Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
600 Washington Street
Boston, MA 02111
www.mass.gov/dma

MASSHEALTH
TRANSMITTAL LETTER HHA-34
July 2003

TO: Home Health Agencies Participating in MassHealth

FROM: Douglas S. Brown, Acting Commissioner

RE: *Home Health Agency Manual* (Revisions to Program Regulations)

This letter transmits revisions to the home health agency program regulations in Subchapter 4 and service codes and descriptions in Subchapter 6. These revisions are effective for dates of service on or after August 1, 2003.

Revisions to Regulations

The Division has made several changes to program regulations. The private duty nurse service that was in a separate *Private-Duty Nursing Manual* is now part of the *Home Health Agency Manual*. The regulations now refer to private duty, intermittent, and part-time nursing as "nursing."

A. Case Management for Complex-Care Members

Revisions to the regulations include case management of MassHealth members under the age of 22 who require a nurse encounter of more than two continuous hours. The Division refers to these members as complex-care members.

Beginning August 1, 2003, the Division or its designee will enroll these members in case management and assign each member a case manager who will perform a comprehensive needs assessment and authorize all medically necessary home health and other community services for the complex-care member.

The Recipient Eligibility Verification System (REVS) will identify those MassHealth members whom the Division or its designee has enrolled in complex-care case management. The Division or its designee will assign a case manager to complex-care members. If REVS indicates that the member is enrolled in case management, you will be advised that PA is needed for nursing, home health aide, personal care worker, and other home health services.

For new referrals for nursing services for MassHealth members under age 22 or questions about complex-care members, you must call the Division's designee on or after August 1, 2003, at 1-800-863-6068 for case management and authorization.

There are no changes to the assessment or authorization process for nursing services for members aged 22 or older.

B. Personal Care Worker

A new home health service, called the personal-care worker (PCW), has been added for complex-care members only. Home health agency providers that choose to provide the PCW service must contact Provider Enrollment and Credentialing at 617-576-4424 or 1-800-322-2909.

C. Multiple Providers

A revision to the PA section of these regulations addresses the situation where more than one provider is authorized to provide nursing services to an individual MassHealth member. Please refer to 130 CMR 403.413(A)(4) for more detailed instructions.

D. Unused Hours

If there are unused hours of nursing services in a calendar week, they may be used at any time during the current authorization period.

Revisions to the Service Codes and Descriptions

The Centers for Medicare and Medicaid Services (CMS) have revised the Healthcare Common Procedure Coding System (HCPCS) for 2003. Some new national service codes have been added and some MassHealth local service codes have been deleted from Subchapter 6 of the *Home Health Agency Manual*.

A. New Personal Care Worker Service Code

A new national code has been added for personal care worker (PCW) services.

B. Replaced Local Codes

I. New National Service Codes

We have deleted local codes in Subchapter 6 of the *Home Health Agency Manual* for private duty nursing services. They have been replaced with new national service codes. You must use a modifier with some codes to accurately reflect the service provided. The attached Subchapter 6 contains service codes with modifiers, where applicable. Please note that the new national service codes are in units of 15-minute increments. These revisions are effective for dates of service on or after August 1, 2003.

II. Weekend and Holiday Nursing Services

Billing for nursing services has been simplified. Providers will no longer need to bill distinct service codes for weekend and holiday nursing services. Providers will bill the applicable service code without specific reference to “weekend” or “holiday.” Payment for nursing services provided on weekends and holidays will be made automatically in accordance with the applicable fee schedule of the Division of Health Care Finance and Policy (DHCFP). Providers must use a service code that accurately reflects the nursing service that was provided.

Providers must use a separate line when billing for weekend or holiday nursing services. If you are billing for weekday nursing services on the same claim form as weekend nursing services, weekday nursing services must be on a separate claim line than weekend nursing services. Holiday nursing services must also be on a separate claim line.

- Holiday – all official Commonwealth of Massachusetts holidays: New Year's Day, Martin Luther King Day, Washington's Birthday, Patriots' Day, Memorial Day, Independence Day, Labor Day, Columbus Day, Veterans Day, Thanksgiving Day, and Christmas Day.
- Weekend – Saturday and Sunday.

III. New and Current Prior Authorizations

Effective for dates of service on or after August 1, 2003, all new PA requests for nursing services must be submitted using the new national service code revised in the Subchapter 6. For dates of service from August 1, 2003, through October 15, 2003, providers who have received PA for private duty nursing under the old local code system may continue to bill, during the approval period of the PA, using the old local service codes. For dates of service beginning October 16, 2003, providers must use the new national service codes that correspond to the old local service codes on the approved PA.

Providers are not required to do anything to convert their approved PA numbers due to the MassHealth transition to national service codes. Previously approved PAs with expiration dates on or after October 16, 2003, will be adjusted by the Division to reflect the appropriate new national service codes.

Modifiers are not required on a PA form. However, you must use the applicable modifier with claims submission.

C. Future Home Health National Service Codes

The Division will notify you in the future when changes are made to the remaining home health local codes.

D. Attachments

Please see the attached crosswalk of the new national service codes and modifiers, which can be found in Subchapter 6, and the obsolete MassHealth local service codes.

Please see the attached claim form examples using new national service codes and modifiers for nursing services.

NEW MATERIAL

(The pages listed here contain new or revised language.)

Home Health Agency Manual

Pages iv, vi, and 4-1 through 4-18, 6-1 and 6-2

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

Home Health Agency Manual

Pages iv, 4-5, 4-6, 4-13, and 4-14 — transmitted by Transmittal Letter HHA-31

Page vi — transmitted by Transmittal Letter HHA-33

Pages 4-1, 4-2, 4-9 through 4-12, 4-15 and 4-16 — transmitted by Transmittal Letter HHA-29

Pages 4-3 and 4-4 — transmitted by Transmittal Letter HHA-28

Pages 4-7 and 4-8 — transmitted by Transmittal Letter HHA-32

Pages 6-1 and 6-2 — transmitted by Transmittal Letter HHA-30

Billing Guidelines for Home Health Agencies
Billing for Nursing Services > 2 Hours

Each line in the table below must be billed on a separate claim line in order to receive appropriate reimbursement. You may span dates of service (bill From-Through) for all similar services that were provided within one line of this table. The following services are in this table:

- Day services provided Monday-Friday (weekday)
- Day services provided Saturday-Sunday (weekend)
- Night services (all days of the week)
- Holiday services

Type of Nurse	# Patients seen	When service was provided *If properly billed on separate claim lines, holiday and weekend services will be automatically recognized.*					New service code – modifier to be billed	Comments *Please note the change in units: effective 09/01/2003, bill in 15-minute increments for the new service code/modifier.*	Obsolete DMA service code
		Day	Night	Mon-Fri	Sat-Sun	Holiday			
RN	1	X		X			T1002	Mon-Fri, day	X9570
RN	1		X	X			T1002-UJ	Mon-Fri nights and/or weekends (any time of day)	X9572
RN	1		X		X		T1002-UJ		
RN	1	X			X		T1002		
RN	1					X	T1002	Holiday	X9574
RN	2	X		X			T1002-TT	Mon-Fri, day, 2:1 Bill per member.	X9578
RN	2		X	X			T1002-U1	Mon-Fri nights and/or weekends (any time of day), 2:1 Bill per member.	X9580
RN	2		X		X		T1002-U1		
RN	2	X			X		T1002-U1		
RN	2					X	T1002-TT	Holiday, 2:1 Bill per member.	X9582
RN	3	X		X			T1002-U2	Mon-Fri, day, 3:1 Bill per member.	X9560
RN	3		X	X			T1002-U3	Mon-Fri nights and/or weekends (any time of day), 3:1 Bill per member.	X9561
RN	3		X		X		T1002-U3		
RN	3	X			X		T1002-U3		
RN	3					X	T1002-U2	Holiday, 3:1 Bill per member.	X9562

