substitute for the plan of care.

(B) Content of the Plan of Care. The orders on the plan of care must specify the service type and frequency of the services to be provided to the member, and the type of professional who must provide them. The physician must sign and date the plan of care before the home health

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agency submits its claim for those services to the MassHealth agency for payment, or must comply with the verbal-order provisions at 130 CMR 403.420(D). Any increase in the frequency of services or any addition of new services must be authorized in advance by the physician with verbal or written orders and authorized by the MassHealth agency or its designee as appropriate. If the member is enrolled in the Primary Care Clinician (PCC) Plan, the home health agency must communicate with the member's PCC both when the goals of the care plan are achieved and when there is a significant change in a member's health status. The plan of care must contain

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- (1) all pertinent diagnoses, including the member's mental status;
- (2) the types of services, supplies, and equipment ordered;
- (3) the frequency of the visits to be made;
- (4) the prognosis, rehabilitation potential, functional limitations, permitted activities, nutritional requirements, medications, and treatments;
- (5) any safety measures to prevent injury;
- (6) any teaching activities to be conducted by the nurse or therapist, to teach the member, family member, or caregiver how to manage the member's treatment regimen (ongoing teaching may be necessary where there is a change in the procedure or the member's condition);
- (7) the discharge plans; and
- (8) any additional items the home health agency or physician chooses to include.

(C) Certification Period. Both the plan of care, required under 130 CMR 403.420(A)(1), and the discipline oriented plan of care, described in 130 CMR 403.420(A)(2), must be reviewed, signed, and dated by a physician at least every 60 days.

(D) Verbal Orders.

- (1) Services that are provided from the beginning of the certification period (*see* 130 CMR 403.420(C)) and before the physician signs the plan of care are considered to be provided under a plan of care established and approved by the physician if
 - (a) the clinical record contains a documented verbal order for the care before the services are provided; and
 - (b) the physician signature is on the 60-day plan of care either before the claim is submitted or within 45 days after submitting a claim for that period.
- (2) If the member has other health insurance (whether commercial or Medicare), the provider must comply with the other insurer's regulations for physician signature before billing the MassHealth agency.
- (3) The home health agency must obtain prior authorization for verbal orders where required.

(E) Face-to-face Encounter Requirements.

- (1) A face-to-face encounter between the member and an authorized practitioner is required for initial orders for home health services. A face-to-face encounter is not required when the plan of care is reviewed and revised as required at 130 CMR 403.420(C) or at resumption of home health services.
- (2) Authorized practitioners include:
 - (a) the ordering physician. In order to be an ordering physician, the physician must be enrolled in MassHealth;
 - (b) the physician who cared for the member in an acute or post-acute care facility (acute/post-acute care attending physician) from which the member was directly admitted to home health; or
 - (c) certain authorized non-physician practitioners (NPP), which include one of the following in a home health context:
 1. a nurse practitioner or clinical nurse specialist who is working in collaboration with the ordering physician or the acute/post-acute care attending physician;
 2. a certified nurse midwife; or
 3. a physician assistant under the ordering or acute/post-acute care attending physician.
- (3) Documenting the Face-to-face Encounter in the Member's Record.
 - (a) The face-to-face encounter must be documented in the member's record either on the plan-of-care or in other medical notes sufficient to make the link between the individual's health conditions, the services ordered, an appropriate face-to-face encounter, and actual

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service provision.

(b) The ordering or acute/post-acute-care attending physician (but not NPP) may serve as the physician writing the plan of care. When the acute/post-acute-care attending physician writes the plan of care, such attending physician must document that the face-to-face encounter is related to the primary reason the patient requires home health services and that the encounter with an authorized practitioner occurred within the required timeframes. The plan of care or the medical notes must include which authorized practitioner conducted the encounter and the date of the encounter.

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(c) If the face-to-face encounter was not provided by the ordering physician, the authorized practitioner who did conduct the face-to-face encounter is required to communicate the clinical findings of the face-to-face encounter to the ordering physician. This requirement is necessary to ensure that the ordering physician has sufficient information to determine the need for home health services in the absence of conducting the face-to-face encounter himself or herself.

(d) The home health agency must maintain a copy of the face-to-face documentation.

(4) Well Mom and Baby Visits. Face-to-face encounters must be conducted prior to home health services that arise from well mom and baby visits. If, in the course of such a visit, an authorized practitioner determines that home health services are required to address the condition of the mother or child, such a visit may be the basis for a documented face-to-face encounter to the extent that the visit involves examining the condition of the mother or child for whom services are being ordered.

(5) Dual-eligible Members. If the source of payment for the member's care has changed from Medicare to Medicaid, and a face-to-face encounter was performed at the start of Medicare-authorized home health services, a new face-to-face encounter is not required.

403.421: Quality Management and Utilization Review

(A) A home health agency must participate in any quality management and program integrity processes as required by the MassHealth agency including making any necessary data available and providing access to visit the home health agency's place of business upon request by MassHealth or its designee.

