Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
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MassHealth
Transmittal Letter HHA-40
October 2007

TO: Home Health Agencies Participating in MassHealth

FROM: Tom Dehner, Medicaid Director TD

RE: *Home Health Agency Manual* (Revised Program Regulations)

This letter transmits revisions to the MassHealth home health agency program regulations. A summary of the revisions, which are effective November 1, 2007, is provided below.

Changes in Screening Procedures for Members Aged 60 or Older

Previously, MassHealth had required home health agencies to obtain screening and approval from Aging Services Access Points (ASAPs) and the Executive Office of Elder Affairs (EOEA) designee before providing part-time or intermittent skilled nursing and home-health-aide services to members aged 60 or older. This requirement was suspended by MassHealth in December 2006, as announced in Home Health Agency Bulletin 45 (November 2006).

Home health agencies are no longer required to complete a MassHealth Screening Request form and obtain approval from an ASAP before providing services. However, effective December 1, 2006, home health agencies must complete an ASAP Referral form for those MassHealth members aged 60 or older. See 130 CMR 403.411.

Revisions to the Place of Residence

MassHealth has deleted language from its regulations requiring the physician to certify that the member is confined to his or her place of residence. Although that language was used as a proxy to both establish that a member was in the community, and to determine the extent of the member's independent mobility, it resulted in some confusion. The deletion clarifies MassHealth's intent. See 130 CMR 403.410(B)

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

MassHealth added a new payment rule for skilled nursing visits provided to two or more members living in the same household and receiving skilled nursing visits during the same time period. When two or more members in the same household are receiving skilled nursing visits the home health agency must provide services to those members during a single visit. Under such circumstances, MassHealth pays the full skilled nursing visit rate for one member and a reduced rate for each additional member in the household. See 130 CMR 403.424(D) and 403.402 (new definition of household). New payment rates have been adopted by the Division of Health Care Finance and Policy.

Provider Eligibility

MassHealth will require all home health agency branches and/or subunit offices to be certified by Medicare. An additional requirement was added for out-of-state providers. See 130 CMR 403.405, 403.406, 403.407, and 403.402 (new definitions of branch office and subunit office)

New Requirements for Those Members Enrolled in the Primary Care Clinician (PCC) Plan

MassHealth added language to the plan of care section for those members enrolled in the PCC Plan. Home health agencies are now required to communicate to the member's PCC when the goals of the plan of care are achieved, and/or when there is a significant change in the member's health status. See 130 CMR 403.419(B)

Personal Care Worker

MassHealth has deleted the reference to personal care worker (PCW) services because the position of a PCW had not been developed or used by home health agencies. See 130 CMR 403.403.

If you have any questions about the information in this transmittal letter please contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.

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, 4-1 through 4-4, 4-17, and 4-18 — transmitted by Transmittal Letter HHA-37

Pages 4-5 through 4-16, 4-19, and 4-20 — transmitted by Transmittal Letter HHA-36

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 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 450.000.

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

Calendar Week – seven consecutive days.

Case Management – a function performed by the MassHealth agency 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 MassHealth agency 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.

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

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

Continuous Skilled Nursing Services – a nurse visit of more than two continuous hours of nursing services.

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 described 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.

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

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

Member – an individual determined by the MassHealth agency 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.

Occupational Therapist – a person who is licensed by the Massachusetts Division of Registration in Allied Health Professions and registered by the American Occupational Therapy Association (AOTA) or is a graduate of a program in occupational therapy approved by the Committee on Allied Health Education and Accreditation of the American Medical Association and engaged in the supplemental clinical experience required before registration by AOTA.

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

Physical Therapist – a person licensed by the Massachusetts Division of Registration in Allied Health Professions.

Physical Therapy – therapy services, including diagnostic evaluation and therapeutic intervention, designed to improve, develop, correct, rehabilitate, or prevent the worsening of physical functions that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Physical therapy emphasizes a form of rehabilitation focused on treatment of dysfunctions involving neuromuscular, musculoskeletal, cardiovascular/pulmonary, or integumentary systems through the use of therapeutic interventions to optimize functioning levels.

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

Request and Justification Form – the form (paper, electronic, or other) authorized by the MassHealth agency or its designee, on which the nursing-care or therapy 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 MassHealth agency or its designee with the request for prior authorization for nursing or therapy services.

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

Speech/Language Therapist – a person who is licensed by the Massachusetts Division of Registration in Speech-Language Pathology and Audiology and has either a Certificate of Clinical Competence from the American Speech-Language-Hearing Association (ASHA) or a statement from ASHA of certification equivalency.