Type of Nurse	# Patients seen	When service was provided *If properly billed on separate claim lines, holiday and weekend services will be automatically recognized.*					New service code – modifier to be billed	Comments *Please note the change in units: effective 09/01/2003, bill in 15-minute increments for the new service code/modifier.*	Obsolete DMA service code
		Day	Night	Mon-Fri	Sat-Sun	Holiday			
LPN	1	X		X			T1003	Mon-Fri, day	X9571
LPN	1		X	X			T1003-UJ	Mon-Fri nights and/or weekends (any time of day) Please Note: Bill using new 15-minute units	X9573
LPN	1		X		X		T1003-UJ		
LPN	1	X			X		T1003		
LPN	1					X	T1003	Holiday	X9575
LPN	2	X		X			T1003-TT	Mon-Fri, day, 2:1 Bill per member.	X9579
LPN	2		X	X			T1003-U1	Mon-Fri nights and/or weekends (any time of day), 2:1 Bill per member.	X9581
LPN	2		X		X		T1003-U1		
LPN	2	X			X		T1003-U1		
LPN	2					X	T1003-TT	Holiday, 2:1 Bill per member.	X9583
LPN	3	X		X			T1003-U2	Mon-Fri, day, 3:1 Bill per member.	X9563
LPN	3		X	X			T1003-U3	Mon-Fri nights and/or weekends (any time of day), 3:1 Bill per member.	X9564
LPN	3		X		X		T1003-U3		
LPN	3	X			X		T1003-U3		
LPN	3					X	T1003-U2	Holiday, 3:1 Bill per member.	X9565

Examples of Completed Paper Claim Forms (claim form no. 9)

This attachment has examples of completed paper claims using the new national service codes for MassHealth nursing services, which were formerly known as private duty nursing services.

For assistance with a billing situation not explained in these examples, contact MassHealth Provider Services at 1-800-325-5231 or 617-628-4141.

REMINDERS:

- The new national service codes for nursing are effective for dates of service on or after August 1, 2003. Please refer to Subchapter 6 of your provider manual for a listing of the new national service codes for nursing.

- The new national service codes are units of 15-minute increments (1 unit = 15 minutes).

- You must use the applicable modifier with claims submission. Please refer to Subchapter 6 for a listing of the modifiers and definitions.

- Payment for nursing services provided on the "weekend" and "holiday" will be made automatically in accordance with the applicable fee schedule of the Division of Health Care Finance and Policy (DHCFP). However, you must use a separate line on the claim form when billing for weekend or holiday nursing services.

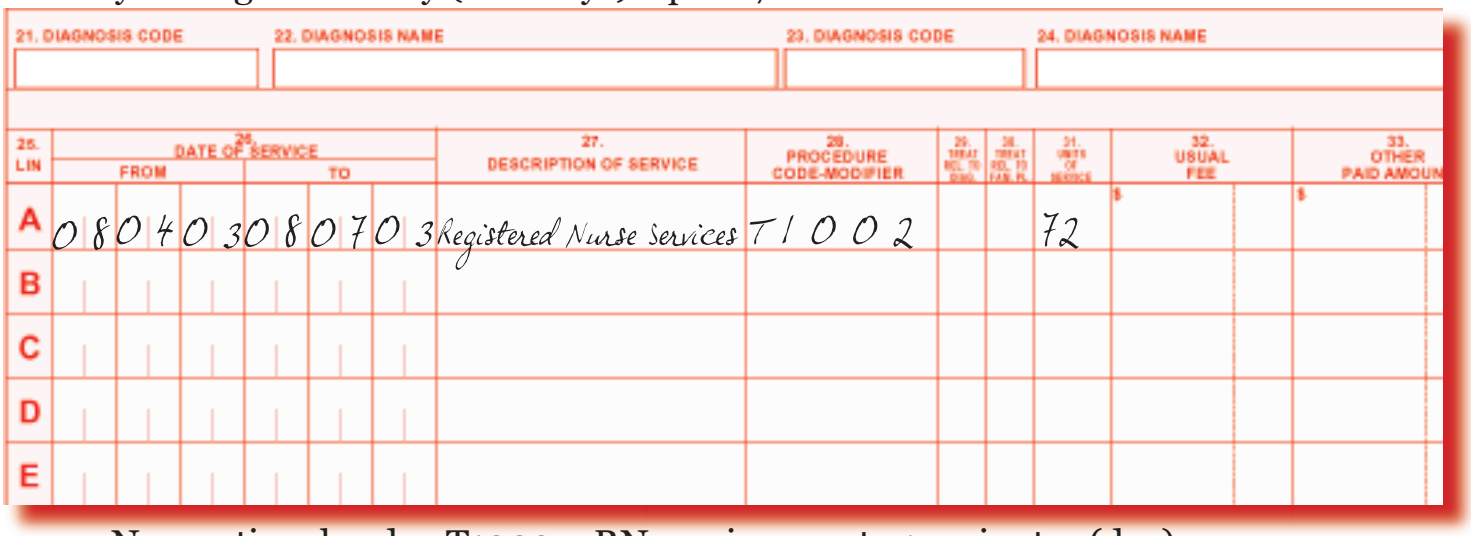
- When you are billing multiple patient nursing services, you must bill a separate claim for each member.

- If you have received a PA for nursing services under the old local code system, you may continue to bill during the approval period of your PA using the old local service codes for dates of service on or before October 15, 2003. For dates of service beginning October 16, 2003, you must use the new national service codes. If you have a PA with an expiration date on or after October 16, 2003, it will be adjusted by the Division to reflect the appropriate new national service codes.

Example (A) – consecutive billing for day

In this example, a registered nurse requests payment for four and a half hours per day of nursing services provided Monday through Thursday (8A.M. to 12:30P.M.).

Four and a half hours per each date of service equals 18 units per day.
Monday through Thursday (four days) equals 72 units.