(B) A home health agency must submit requested documentation to the MassHealth agency or its designee for purposes of utilization review and provider review and audit, within the MassHealth agency's or its designee's time specifications. The MassHealth agency or its designee may periodically review a member's plan of care and other records to determine if services are medically necessary in accordance with 130 CMR 403.409(C). The home health agency must provide the MassHealth agency or its designee with any supporting documentation the MassHealth agency or its designee requests, in accordance with M.G.L. c. 118E, § 38 and 130 CMR 450.000: *Administrative and Billing Regulations*.

403.422: Transfers and Discharge Planning

(A) Discharge Procedures.

(1) A member shall be discharged by the home health agency provider under the following conditions:

- (a) upon the member's request;
- (b) if the member ceases to benefit from home health services;
- (c) if the member no longer meets the clinical eligibility for home health services;
- (d) if the member selects another service that is duplicative of home health;
- (e) if the member transitions to another home health provider; or
- (f) if the home health agency ceases operations.

(2) A member may be discharged by the home health agency provider if the home health agency cannot safely serve the member in the home in accordance with 42 CFR 484.50(d)(5).

(B) Safe Discharge Planning when other Community Services Needed. Home health agencies must:

(1) begin to develop a discharge and transition plan for members during the admission process/start of care;

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- (2) coordinate community long-term services that are most appropriate for the member's needs at discharge and refer to other community services accordingly;
 - (3) provide assistance to the member in identifying and locating other community long-term services;
 - (4) document coordination with community resources and keep documentation of referrals to other community resources in the member's record;
 - (5) coordinate the discharge and transition with the member, member's family/caregiver, and the staff of the provider, program or agency to which the member is to be transferred;
- and

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(6) make best efforts to ensure the continuity of care until the new service has commenced.

(C) Members 60 Years of Age or Older. Home health agencies must complete an Aging Service Access Point (ASAP) referral form for those MassHealth members 60 years of age or older within 15 days of a planned discharge from home health services or whenever the agency determines that the MassHealth member could benefit from ASAP services. See 651 CMR 14.00: *Aging Services Access Points*, for a description and definition of ASAP. Home health agencies shall forward the completed referral form to the ASAP serving the area in which the member resides and must keep a copy of the completed ASAP referral form in the member's record.

(D) Transfers of Members to Alternate Home Health Agencies.

(1) When a member transfers from one home health agency to an alternate home health agency, the transferring home health agency must inform MassHealth within ten days of the transfer. When informing the MassHealth agency of the transfer, the transferring home health agency must include the following information in the form and format required by the MassHealth agency and maintain this information in the member's record:

- (a) Member Name;
- (b) Member ID;
- (c) Member care plan;
- (d) Receiving home health agency;
- (e) Date of transfer; and
- (f) Reason for transfer.

(2) The receiving home health agency must complete an initial member assessment and must obtain prior authorization. The new agency must collaborate with the transferring agency in regards to the prior authorization timeline, number of visits completed, and must ensure that there are no overlapping dates of service.

403.423: Conditions of Payment

The following conditions for payment apply to all home health services, in addition to conditions of payment described throughout 130 CMR 403.000.

(A) The MassHealth agency pays for home health in accordance with the applicable payment methodology and rate schedule established by EOHHS.

(B) The home health provider must review each member in its care to ensure that the clinical eligibility criteria for home health continue to be met. A home health provider may not bill and the MassHealth agency will not pay for any member who does not meet the clinical criteria for home health.

(C) Initial Patient Assessments. The MassHealth agency pays for one initial member assessment visit by a home health agency with or without a physician's order. The MassHealth agency does not pay for any subsequent services provided to the member unless the physician includes them in the written plan of care.

(D) Observation and Evaluation Visits. The MassHealth agency pays for observation and evaluation (or reevaluation) visits when they are made by a registered nurse or physical, occupational, or speech/language therapist ordered by the physician, for the purpose of evaluating the member's condition and his or her continuing need for home health services.

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(E) Supervisory Visits. The MassHealth agency does not pay for a supervisory visit made by a nurse or physical and occupational therapist for the purpose of evaluating the specific personal-care needs of the member, or reviewing the manner in which the personal-care needs of the member are being met by the home health aide. These visits are administrative and are, therefore, not payable.

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(F) 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 MassHealth agency pays the full skilled nursing visit rate for one member and a reduced rate for each subsequent member in the household. When billing the MassHealth agency 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. Failure to do so constitutes an unacceptable billing practice in accordance with 130 CMR 450.307: *Unacceptable Billing Practices*.