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

Subunit Office – a semi-autonomous location or site that serves members in a geographic area different from that of the parent home health agency and that is too far from the parent home health agency to share administration, supervision, and services on a daily basis.

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

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

(A) nursing;

(B) home health aide; and

(C) 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

To participate in MassHealth, a Massachusetts Home Health agency must

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

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

(C) notify the MassHealth agency in writing within 14 days of any change in any of the information submitted in the provider application in accordance with 130 CMR 450.223(B); including, but not limited to, change of ownership, change of address, and additional home health agency branch office or subunit offices.

403.406: Provider Eligibility: Out of State

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

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

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

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

(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 (e.g., hospital, nursing facility, another home health agency, or hospice), a written contract must document the services to be provided and the corresponding financial arrangements.

(2) If the home health agency contracts with a provider that does not participate in MassHealth, the written contract must include

(a) a description of the services to be provided;

(b) the duration of the agreement and how frequently it is to be reviewed;

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

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

(D) Members for Whom Services Are Approved. The MassHealth agency does not pay for nursing services provided to any individual other than the member who is eligible to receive such services and for whom such services have been approved by the MassHealth agency 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. The MassHealth agency pays for home health agency services only when services are no more costly than medically comparable care in an appropriate institution and the least costly form of comparable care available in the community.

(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) Continuous Skilled Nursing Services.

(1) A member may be eligible for up to a maximum of 112 hours of continuous skilled nursing services per calendar week if he or she meets the criteria for nursing services as stated in 130 CMR 403.420 and has obtained prior authorization from the MassHealth agency or its designee.

(2) Members may be eligible on a short-term basis, not to exceed three months, for continuous skilled nursing services over the maximum amount if such additional services are determined to be medically necessary by the MassHealth agency 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 MassHealth agency 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 for Continuous Skilled Nursing Services.

(1) The MassHealth agency 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 MassHealth agency 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

Home health agencies must complete an Aging Service Access Point (ASAP) referral form for those MassHealth members aged 60 and older. See 651 CMR 14.00 for a description and definition of ASAP. Home health agencies must complete this referral form upon assessment or reassessment for home health services or discharge from home health services. Home health agencies should forward the completed referral form to an Executive Office of Elder Affairs (EOEA) designee whenever the agency determines that the MassHealth member could benefit from EOEA's designee's services. Home health agencies must keep a copy of the completed ASAP referral form in the member's record for all MassHealth members aged 60 and older.

403.412: Complex-Care Members

For complex-care members, as defined in 130 CMR 403.402, the MassHealth agency 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 MassHealth agency pays for home health and other CLTC services only if they are medically necessary in accordance with 130 CMR 403.410(C).

(A) MassHealth – Case Management Activities.

(1) Enrollment. The MassHealth agency or its designee automatically enrolls members under the age of 22 who require a nurse visit 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 the primary caregiver, or some combination, that

(a) includes the appropriate assignment of home health services; and

(b) incorporates full consideration of the member's and the caregiver's preferences for service arrangements.

(2) Coordination and Communication. The home health agency closely communicates and coordinates with MassHealth's or its designee's 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 the MassHealth agency as a prerequisite to payment for certain home health services and before services are provided to the member. Without such prior authorization, these services will not be paid by the MassHealth agency.

(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 or visits 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 continuous skilled nursing services may be approved for more than one home health provider or independent nurse, or both, 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 the MassHealth agency 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 MassHealth agency or its designee for review.

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

(7) If continuous skilled nursing services in excess of the authorized weekly amount are necessary, the home health agency must contact the MassHealth agency 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 continuous skilled 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 MassHealth agency or its designee, as a prerequisite to payment, prior authorization for all nursing services 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 MassHealth agency or its designee written physician's orders that identify the member's admitting diagnosis, frequency, and duration of nursing services, and a description of the intended nursing intervention.

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

(C) Complex-Care Members.

(1) The home health agency must obtain from the MassHealth agency 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 MassHealth agency 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 MassHealth agency 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 MassHealth agency 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 20 occupational-therapy or 20 physical-therapy visits, including any initial patient assessment or observation and evaluation or reevaluation visits, for a member within a 12-month period; and

(2) more than 35 speech/language therapy visits, including any initial patient assessment or observation and evaluation or reevaluation visits, for a member within a 12-month period.