21. DIAGNOSIS CODE	22. DIAGNOSIS NAME	23. DIAGNOSIS CODE	24. DIAGNOSIS NAME

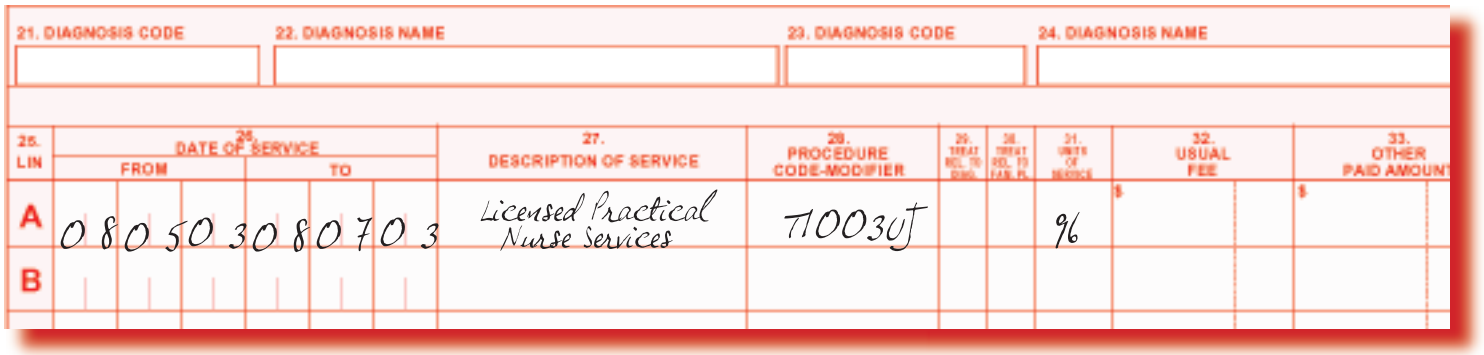
25. LIN	26. DATE OF SERVICE FROM	26. DATE OF SERVICE TO	27. DESCRIPTION OF SERVICE	28. PROCEDURE CODE-MODIFIER	29.	30.	31. UNITS OF SERVICE	32. USUAL FEE	33. OTHER PAID AMOUNT
A	080403	080703	Registered Nurse Services	T1002			72	$	$
B									
C									
D									
E									

New national code: T1002 – RN services, up to 15 minutes (day)

Example (B) – consecutive billing for night

In this example, a licensed practical nurse requests payment for eight hours per night of nursing services provided Tuesday through Thursday (3P.M. to 11P.M).

Eight hours per each date of service equals 32 units per night.
Tuesday through Thursday (three days) equals 96 units.



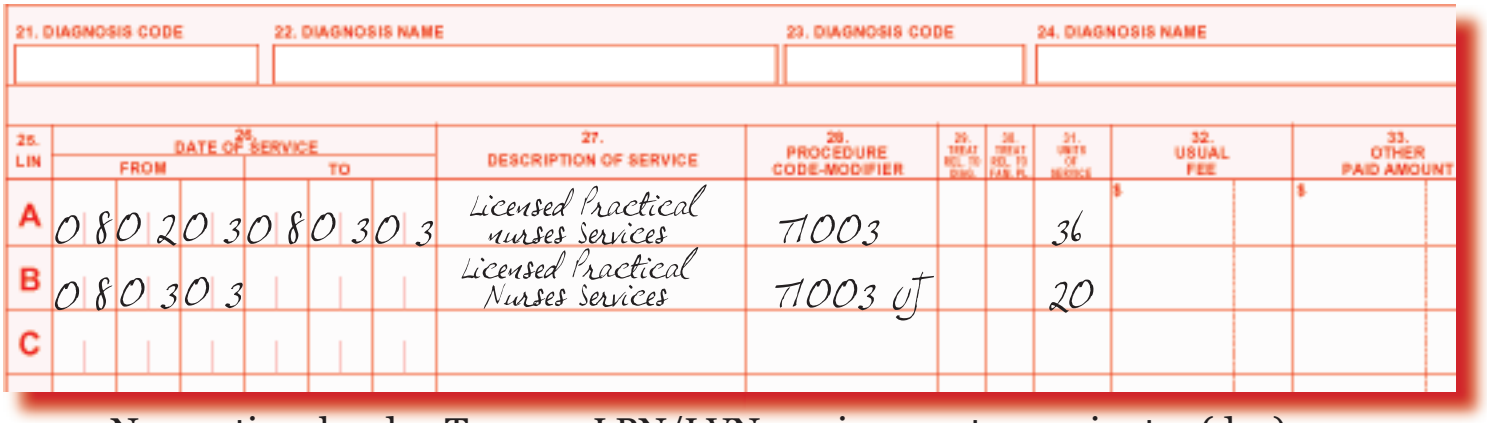
21. DIAGNOSIS CODE	22. DIAGNOSIS NAME	23. DIAGNOSIS CODE	24. DIAGNOSIS NAME

25. LIN	26. DATE OF SERVICE FROM	26. DATE OF SERVICE TO	27. DESCRIPTION OF SERVICE	28. PROCEDURE CODE-MODIFIER	29.	30.	31. UNITS OF SERVICE	32. USUAL FEE	33. OTHER PAID AMOUNT
A	080503	080703	Licensed Practical Nurse Services	T1003UJ			96	$	$
B									

New national code: T1003-UJ – LPN/LVN services, up to 15 minutes (night)

Example (C) – billing for weekend

In this example, a licensed practical nurse requests payment for six hours per day of nursing services provided Saturday and Sunday. On Saturday the nurse provides six hours (7 A.M. to 1 P.M.). On Sunday the nurse provides eight hours (12 P.M. to 8 P.M.).



21. DIAGNOSIS CODE	22. DIAGNOSIS NAME	23. DIAGNOSIS CODE	24. DIAGNOSIS NAME

25. LIN	24. DATE OF SERVICE FROM	TO	27. DESCRIPTION OF SERVICE	28. PROCEDURE CODE-MODIFIER	29.	30.	31.	32. USUAL FEE	33. OTHER PAID AMOUNT
A	080203	080303	Licensed Practical nurses Services	T1003			36	$	$
B	080303		Licensed Practical Nurses Services	T1003 UJ			20		
C									

New national code: T1003 – LPN/LVN services, up to 15 minutes (day)
T1003-UJ – LPN/LVN services, up to 15 minutes (night)

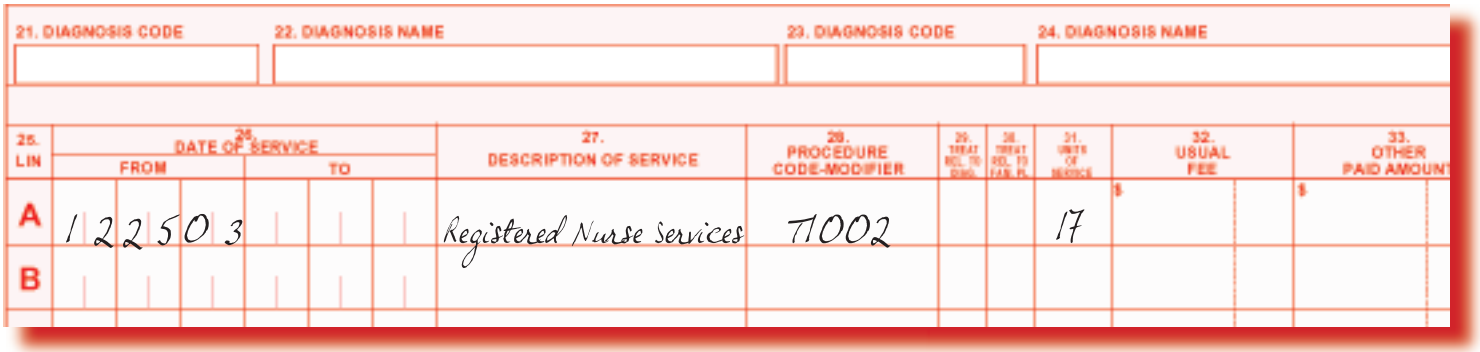
Line (A) on the claim form: day nursing services on the weekend
Saturday is six hours of day nursing and Sunday is three hours of day nursing (total of nine hours of day nursing), which equals 36 units

Line (B) on the claim form: night nursing service on the weekend
Sunday equals five hours of night nursing, which equals 20 units

Please Note: Payment for weekend rate is automated to reimburse in accordance with the applicable fee schedule of the Division of Health Care Finance and Policy (DHCFP).

