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-36
January 2004

TO: Home Health Agencies Participating in MassHealth

FROM: Beth Waldman, Acting Commissioner Beth Waldman

RE: *Home Health Agency Manual* (Prior Authorization for Certain Therapy Visits)

This letter transmits revisions to the home health agency regulations about therapy services. Effective February 1, 2004, a provider must obtain prior authorization from MassHealth before providing more than **eight** physical-therapy visits, **eight** occupational-therapy visits, and **15** speech/language therapy visits (including group therapy and evaluation) to a member within a 12-month period.

The 12-month period for the initial eight or 15 visits begins on the date of the first therapy visit on or after February 1, 2004. For example, if a member's first therapy visit is February 20, 2004, the 12-month period is February 20, 2004, through February 19, 2005. To simplify accounting of therapy visits, and to allow time for providers to request prior authorization without interrupting an established regimen of therapy to members currently receiving therapy services, MassHealth will begin counting therapy visits for dates of service on or after February 1, 2004. Regardless of the number of therapy visits a member has had before February 1, MassHealth will count the first visit occurring on or after February 1, 2004, as the first visit toward the eight or 15 visits that are allowed without prior authorization. No payment is made for services in excess of eight physical therapy, eight occupational therapy, and 15 speech/language therapy visits to a provider in a 12-month period, unless prior authorization has been obtained from MassHealth.

Examples:

1. If a member's first physical-therapy visit after February 1, 2004, is March 22, 2004, then the 12-month period for physical therapy is March 22, 2004, through March 21, 2005. MassHealth will pay the provider for seven additional physical-therapy visits before March 22, 2005, without prior authorization. To avoid disruption in treatment, providers are encouraged to request prior authorization as soon as they believe that medically necessary therapy will exceed the number of visits allowed without prior authorization.

2. If the same member receives occupational therapy in addition to physical therapy, and the first occupational-therapy visit is April 29, 2004, then the 12-month period for occupational therapy is April 29, 2004, through April 28, 2005. MassHealth will pay the provider for seven additional occupational-therapy visits before April 29, 2005, without prior authorization.

Requesting Prior Authorization

To request prior authorization, the provider must complete the Request for Prior Authorization form as instructed in MassHealth's billing instructions, or use the Web-based Automated Prior Authorization System (APAS), which is available at www.masshealth-apas.com.

In addition, the provider must complete a Request and Justification for Therapy Services form and attach it to the prior-authorization request, whether the request is submitted on paper or using APAS. If you are using APAS, you can either download this MassHealth form from APAS, or complete it on line and submit it electronically as part of the request.

You can also download the Request and Justification form from the MassHealth Provider Services Web site at www.mahealthweb.com. Click on Publications and Forms. If you prefer, you can also request supplies of this form from this Web site or by submitting a written request to the following address or fax number.

MassHealth
Attn: Forms Distribution
P.O. Box 9101
Somerville, MA 02145
Fax: 703-917-4937

When requesting forms, include the name and quantity of the form, your MassHealth provider number, street address (no post office boxes), and contact name and telephone number.

Billing for Services with Prior Authorization

MassHealth will notify the provider and member in writing of its decision on the request for prior authorization. When billing for services, you must enter the prior-authorization number on the claim as indicated below. This prior-authorization number is printed on the approval letter, and if you used APAS to request prior authorization, it is also listed on APAS. When billing for authorized services:

- Enter the six-character prior-authorization number in Item 4 of claim form no. 9 or its electronic equivalent. If you are billing in the 837I format, refer to the Detail Data section of the *MassHealth 837I Companion Guide* for correct placement of this number on the claim.

- Do not include on the same claim form (or electronic equivalent) any therapy services that are part of the original eight or 15 that do not require prior authorization.

- Submit a separate claim form (or its electronic equivalent) for each type of therapy (physical, occupational, or speech/language) for members who have received authorization for more than one type. (**Note:** Each type of therapy will have a separate prior-authorization number.)

Maintenance Program

The attached revisions to the home health agency regulations also clarify that MassHealth does not pay for performance of a maintenance program. A maintenance program is defined as repetitive activities intended to maintain function that can be performed safely and effectively without the skilled assistance of a qualified therapist. MassHealth pays for designing a maintenance program and instructing the member, member's family, or other persons in its use as part of a regular treatment visit, not as a separate service.

Effective Date

These regulations are effective February 1, 2004.

Questions

If you have any questions about the information in this letter, please call MassHealth Provider Services at 617-628-4141 or 1-800-325-5231.

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

Home Health Agency Manual

Pages iv and 4-1 through 4-20

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

Home Health Agency Manual

Pages iv and 4-1 through 4-18 — transmitted by Transmittal Letter HHA-34

4. PROGRAM REGULATIONS

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 130 CMR 450.000.

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 in 130 CMR 450.000.

Calendar Week — seven consecutive days.

Case Management — a function performed by MassHealth 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 MassHealth 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 MassHealth or its designee.

Complex-Care Member — a MassHealth member, under the age of 22 at enrollment, whose medical needs, as determined by MassHealth 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.

Maintenance Program — repetitive activities intended to maintain function that can be performed safely and effectively without the skilled assistance of a qualified therapist.

Member — an individual determined by MassHealth 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 MassHealth, 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 MassHealth 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 MassHealth 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.