(E) MCO Members. For those members who are enrolled in a MassHealth-approved managed care organization (MCO), 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 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 continuous skilled nursing services and refer members under the age of 22 who require continuous skilled nursing services to the MassHealth agency or its designee for case management.

(G) Continuous Skilled Nursing Services. The home health agency must obtain prior authorization for continuous skilled nursing services from the MassHealth agency or its designee, as prerequisite for payment and before continuous skilled nursing services are provided to the member.

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, the MassHealth agency or its designee notifies both the member and the home health agency of the denial or modification, and the reason. In addition, the member will receive information about the member's right to appeal, and appeal procedure.

(2) A member may request a fair hearing if the MassHealth agency or its designee denies or modifies a prior-authorization request. The member must request a fair hearing in writing within 30 days after the date of the notice of denial or modification. The MassHealth agency'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 the MassHealth agency 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 MassHealth agency or its designee as appropriate. If the member is enrolled in the Primary Care Clinician (PCC) Plan, the home health agency must communicate with the member's PCC both when the goals of the care plan are achieved or when there is a significant change in a member's health status. 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 described in 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 the MassHealth agency.

(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 a 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 visits provided by a home health agency are 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 nursing visits 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 has a medically predictable recurring need for nursing services or therapy services;

(2) the frequency and duration of the home health aide services must be ordered by the physician and must be included in the physician's plan of care for the member;

(3) the services are medically necessary to provide personal care to the member, to maintain the member's health, or to facilitate treatment of the member's injury or illness; and

(4) 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. The MassHealth agency 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 MassHealth agency pays for nursing visits and home health aide services only on an intermittent or part-time basis, and only as described 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 visits 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 visits and home health aide services does not exceed 35 hours per calendar week, and those services are provided on a less-than-daily basis.

(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 visit at least every 90 days. These nursing visits, which supplement the physician's contacts with the member, are necessary to observe and determine the need for changes in the level and type of care that have been prescribed.

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

(B) Exceptions. Nursing visits and home health aide services in excess of the intermittent or part-time limit, as described in 130 CMR 403.422(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: Physical, Occupational, and Speech and Language Therapy

(A) Physical Therapy. The MassHealth agency pays for up to 20 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) considered under accepted standards of medical practice to be a specific and effective treatment for the member's condition;
(6) medically necessary for treatment of the member's condition. Services related to activities for the general good and welfare of 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
(7) certified by the physician every 60 days.

(B) Occupational Therapy. The MassHealth agency pays for up to 20 visits within a 12-month period 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. The MassHealth agency pays for up to 35 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.

(1) The MassHealth agency pays for the establishment of a maintenance program and the training of the member, member’s family, or other persons to carry it out, as part of a regular treatment visit, not as a separate service. The MassHealth agency does not pay for performance of a maintenance program, except as provided in 130 CMR 403.424(D)(2).
(2) In certain instances, the specialized knowledge and judgment of a licensed therapist may be required to perform services that are part of a maintenance program, to ensure safety or effectiveness that may otherwise be compromised due to the member’s medical condition. At the time the decision is made that the services must be performed by a licensed therapist, all information that supports the medical necessity for performance of such services by a licensed therapist, rather than a non-therapist, must be documented in the medical record.

403.424: Payment Rules for Assessments and Visits

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

(B) Observation and Evaluation Visits. The MassHealth agency 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 MassHealth agency 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. These visits are administrative and are, therefore, not payable.

(D) Skilled Nursing Visits for Two or More Members Living in the Same Household. When two or more members in the same household are receiving skilled nursing visits, the home health agency must provide services to all members during a single visit. Under such circumstances, the MassHealth agency pays the full skilled nursing visit rate for one member and a reduced rate for each subsequent member in the household. When billing the MassHealth agency for the second or any additional members, the service code and modifier must reflect the visit for each subsequent member. Home health agencies must document the medical necessity in the member’s medical record in those cases where two or more members living in the same household cannot be provided skilled nursing services during a single visit. Failure to do so constitutes an unacceptable billing practice in accordance with 130 CMR 450.307.

403.425: Medical Supplies

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

403.426: Recordkeeping Requirement and Utilization Review

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

403.427: 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.

403.428: Maximum Allowable Fees

The Division of Health Care Finance and Policy (DHCFP) determines the maximum allowable fees for home health agency services as set forth in 114.3 CMR 50.00. 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 DHCFP has established for that service.

403.429: Denial of Services and Administrative Review

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

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

REGULATORY AUTHORITY

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

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