Example (D) – billing for holiday

In this example, a registered nurse requests payment for four hours and 15 minutes, which equals 17 units of nursing services (8 A.M. to 12:15 P.M.) for the December 25, 2003, holiday.



21. DIAGNOSIS CODE	22. DIAGNOSIS NAME	23. DIAGNOSIS CODE	24. DIAGNOSIS NAME

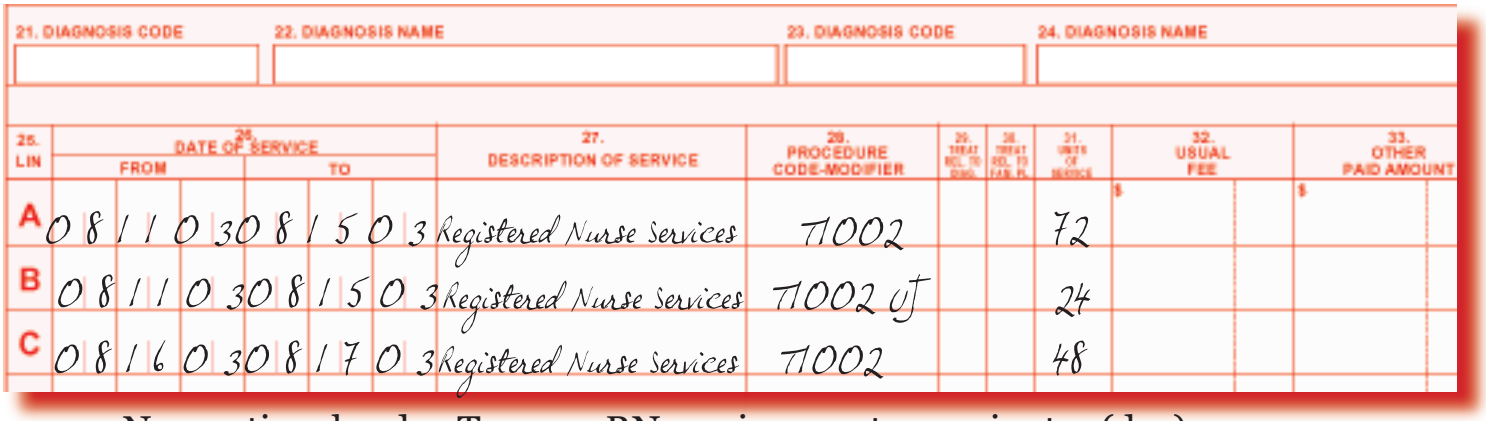
25. LIN	24. DATE OF SERVICE FROM	TO	27. DESCRIPTION OF SERVICE	28. PROCEDURE CODE-MODIFIER	29.	30.	31.	32. USUAL FEE	33. OTHER PAID AMOUNT
A	122503		Registered Nurse Services	T1002			17	$	$
B									

New national code: T1002 – RN services, up to 15 minutes (day)

Please Note: Payment for holiday rate is automated to reimburse in accordance with applicable fee schedule of the Division of Health Care Finance and Policy (DHCFP).

Example (E) – billing for weekday and nights and weekend

In this example, a registered nurse requests payment for six hours of nursing services per day (9 A.M. to 3 P.M.) and two hours per night (3 P.M. to 5 P.M.) for Monday, Wednesday, and Thursday. The registered nurse also request payment for six hours per day (8 A.M. to 2 P.M.) for Saturday and Sunday.



21. DIAGNOSIS CODE	22. DIAGNOSIS NAME	23. DIAGNOSIS CODE	24. DIAGNOSIS NAME

25. LIN	26. DATE OF SERVICE FROM	TO	27. DESCRIPTION OF SERVICE	28. PROCEDURE CODE-MODIFIER	29.	30.	31. UNITS OF SERVICE	32. USUAL FEE	33. OTHER PAID AMOUNT
A	08 11 03	08 15 03	Registered Nurse Services	T1002			72	$	$
B	08 11 03	08 15 03	Registered Nurse Services	T1002 UJ			24		
C	08 16 03	08 17 03	Registered Nurse Services	T1002			48		

New national code: T1002 – RN services, up to 15 minutes (day)
T1002-UJ – RN services, up to 15 minutes (night)

Line (A) on the claim form: day nursing services during the week
Six hours for each day equals 24 units per day.
Day hours for Monday, Wednesday, and Thursday (three days) equal 72 units.

Line (B) on the claim form: night nursing services during the week
Two hours for each date of service equals 16 units per night.
Night hours for Monday, Wednesday, and Thursday (three days) equal 48 units.

Line (C) on the claim form: day nursing service on the weekend
Six weekend hours per date of service equals 24 units per day.
Day hours for Saturday and Sunday (two days) equal 48 units.

Please Note: Billing for nursing services provided on the weekend must be on a separate claim line from weekday nursing services.

Example (F) - billing for multiple-patient (nursing care provided simultaneously to two patients)
In this example, a registered nurse requests payment for four hours per day Monday through Saturday. The registered nurse also requests payment for five hours at night on Sunday.

Patient One:

21. DIAGNOSIS CODE	22. DIAGNOSIS NAME	23. DIAGNOSIS CODE	24. DIAGNOSIS NAME

25. LIN	26. DATE OF SERVICE FROM	TO	27. DESCRIPTION OF SERVICE	28. PROCEDURE CODE-MODIFIER	29.	30.	31. UNITS OF SERVICE	32. USUAL FEE	33. OTHER PAID AMOUNT
A	080403080 3		Registered nurse services	T1002TT			80	$	$
B	08090 3		Registered nurse services	T1002TT			16		
C	08100 3		Registered nurse services	T1002U1			20		

Patient Two:

21. DIAGNOSIS CODE	22. DIAGNOSIS NAME	23. DIAGNOSIS CODE	24. DIAGNOSIS NAME

25. LIN	26. DATE OF SERVICE FROM	TO	27. DESCRIPTION OF SERVICE	28. PROCEDURE CODE-MODIFIER	29.	30.	31. UNITS OF SERVICE	32. USUAL FEE	33. OTHER PAID AMOUNT
A	080403080 3		Registered nurse services	T1002 TT			80	$	$
B	08090 3		Registered nurse services	T1002TT			16		
C	08100 3		Registered nurse services	T1002U1			20		

New national code: T1002-TT – RN services, up to 15 minutes (day) (one nurse to two patients)
T1002-U1 – RN services, up to 15 minutes (night) (one nurse to two patients)

Line (A) on the claim form: day nursing services during the week
Four hour per day equals 16 units per day.
Monday through Friday (five days) equals 80 units.

Line (B) on the claim form: day nursing services on the weekend (Saturday)
Four hours per day equals 16 units per day.
Saturday (one day) equals 16 units.

Line (C) on the claim form: night nursing services on the weekend (Sunday)
Five hours per day equals 20 units per day.
Sunday (one day) equals 20 units total.

Please note: when billing for multiple-patient nursing services, you must bill a separate claim form for each member. Also in this example, billing for Saturday and Sunday are on separate lines because of night and day billing modifiers.