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

403.403: Home Health Services

MassHealth 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:

(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. MassHealth covers home health services only when provided to eligible MassHealth members, subject to the restrictions and limitations described in 130 CMR 403.000 and 450.000. 130 CMR 450.105 specifically states, 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. MassHealth does not pay a home health agency for services provided before the home health agency 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. MassHealth does not pay a home health agency for services provided before the home health agency obtains a MassHealth provider number.

(130 CMR 403.407 and 403.408 Reserved)

403.409: Services Provided Under Contract

(A) Introduction. A home health agency may provide home health services directly or through contractual arrangements made by the 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 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 payments 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. MassHealth 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 payable 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 provided 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, MassHealth, 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, MassHealth 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. MassHealth 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 MassHealth 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 provide such services.

(F) Least Costly Form of Care. MassHealth 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) 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.

(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 MassHealth 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 MassHealth 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) MassHealth 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 MassHealth or its designee to meet the criteria listed at 130 CMR 403.420;

(b) the members receive 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

The Executive Office of Elder Affairs (EOEA) 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. EOEA 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. MassHealth pays for home health services only if the member meets the criteria described in 130 CMR 403.420, 403.421, or 403.423.

(B) Case Management Activities. EOEA 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 MassHealth 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. EOEA 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. MassHealth 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, MassHealth 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 MassHealth 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. MassHealth 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 MassHealth's or its designee's case manager about the status of the member's home health needs.

403.413: Prior-Authorization Requirements

(A) General Terms.
(1) Prior authorization must be obtained from MassHealth as a prerequisite to payment for certain home health services. MassHealth bases its decision on the criteria set forth in 130 CMR 403.420(B). Prior authorization must be obtained from MassHealth before services are provided to the member. Without such prior authorization, these services will not be paid by MassHealth.
(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 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) 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 does not exceed what MassHealth 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 MassHealth 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 MassHealth or its designee. The home health agency must submit all prior-authorization requests in accordance with MassHealth's billing instructions.

(7) If home health services in excess of the authorized weekly amount are necessary, the home health agency must contact MassHealth 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 MassHealth 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 MassHealth 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 MassHealth 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 MassHealth 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 MassHealth 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 MassHealth 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 MassHealth 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 MassHealth or its designee within two weeks of the date of the verbal request.

(D) Therapy Services for All Members for Whom Therapies Are a Covered Service. The home health agency must obtain prior authorization for the following services to eligible MassHealth members:
(1) more than eight occupational-therapy or eight physical-therapy visits, including any initial patient assessment or observation and evaluation or reevaluation visits, for a member within a 12-month period; and
(2) more than 15 speech/language therapy visits, including any initial patient assessment or observation and evaluation or reevaluation visits, for a member within a 12-month period.

(E) MCO Members. For those members who are enrolled in one of MassHealth'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.

(F) 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 MassHealth 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, MassHealth 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, MassHealth 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.

(2) A member may request a fair hearing from MassHealth if MassHealth 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. MassHealth'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 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. 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 MassHealth 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 MassHealth 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 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 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 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 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 payable 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) Payable Home Health Aide Services. Payable 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) Nonpayable Home Health Aide Services. MassHealth 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

MassHealth 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 those services 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 payable.

(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 payable.

(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 two hours in duration.

403.423: Personal-Care Worker Services

(A) Conditions of Payment. Personal-care worker services are payable 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) Payable Personal-Care Worker Services. Only personal-care worker services determined to be medically necessary by MassHealth or its designee for the complex-care member are payable under MassHealth. Payable 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 that 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. MassHealth pays for up to eight visits within a 12-month period 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) provided based on the physician's assessment that the member will improve significantly in a predictable period;
(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 payment; and
(8) certified by the physician every 60 days.

(B) Occupational Therapy. MassHealth pays for up to eight visits within a 12-month period 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) 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. MassHealth pays for up to 15 visits within a 12-month period 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.

(D) Maintenance Program. MassHealth does not pay for performance of a maintenance program. MassHealth pays for designing a maintenance program and instructing the member, member’s family, or other persons in its use as part of a regular treatment visit, not as a separate service.

403.425: Payment Rules for Initial Patient Assessments, Observation and Evaluation Visits, and Supervisory Visits

(A) Initial Patient Assessments. MassHealth pays for an initial patient assessment visit by a home health agency with or without a physician's order. MassHealth 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. MassHealth 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. MassHealth 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 payable.

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 provided and claimed directly by appropriate vendors in accordance with MassHealth'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 MassHealth's administrative and billing regulations at 130 CMR 450.000. The home health agency must submit requested documentation to MassHealth or its designee for purposes of utilization review and provider review and audit, within MassHealth's or its designee's time specifications. MassHealth 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 MassHealth or its designee with any supporting documentation MassHealth or its designee requests within 10 business days of that request. If MassHealth or its designee determines that the skilled nursing services are no longer medically necessary, MassHealth will not pay the home health agency for continuing services.

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

(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 is 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 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 MassHealth 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. MassHealth 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 MassHealth or its designee that a member may appeal.

(B) When a home health agency believes that services ordered by the attending physician are not payable under 130 CMR 403.000, the agency must refer the matter to MassHealth for a payment decision. If and to the extent MassHealth 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.

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