(G) Skilled Nursing Visits for Members Receiving Home Health Services After 30 Calendar Days. The MassHealth agency pays 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 or paid by a third-party insurer other than MassHealth. When billing the MassHealth agency for any skilled nursing visit on or after the 31st calendar day, the service code and modifier must reflect the skilled nursing visit. The MassHealth agency resumes the full skilled nursing visit rate of one through 30 calendar days under the following conditions:

- (1) Admission to a hospital of at least one overnight.
- (2) Admission to a Crises Stabilization Unit of at least one overnight.
- (3) Admission to a skilled nursing facility of at least three nights.
- (4) Following a break in home health services of 60 days or more.

(H) Medication Administration Visit. The MassHealth agency pays a separate rate for skilled nursing visits conducted for the purpose of medication administration, as defined in 130 CMR 403.402. Medication Administration Visits must include teaching on medication management to maximize independence, as applicable, documentation as specified in 130 CMR 403.419(C)(3)(b)9., and assessment of the member response to medication.

(I) Members for Whom Services Are Approved. The MassHealth agency does not pay for nursing services provided to any individual other than the member who is eligible to receive such services and for whom such services have been authorized by the MassHealth agency or its designee.

403.424: Intermittent or Part Time Requirement

The MassHealth agency pays for nursing visits and home health aide services provided pursuant to a need for skilled nursing services only on an intermittent or part time basis, and only as described in 130 CMR 403.423(E), except as provided in 130 CMR 403.423(F). Services described in 130 CMR 403.424 are paid for subject to any applicable prior authorization requirements as described at 130 CMR 403.410.

(A) Intermittent and Part Time Services.

- (1) 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.
- (2) 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.

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- (3) To receive intermittent or part time nursing care, the member must have a medically predictable recurring need for skilled nursing services at least once every 60 days, or the member must meet the conditions in 130 CMR 403.424(A)(4).
- (4) In certain circumstances, the member needs infrequent, yet intermittent, nursing services. The following are nonexclusive examples of such services, which are payable.
 - (a) The member has an indwelling silicone catheter and generally needs a catheter change only at 90-day intervals.

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(b) The member experiences a fecal impaction due to the normal aging process (that is, loss of bowel tone, restrictive mobility, and a breakdown in good health habits) and must be manually disimpacted. Although these impactions are likely to recur, it is not possible to predict a specific time frame.

(c) The member is diabetic and visually impaired. He or she self-injects insulin, and has a medically predictable recurring need for a nursing visit at least every 90 days. These nursing visits, which supplement the physician's contacts with the member, are necessary to observe and determine the need for changes in the level and type of care that have been prescribed.

(d) The need for intermittent or part time nursing is medically predictable, but a situation arises after the first nursing visit that makes additional visits unnecessary (for example, the member becomes institutionalized or dies, or a primary caregiver has been trained to provide care). In this situation, the one nursing visit is payable.

(B) Exceptions. Nursing visits and home health aide services in excess of the intermittent or part time limit, as described in 130 CMR 403.424(A), may be provided to members under any of the following conditions:

(1) the physician has documented that the death of the member is imminent, and the physician has recommended that the member be permitted to die at home;

(2) the home health agency has documented that the services are no more costly than medically comparable care in an appropriate institution (for example, long-term care or chronic disease and rehabilitation hospital care) and the least-costly form of comparable care available in the community, and the member prefers to remain at home;

(3) the home health agency has documented that it is seeking appropriate alternative modes of care, but has not yet found them;

(4) the physician has documented that the need for care in excess of 30 days or in excess of 35 hours per calendar week is medically necessary in accordance with 130 CMR 403.409(C);

(5) the member qualifies for CSN services; or

(6) for daily skilled nursing services for diabetics unable to administer their insulin (when there is no able and willing caregiver).

403.428: Maximum Allowable Fees

Home health agencies must accept MassHealth payment in full for home health services according to the rates and regulations established by EOHHS as set forth in 114.3 CMR 50.00: *Home Health Services*. Payments are subject to the conditions, exclusions, and limitations set forth in 130 CMR 403.000 and 450.000: *Administrative and Billing Regulations*.

403.429: Denial of Services and Administrative Review

(A) A failure or refusal by a home health agency to provide services that have been ordered by the member's attending physician and that are within the range of payable services is not an action by the MassHealth agency or its designee that a member may appeal; but such failure or refusal constitutes a violation of 130 CMR 403.000 for which administrative sanctions may be imposed. The MassHealth agency receives and acts upon complaints from physicians, continuing-care coordinators, and other social-services agencies, as well as from members and their families. A failure or refusal by a physician to order services or to certify their medical necessity is not an action by the MassHealth agency or its designee that a member may appeal.

(B) When a home health agency believes that services ordered by the attending physician are

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not payable under 130 CMR 403.000, the agency must refer the matter to the MassHealth agency for a payment decision. If and to the extent the MassHealth agency determines that the ordered services are payable, the agency must provide those services.

REGULATORY AUTHORITY

130 CMR 403.000: M.G.L. c. 118E, §§7 and 12.