Example (G) – billing for day and night nursing service on the same day

In this example, a licensed practical nurse requests payment for three and a half hour of nursing services for a Monday (1:30 P.M. to 5 P.M.).

21. DIAGNOSIS CODE	22. DIAGNOSIS NAME	23. DIAGNOSIS CODE	24. DIAGNOSIS NAME

25. LIN	26. DATE OF SERVICE FROM	TO	27. DESCRIPTION OF SERVICE	28. PROCEDURE CODE-MODIFIER	29.	30.	31.	32. USUAL FEE	33. OTHER PAID AMOUNT
A	082503		Licensed Practical Nurse Services	T1003		6		$	$
B	082503		Licensed Practical Nurse Services	T1003 UJ		8			
C									

New national code: T1003 – LPN/LVN services, up to 15 minutes (day)
T1003-UJ – LPN/LVN services, up to 15 minutes (night)

Line (A) on the claim form: day nursing service during the week
One and a half hours for Monday during the day (1:30 P.M. to 3 P.M.) equals 6 units.

Line (B) on the claim form: night nursing service during the week
Two hours for Monday during the night (3 P.M. to 5 P.M.) equals 8 units.

4. PROGRAM REGULATIONS

6. SERVICE CODES AND DESCRIPTIONS

403.401: Introduction

All home health agencies participating in MassHealth must comply with the regulations of the Division governing MassHealth including, but not limited to, Division regulations set forth in 130 CMR 403.000 and 130 CMR 450.000.

403.402: Definitions

The following terms used in 130 CMR 403.000 shall 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 in 130 CMR 450.000.

Calendar Week — seven consecutive days.

Case Management — a function performed by the Division or its designee that assesses and reassesses the medical needs of complex-care members and authorizes or coordinates community long-term-care (CLTC) services that are medically necessary for such members to remain safely in the community.

Case Manager — a registered nurse employed by the Division or its designee to provide case management to complex-care members, to work cooperatively with that member, his or her family and primary caregiver(s), and all relevant providers.

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.

Chore Services — household duties (for example, heavy cleaning or minor home repairs) performed on behalf of a person who is unable to manage these tasks due to impairment.

Community Long-Term-Care (CLTC) Services — certain MassHealth-covered services intended to enable a complex-care member to remain in the community, which 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 Division or its designee.

Complex-Care Member — a MassHealth member, under the age of 22 at enrollment, whose medical needs, as determined by the Division or its designee, are such that he or she requires a nurse encounter of more than two continuous hours of nursing services to remain in the community.

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 Aide — a person who is employed by a MassHealth-approved home health agency to perform certain personal-care and other health-related services as listed in 130 CMR 403.421(B).

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

Member — an individual determined by the Division to be eligible for MassHealth.

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

Nursing Services — the planning, provision, 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.

Personal-Care Worker (PCW) — a person employed by a MassHealth-approved home health agency provider and trained as required by the Division, whose function is to provide certain personal-care and related ancillary services, and who plays an integral, ongoing role in the complex-care member's plan of care, under the supervision of a nurse.

Primary Caregiver — the individual, other than the nurse, home health aide, or personal-care worker, who is primarily responsible for providing ongoing care to the member.

Request and Justification Form — the form (paper, electronic, or other) authorized by the Division or its designee, on which the nursing-care needs of the member, other than a complex-care member, as identified in the screening are described by the provider. This form is submitted to the Division or its designee with the request for prior authorization for nursing 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.

403.403: Home Health Services

The Division pays for the following home health services for eligible MassHealth members:

(A) nursing;

(B) home health aide;

(C) personal-care worker for complex-care members; and

(D) physical, occupational, and speech and language therapy.

403.404: Eligible Members

(A) (1) MassHealth Members. The Division covers home health services only when provided to eligible MassHealth members, subject to the restrictions and limitations described in the Division's regulations. The Division's regulations at 130 CMR 450.105 specifically state, for each MassHealth coverage type, which services are covered and which members are eligible to receive those services.
(2) 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.

(B) For information on verifying member eligibility and coverage type, see 130 CMR 450.107.

403.405: Provider Eligibility: In State

A Massachusetts home health agency is eligible to participate in MassHealth only if the Department of Public Health has certified that the home health agency is qualified to participate as such in the Medicare program. The Division will not reimburse a home health agency for services provided before the home health agency signs a MassHealth provider agreement and obtains a MassHealth provider number.

403.406: Provider Eligibility: Out of State

A home health agency located outside of Massachusetts must be certified as a home health agency by the Medicare-certifying agency in its state. The Division will not reimburse a home health agency for services provided before the home health agency signs a MassHealth provider agreement and obtains a MassHealth provider number.

(130 CMR 403.407 and 403.408 Reserved)

403.409: Services Furnished Under Contract

(A) Introduction. A home health agency may furnish home health services directly or through contractual arrangements made by the agency. Whether the services are furnished 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 furnish services through contracts in the following situations:

(1) when an agency or organization, in order to be approved to participate in MassHealth, makes arrangements with another agency or organization to provide the nursing or other therapeutic services that it does not provide directly; and

(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 (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;

(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 patient'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 reimbursements by the home health agency for the specific services to be provided by the contracting organization; and

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

403.410: Home Health Conditions of Coverage

(A) Member Must Be Under the Care of a Physician. The Division pays for home health services only if a physician certifies the medical necessity for such services and establishes an individual plan of care in accordance with 130 CMR 403.419. A member may receive home health services only if he or she is under the care of a physician. (A podiatrist or a dentist may be considered a physician for the purposes of meeting this requirement.) This physician may be the member's private physician or a physician on the staff of the home health agency.

(B) Services Must Be Provided at Place of Residence.

(1) Home health services are reimbursable by MassHealth only when the following conditions apply:

(a) a physician certifies that, in general, the member is confined to his or her place of residence; and

(b) the services are furnished in the member's place of residence, except as provided in 130 CMR 403.410(B)(4) and (5).

(2) In accordance with 42 CFR 440.70(c), the member's place of residence for home health services does not include a hospital, nursing facility, intermediate care facility for the mentally retarded, or any other institutional facility providing medical, nursing, rehabilitative, or related care. The member's place of residence is where the member is physically located, and may include, without limitation, a homeless shelter, a school, or other temporary residence or community setting outside the home during those hours when the member's normal life activities take the member outside the home.

(3) A member is considered confined to his or her place of residence when:

(a) an illness or injury restricts his or her ability to leave the home except with the aid of supportive devices, such as crutches, canes, wheelchairs, and walkers, the use of special transitional equipment, or the assistance of another person; or

(b) leaving the home is medically contraindicated (for example, a member with an acute illness).

(4) A member does not need to be confined to his or her place of residence to receive coverage for home health agency services if at least one of the following conditions is met:

(a) there has been a formal complaint of child or elder abuse, or child or elder neglect, or the physician orders home health services in cases of potential abuse or neglect;

(b) the agency has documented that alternative placement to meet the member's needs is more costly (for example, long-term care or chronic disease and rehabilitation hospital care), and that the home health services are the least-costly form of comparable care available in the community; or

(c) the services are provided by a home health agency at a MassHealth-approved program other than those listed in 130 CMR 403.410(B)(3).

(5) Subject to prior authorization, the Division, in its discretion, may pay for services provided to homeless members outside of the member's place of residence when no other home health services are being provided.

