Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MassHealth
Transmittal Letter HHA-49
December 2013

TO: Home Health Agencies Participating in MassHealth

FROM: Kristin L. Thorn, Medicaid Director

RE: *Home Health Agency* (Revisions to MassHealth Regulations-Affordable Care Act)

This letter transmits revised regulations and an updated Subchapter 6 of the *Home Health Agency Manual*.

The revised regulations and Subchapter 6 delete references to MassHealth Basic since that coverage type is being discontinued as part of the transition to new coverage types under the Affordable Care Act. The revised regulations add a description of home health services covered for MassHealth CarePlus members.

These regulations are effective January 1, 2014. The revised Subchapter 6 is effective for dates of service on or after January 1, 2014.

MassHealth Website

This transmittal letter and attached pages are available on the MassHealth website at www.mass.gov/masshealth.

Questions

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 4-9, 4-10, 4-15, 4-16, 6-1, and 6-2

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(The pages listed here are no longer in effect.)

Home Health Agency Manual

Pages 4-9, 4-10, 4-15, and 4-16 — transmitted by Transmittal Letter HHA-48

Pages 6-1 and 6-2 — transmitted by Transmittal Letter HHA-41

(3) Service Record. The clinical manager

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

(i) lists those MassHealth-covered services to be authorized by the clinical 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 record, one copy of which the member or the member's primary caregiver must sign and return to the clinical manager. On the copy being returned, the member must indicate whether he or she accepts or rejects each service as offered and that he or she has been notified of the right to appeal and provided an appeal form; and

(c) provides to the home health agency information from the service record that is applicable to the home health agency.

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

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

(7) Clinical Manager Follow-up and Reassessment. The clinical manager provides ongoing care management for members and in coordination with the home health agency to

(a) determine whether the member continues to be a complex-care member; and

(b) reassess whether services in the service record are appropriate to meet the member's needs.

(B) Home Health Agency – Case Management Activities.

(1) Plan of Care. The home health agency participates in the development of the physician's plan of care for each complex-care member as described in 130 CMR 403.419, in consultation with the clinical manager, the member, and the primary caregiver, or some combination, that

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

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

(2) Coordination and Communication. The home health agency closely communicates and coordinates with MassHealth's or its designee's clinical manager about the status of the member's home health needs.

403.413: Prior-Authorization Requirements

(A) General Terms.

(1) Prior authorization must be obtained from the MassHealth agency or its designee as a prerequisite to payment for certain home health services and before services are provided to the member. Without such prior authorization, the MassHealth agency will not pay providers for these services.

(2) Prior authorization determines only the medical necessity of the authorized service, and does not establish or waive any other prerequisites for payment such as member eligibility or resort to health insurance payment.

(3) Approvals for prior authorization specify the number of hours or visits for each service that are medically necessary and payable each calendar week and the duration of the prior-authorization period. The authorization is issued in the member's name and specifies frequency and duration of care for each service approved per calendar week.

(4) If there are unused hours of continuous skilled nursing services in a calendar week, they may be used at any time during the current authorized period.

(5) The home health agency must submit all prior-authorization requests in accordance with the MassHealth agency's administrative and billing regulations and instructions and must submit each such request to the appropriate addresses listed in Appendix A of the *Home Health Agency Manual*.

(B) MassHealth CarePlus 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 CarePlus 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 CarePlus members.

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

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

(C) CSN Services.

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

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

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

(1) such care is provided following an overnight hospital or skilled nursing facility stay;

(2) such care is intended to help resolve an identified skilled-nursing need directly related to the member's hospital or skilled nursing facility stay; and

(3) for members other than those enrolled in an MCO, the home health agency obtains prior authorization as a prerequisite to payment for nursing visits following a referral from the hospital or skilled nursing facility.

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 homemaker, respite, or chore services provided to any MassHealth member.

(D) Incidental Services. When a home health aide visits a member to provide a health-related service, the home health aide may also perform some incidental services that do not meet the definition of a home health aide service (for example, light cleaning, preparing a meal, removing trash, 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 home health agency has documented that the services are no more costly than medically comparable care in an appropriate institution (for example, long-term care or chronic disease and rehabilitation hospital care) and the least-costly form of comparable care available in the community, and the member prefers to remain at home;

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

(4) the physician has documented that the need for care in excess of 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 for CSN services.

601 Explanation of Abbreviation

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

602 Definitions

Providers must use a service code and modifier that accurately reflect the nursing service provided. With nursing Service Codes T1002 and T1003, nursing services provided on a weekend or holiday will be automatically reimbursed in accordance with the applicable fee schedule of the Division of Health Care Finance and Policy (DHCFP). No additional service code or modifier is required to indicate weekend or holiday services.

(A) Day – the hours from 7:00 A.M. to 2:59 P.M., Sunday through Saturday.

(B) Night – the hours from 3:00 P.M. to 6:59 A.M., Sunday through Saturday.

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

Revenue Code	Service Code-Modifier	Service Description
		Nursing (for a Visit of Two Hours or Less) and Home Health Aide
0551	G0154	Services of skilled nurse in home health setting, each 15 minutes (PA for MassHealth CarePlus members not enrolled with a managed care organization and for complex-care members)
0551	G0154 TT	Services of skilled nurse in a home health setting, each 15 minutes (use when billing for each subsequent member–not for the first member–when two or more members in the same household are receiving a nursing visit during the same time period.) (PA for MassHealth CarePlus members not enrolled with a managed care organization and for complex-care members)
0551	G0154 UD	Services of skilled nurse in a home setting, each 15 minutes (use when billing for a member in home health services for 61 consecutive calendar days or longer)
0551	99058	Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service (use for emergency office services)
0572	G0156	Services of home health aide in home health setting, each 15 minutes (PA for complex-care members)
		Therapy
0421	G0151	Services of physical therapist in home health setting, each 15 minutes (PA after 20 visits)
0431	G0152	Services of occupational therapist in home health setting, each 15 minutes (PA after 20 visits)
0441	G0153	Services of speech and language pathologist in home health setting, each 15 minutes (PA after 35 visits)

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

Revenue Code	Service Code-Modifier	Service Description
		Continuous Skilled Nursing Services (More Than a Two-Hour Visit)
		Individual Patient Nursing
		The following service codes must be used for nursing care provided by one nurse to one member.
0552	T1002	RN services, up to 15 minutes (day) (PA)
0552	T1003	LPN/LVN services, up to 15 minutes (day) (PA)
0552	T1002 UJ	RN services, up to 15 minutes (night) (PA)
0552	T1003 UJ	LPN/LVN services, up to 15 minutes (night) (PA)
		Multiple-Patient Nursing
		The following service codes are to be used for nursing care provided by one nurse simultaneously to two members.
0552	T1002 TT	RN services, up to 15 minutes (day) (each member) (PA)
0552	T1003 TT	LPN/LVN services, up to 15 minutes (day) (each member) (PA)
0552	T1002 U1	RN services, up to 15 minutes (night) (each member) (PA)
0552	T1003 U1	LPN/LVN services, up to 15 minutes (night) (each member) (PA)
		The following service codes are to be used for nursing care provided by one nurse simultaneously to three members.
0552	T1002 U2	RN services, up to 15 minutes (day) (each member) (PA)
0552	T1003 U2	LPN/LVN services, up to 15 minutes (day) (each member) (PA)
0552	T1002 U3	RN services, up to 15 minutes (night) (each member) (PA)
0552	T1003 U3	LPN/LVN services, up to 15 minutes (night) (each member) (PA)