(C) Medical Necessity Requirement. In accordance with 130 CMR 450.204, the Division pays for only those home health services that are medically necessary. Home health services are not to be used for homemaker, respite, or chore services.

(D) Members for Whom Services Are Approved. The Division 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 approved by the Division or its designee.

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

(F) Least Costly Form of Care. The Division 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.

(G) Maintained Safely in the Community. The member's physician and home health agency must determine that the member can be maintained safely in the community.

(H) Prior Authorization. Certain home health services require prior authorization. See 130 CMR 403.413 for requirements.

(I) Maximum Nursing Hours.

(1) A member may be eligible for up to a maximum of 112 hours of nursing services per calendar week if he or she meets the criteria for nursing services as stated in 130 CMR 403.420.

(2) Members may be eligible on a short-term basis, not to exceed three months, for nursing services over the maximum amount if such additional services are determined to be medically necessary by the Division or its designee, and at least one of the following criteria is met:

(a) the member's physician has submitted a determination in writing that the death of the member will likely occur within three months and a request has been made that the member be permitted to die at home;

(b) the member has repeated, acute exacerbations of, or develops acute complications in addition to, a chronic medical condition that would result in an acute hospitalization;

(c) the member has been discharged following a lengthy acute hospitalization and may be clinically unstable in the community. Before providing such services, the home health agency must telephone the Division or its designee with information about the need for such additional services on a weekly basis; or

(d) the member meets the clinical criteria for nursing services and the primary caregiver is temporarily unavailable because he or she:

(i) has an acute illness or has been hospitalized;

(ii) has abandoned the member or has died within the past 30 days;

(iii) has a high-risk pregnancy that requires significant restrictions; or

(iv) has given birth within the four weeks prior to a request for additional services.

(J) Multiple-Patient Care.

(1) The Division pays for one nurse to provide nursing services simultaneously to more than one, but not more than three, members if:

(a) the members have been determined by the Division or its designee to meet the criteria listed at 130 CMR 403.420;

(b) the members receives services in the same physical location and during the same time period;

(c) the home health agency has determined that it is safe and appropriate for one nurse to provide nursing services to the members simultaneously; and

(d) the home health agency has received a separate prior-authorization approval for each member as described in 130 CMR 403.413.

(2) Services provided pursuant to 130 CMR 403.410(J)(1) must be billed by using the multiple-patient service code that reflects the number of members receiving the services.

403.411: Members Aged 60 and Over

Elder Affairs (EA) or its designee is responsible for performing utilization review of covered home health services provided to members aged 60 and over who are not enrolled in a MassHealth-contracted managed care organization (MCO) or who do not have MassHealth CommonHealth coverage. Utilization review may include, without limitation, screening, case management, and intake.

(A) Screening. EA or its designee performs an initial screening and periodic rescreening of the appropriateness and medical necessity of home health services. The initial screening must be completed prior to the provision of home health services. Refer to 130 CMR 403.410(C) and 130 CMR 450.204 for a definition of medical necessity. The Division pays for home health services only if the member meets the criteria described in 130 CMR 403.420, 130 CMR 403.421, or 130 CMR 403.423.

(B) Case Management Activities. EA or its designee performs limited case-management activities to develop, authorize, coordinate, and monitor medically necessary community-based services that may include home health care. A purpose of case management is to ensure that the Division pays for home health services only if they are medically necessary in accordance with 130 CMR 403.410(C), and to ensure that individuals aged 60 and over are provided with a total service package that meets their individual needs. EA reviews the member's total community-based service package to ensure that:

(1) home health services are the most clinically appropriate and least-costly plan of care; and

(2) the services are no more costly than medically comparable care in an appropriate institutional setting.

(C) Conditions of Coverage. The Division pays for home health services if they are included in the service package developed pursuant to 130 CMR 403.000 et seq. Screening and case management are ongoing processes. The member may be reassessed periodically.

403.412: Complex-Care Members

For complex-care members, as defined in 130 CMR 403.402, the Division or its designee provides case management that includes service coordination with home health agencies as appropriate. The purpose of case management is to ensure that complex-care members are provided with a coordinated CLTC service package that meets such members' individual needs and to ensure that the Division pays for home health and other CLTC services only if they are medically necessary in accordance with 130 CMR 403.410(B).

(A) DMA – Case Management Activities.

(1) Enrollment. The Division or its designee automatically enrolls members, under the age of 22, who require a nurse encounter of more than two continuous hours of nursing, assigns each member a case manager, and informs the member of the name, telephone number, and role of the assigned case manager.

(2) Comprehensive Needs Assessment. The case manager may perform 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 and to complete a comprehensive needs assessment. The comprehensive needs assessment identifies, but may not be limited to identifying:

(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 Plan. The case manager:

(a) develops a service plan, in consultation with the member, the member's physician, the primary caregiver and, where appropriate, the home health agency that:

(i) lists those MassHealth-covered services to be authorized by the case manager;

(ii) describes the scope and duration of each service;

(iii) lists service arrangements approved by the member or the member's primary caregiver; and

(iv) informs the member of his or her right to a hearing, as described in 130 CMR 403.414.

(b) provides to the member copies of the service plan, one copy of which the member or the member's primary caregiver must sign and return to the case 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 plan that is applicable to the home health agency.

(4) Service Authorizations. The case manager authorizes those CLTC services in the service plan, including home health, that require prior authorization (PA) and that are medically necessary, as provided in 130 CMR 403.413, and coordinates all home health services and any subsequent changes with the home health agency.

(5) Discharge Planning. The case manager may participate in member hospital discharge planning meetings as necessary to ensure that CLTC services 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 case manager works collaboratively with any other identified case managers assigned to the member.

(7) Case Manager Follow-up and Reassessment. The case manager provides ongoing case 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 plan 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 physician's plan of care for each complex-care member as described in 130 CMR 403.419, in consultation with the case manager, the member, and/or the primary caregiver 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 the Division's or its designee's case manager concerning the status of the member's home health needs.

403.413: Prior-Authorization Requirements

(A) General Terms.

(1) Prior authorization must be obtained from the Division as a prerequisite to payment for certain home health services. The Division bases its decision on the criteria set forth in 130 CMR 403.420(B). Prior authorization must be obtained from the Division before services are provided to the member. Without such prior authorization, these services will not be reimbursed by the Division.

(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 for each service that are reimbursable 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) Prior authorization for home health services may be approved for more than one home health provider and/or independent nurse, provided that:

(a) each provider is authorized only for a specified portion of the member's total hours; and

(b) the sum total of the hours approved over the duration of the approved period do not exceed what the Division or its designee has determined to be medically necessary for the member.

(5) The home health agency must complete the Request and Justification form for all non-complex-care members who require more than two continuous hours of nursing. The Request and Justification form must be signed and dated by the member's physician and submitted to the Division or its designee for review.

(6) The home health agency may initiate the prior-authorization process by telephone or by submitting a completed prior-authorization request form to the Division or its designee. The home health agency must submit all prior-authorization requests in accordance with the Division's billing instructions.

(7) If home health services in excess of the authorized weekly amount are necessary, the home health agency must contact the Division or its designee by telephone to request additional hours. The verbal request for additional hours must be followed up in writing within two calendar weeks of the verbal request.
(8) If there are unused hours of nursing services in a calendar week, they may be used at any time during the current authorization period.

(B) MassHealth Basic Members Not Enrolled in a Managed Care Organization.
(1) The home health agency must obtain from the Division or its designee, as a prerequisite to payment, prior authorization for all nursing care for MassHealth Basic members who are not enrolled in a managed care organization (MCO). See 130 CMR 403.420(C) for service limitations of nursing care provided to MassHealth Basic members.
(2) The home health agency must submit to the Division or its designee written physician's orders that identify the member's admitting diagnosis, frequency, and duration of nursing need, 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 Division or its designee by telephone to request an adjustment to the prior authorization. Any verbal request for changes in service authorization must be followed up in writing to the Division or its designee within two weeks of the date of the verbal request.

(C) Complex-Care Members.
(1) The home health agency must obtain from the Division or its designee, as a prerequisite for payment, prior authorization for all home health services defined in 130 CMR 403.403 provided to complex-care members.
(2) The home health agency must refer potential complex-care members to the Division or its designee for a comprehensive needs assessment.
(3) If authorized services need to be adjusted because the complex-care member's medical needs have changed, the home health agency must contact the Division or its designee by telephone to request an adjustment to the prior authorization.
(4) Any verbal request for changes in service authorization must be followed up in writing to the Division or its designee within two weeks of the date of the verbal request.

(D) MCO Members. For those members who are enrolled in one of the Division's managed care organizations (MCOs), the home health agency must follow the authorization procedures of the MCO where applicable for home health services. For those MCO members whose nursing service needs are more than two hours in duration and which are not covered by the MCO, the home health agency must comply with 130 CMR 403.000.

(E) Screening. The home health agency must perform a screening of any member aged 22 and older who requires more than two continuous hours of nursing services and refer members under the age of 22 to the Division or its designee for case management.

403.414: Notice of Approval or Denial of Prior Authorization

(A) Notice of Approval. For all approved prior-authorization requests for home health services, the Division or its designee sends written notice to the member and the home health agency regarding 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 Division or its designee notifies both the member and the home health agency of the denial or modification, reason, right to appeal, and appeal procedure.

(2) A member may request a fair hearing from the Division if the Division 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 the notice of denial or modification. The Division's Board of Hearings conducts the hearing in accordance with 130 CMR 610.000.

(130 CMR 403.415 through 403.418 Reserved)

403.419: Physician Plan-of-Care Requirements

All home health services must be furnished 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. The physician must recertify and sign the plan of care every 60 days.

(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 physician's plan of care, or be prepared separately, but do not substitute for the physician's plan of care.

(B) Content of the Plan of Care. The orders on the plan of care must specify the nature and frequency of the services to be provided to the member, and the type of professional who must provide them. The physician must sign the plan of care before the home health agency submits its claim for those services to the Division for payment, or must comply with the verbal-order provisions at 130 CMR 403.419(D). Any increase in the frequency of services or any addition of new services during a certification period must be authorized in advance by a physician with verbal or written orders and authorized by the Division or its designee as appropriate. The plan of care must contain:

(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) the discharge plans; and
(7) any additional items the home health agency or physician chooses to include.

(C) Certification Period. Both the plan of care, required under 130 CMR 403.419(A)(1), and the discipline-oriented plan of care, as provided under 130 CMR 403.419(A)(2), must be reviewed and signed 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 403.419(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 furnished; 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 MassHealth.

(3) The home health agency must obtain prior authorization for verbal orders where required.

403.420: Nursing Services

(A) Conditions of Payment. Nursing services are reimbursable 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 physician's plan of care;

(3) the services require the skills of a registered nurse, or of a licensed practical nurse or licensed vocational nurse under the supervision of a registered nurse, in accordance with 130 CMR 403.420(B);

(4) the services are medically necessary to treat an illness or injury in accordance with 130 CMR 403.410(C); and

(5) prior authorization is obtained where required in compliance with 130 CMR 403.413.

(B) Clinical Criteria.

(1) A nursing service is a service that must be provided by a registered nurse, or by a licensed practical nurse or licensed vocational nurse under the supervision of a registered nurse, to be safe and effective, considering the inherent complexity of the service, the condition of the patient, 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 or licensed nurse can safely and effectively provide the service.

(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 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 or licensed 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 patient at the time the services were ordered and what was, at that time, expected to be appropriate treatment throughout the certification period.
(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.

(C) Service Limitations for MassHealth Basic Members. Nursing care provided by a home health agency is covered for a MassHealth Basic member only when the following conditions and all other requirements of 130 CMR 403.000 et seq. are met:
(1) such care is provided following an acute inpatient hospitalization;
(2) such care is intended to help resolve an identified short-term (for example, 14 days) skilled-nursing need directly related to the member's acute hospitalization; and
(3) for members other than those enrolled in an MCO, the home health agency obtains prior authorization as a prerequisite to payment for such care following a referral from the hospital directing the member's discharge.

403.421: Home Health Aide Services

(A) Conditions of Payment. Home health aide services are reimbursable only if all of the following conditions are met:
(1) the member does not have MassHealth Basic coverage;
(2) the member has a medically predictable recurring need for nursing services or therapy services;
(3) the frequency and duration of the home health aide services must be ordered by the physician and must be included in the physician's plan of care for the member;
(4) 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; and
(5) prior authorization, where applicable, has been obtained where required in compliance with 130 CMR 403.413.

(B) Reimbursable Home Health Aide Services. Reimbursable home health aide services include, but are not limited to:
(1) personal-care services;
(2) simple dressing changes that do not require the skills of a registered or licensed nurse;
(3) assistance with 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) Nonreimbursable Home Health Aide Services. The Division does not pay for:
(1) home health aide services provided to MassHealth Basic members; or
(2) homemaker, respite, and 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, or shopping). However, the purpose of a home health aide visit must not be to provide these incidental services, since they are not health-related services.

403.422: Intermittent or Part-Time Requirement

The Division pays for nursing and home health aide services only on an intermittent or part-time basis, and only as defined in 130 CMR 403.422(A), except as provided in 130 CMR 403.422(B). The time limits are maximum thresholds.

(A) Intermittent and Part-Time Services.

(1) Services are intermittent if up to eight hours per day of medically-necessary nursing and home health aide services, combined, are provided seven days per calendar week for temporary periods of up to 21 days.

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

(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 403.422(A)(4).

(4) In certain circumstances, the member needs infrequent, yet intermittent, nursing services. The following are nonexclusive examples of such services, which are reimbursable.

(a) The member has an indwelling silicone catheter and generally needs a catheter change only at 90-day intervals.

(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 encounter at least every 90 days. These nursing encounters, 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 encounter that makes additional encounters 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 encounter is reimbursable.

(B) Exceptions. Home health aide and nursing services in excess of the intermittent or part-time limit, as defined in 130 CMR 403.422(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 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 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 21 days or in excess of 35 hours per calendar week is medically necessary in accordance with 130 CMR 403.410(C); or
(5) the member qualifies as a complex-care member, or the member is over the age of 22 and requires a nursing encounter of more than 2 hours in duration.

403.423: Personal-Care Worker Services

(A) Conditions of Payment. Personal-care worker services are reimbursable only if all of the following conditions are met:
(1) the member is a complex-care member, as defined in 130 CMR 403.402;
(2) the case manager has included personal-care worker services in the member's service plan;
(3) personal-care worker services are ordered by the physician and included in the physician's plan of care for the member;
(4) the services to be provided are necessary to assist the member to remain safely in the community; and
(5) prior authorization has been obtained in compliance with 130 CMR 403.413.

(B) Reimbursable Personal-Care Worker Services. Only personal-care worker services determined to be medically necessary by the Division or its designee for the complex-care member are reimbursable by MassHealth. Reimbursable personal-care worker services include, but are not limited to:
(1) Activities of Daily Living (ADLs). Activities of daily living may include the following:
(a) physically assisting a member who has a mobility impairment that prevents unassisted transferring, walking, or use of prescribed durable medical equipment;
(b) physically assisting a member with basic care such as bathing, personal hygiene, and grooming skills;
(c) physically assisting a member to dress or undress;
(d) physically assisting a member to perform range-of-motion exercises;
(e) physically assisting a member with nutritional and dietary needs; and
(f) physically assisting a member with bowel and bladder needs.
(2) Instrumental Activities of Daily Living (IADLs). Instrumental activities of daily living which are intended to support the provision of the ADLs, may include the following:
(a) assisting with household tasks that are incidental to the care of the member, including laundry, shopping, and housekeeping specific to that member;
(b) meal preparation and clean-up for the member;
(c) accompanying the member to medical providers; and
(d) assisting with the care and maintenance of wheelchairs and other medical equipment and devices.

403.424: Physical, Occupational, and Speech and Language Therapy

(A) Physical Therapy. The Division pays for physical therapy services 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) provided based on the physician's assessment that the member will improve significantly in a predictable period, or are a necessary component of a safe and effective maintenance program required for treatment of a specific disease or injury;
(6) considered under accepted standards of medical practice to be a specific and effective treatment for the member's condition;
(7) medically necessary for treatment of the member's condition. Services related to activities for the general good and welfare of patients (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 reimbursement; and
(8) certified by the physician every 60 days.

(B) Occupational Therapy. The Division pays for occupational therapy services 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) medically necessary for treatment of the member's illness or injury; and
(4) certified by the physician every 60 days.

(C) Speech and Language Therapy. The Division pays for speech and language therapy services visits 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.

403.425: Visits

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

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

(C) Supervisory Visits. The Division does not pay for a supervisory visit made by a nurse or physical, occupational, or speech and language 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 or personal-care worker. These visits are administrative and are, therefore, not reimbursable.

403.426: 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 furnished and claimed directly by appropriate vendors in accordance with the Division's regulations governing drugs, restorative therapy services, rehabilitative services, and durable medical equipment.

403.427: Recordkeeping Requirement and Utilization Review

The record maintained by a home health agency for each member must conform to the Division's administrative and billing regulations at 130 CMR 450.000. The home health agency must submit requested documentation to the Division or its designee for purposes of utilization review and provider review and audit, within the Division's or its designee's time specifications. The Division or its designee may periodically review a member's plan of care and other records to determine if skilled nursing services are medically necessary in accordance with 130 CMR 403.410(C). The home health agency must provide the Division or its designee with any supporting documentation the Division or its designee requests within 10 business days of that request. If the Division or its designee determines that the skilled nursing services are no longer medically necessary, the Division will not pay the home health agency for continuing services.

403.428: Administrative Requirement

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 clinical record for the member that includes diagnosis, medical history, physician's orders, and progress notes relating to all services furnished;

(C) obtain from the physician the required certifications and recertifications of the plan of care as set forth in 130 CMR 403.419(C); and

(D) ensure that the home health agency's staff or designated review group review the medical necessity of services on a sample basis.

403.429: Maximum Allowable Fees

The Division of Health Care Finance and Policy (DHCFP) determines the maximum allowable fees for home health agency services. The maximum allowable payment for a service shall be the lower of the following:

(A) the home health agency's usual and customary fee; or

(B) the rate that the DHCFP has established for that service.

403.430: Denial of Services and Administrative Review

(A) A failure or refusal by a home health agency to furnish services that have been ordered by the member's attending physician and that are within the range of reimbursable services is not an action by the Division or its designee that a member may appeal; but such failure or refusal constitutes a violation of these regulations for which administrative sanctions may be imposed. The Division 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 Division or its designee that a member may appeal.

(B) When a home health agency believes that services ordered by the attending physician are not reimbursable under these regulations, the agency must refer the matter to the Division for a payment decision. If and to the extent the Division determines that the ordered services are reimbursable, the agency must provide those services.

REGULATORY AUTHORITY

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

This page is reserved.

601 Explanation of Abbreviation

The abbreviation "P.A." indicates that Division authorization is required (see the program regulations in Subchapter 4 of the *Home Health Agency Manual*).

602 Definitions

With nursing service codes T1002 and T1003, the nursing services provided on a "weekend" or "holiday" will be automatically reimbursed in accordance with the applicable fee schedule of the Division of Health Care Finance and Policy (DHCFP). Providers must use a service code that accurately reflects the nursing service provided.

(A) Day – the hours from 7:00 A.M. to 3:00 P.M., Sunday through Saturday.

(B) Night – the hours from 3:00 P.M. to 7:00 A.M., Sunday through Saturday.

(C) Nursing modifiers:
- (1) UJ-night
- (2) TT-one nurse to two patients (day)
- (3) U1-one nurse to two patients (night)
- (4) U2-one nurse to three patients (day)
- (5) U3-one nurse to three patients (night)

603 Service Codes and Descriptions: Home Health Aide, Personal Care Worker, Therapy, and Nursing Services

Service Code	Service Description
	Nursing (for a Visit of Two Hour or Less), Home Health, and Personal Care
X0031	Nursing care visit
X0032	Nursing visit, office
X0037	Home health aide services (per six-minute unit)
T1019	Personal care services, per 15 minutes
	Therapy
X0038	Physical therapy visit
X0039	Speech/language therapy visit
X0040	Occupational therapy visit

603 Service Codes and Descriptions: Home Health Aide, Personal Care Worker, Therapy, and Nursing Services (cont.)

Service Code-Modifier	Service Description
	Nursing Services (More Than a Two-Hour Visit)
	Individual Patient Nursing
	The following service codes must be used for nursing care provided by one nurse to one member.
T1002	RN services, up to 15 minutes (day) (P.A.)
T1003	LPN/LVN services, up to 15 minutes (day) (P.A.)
T1002-UJ	RN services, up to 15 minutes (night) (P.A.)
T1003-UJ	LPN/LVN services, up to 15 minutes (night) (P.A.)
	Multiple-Patient Nursing
	The following service codes are to be used for nursing care provided by one nurse simultaneously to two members.
T1002-TT	RN services, up to 15 minutes (day) (each member) (P.A.)
T1003-TT	LPN/LVN services, up to 15 minutes (day) (each member) (P.A.)
T1002-U1	RN services, up to 15 minutes (night) (each member) (P.A.)
T1003-U1	LPN/LVN services, up to 15 minutes (night) (each member) (P.A.)
	The following service codes are to be used for nursing care provided by one nurse simultaneously to three members.
T1002-U2	RN services, up to 15 minutes (day) (each member) (P.A.)
T1003-U2	LPN/LVN services, up to 15 minutes (day) (each member) (P.A.)
T1002-U3	RN services, up to 15 minutes (night) (each member) (P.A.)
T1003-U3	LPN/LVN services, up to 15 minutes (night) (each member) (P.A.)