



Home Health Agency

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I. Overview

Blue Cross and Blue Shield of Kansas offers a wide range of contracts to meet the needs of the groups we serve.

Some contracts, such as the Federal Employee Program, cover a group's employees nation-wide. These types of programs are commonly referred to as national accounts.

Other contract types, such as Blue Choice, etc., are underwritten locally and marketed to Kansas groups. You'll hear these referred to as local groups.

Whether it's a national account or local group, some contracts include home health or hospice benefits and others do not.

When a local account includes home health or hospice benefits, it's usually done by adding coverage referred to as Home Care Benefits.

II. General Guidelines

- A. Agency will not charge the member for services prior to them being provided except for deductible and coinsurance amounts or non-covered services.
- Up front collection of these amounts is the provider's decision. BCBSKS does not have a policy that requires providers to collect up front.
 - If the member has already satisfied part of their deductible, coinsurance or share payment, providers can only bill up front for the balance.
 - Member responsibility must be calculated based on the BCBSKS MAP or allowance and not on the total charge.
 - If the up front collection results in an overpayment that is due the patient, a refund must be made to them timely.
- B. Agency will not bill the member for services that are medically unnecessary or experimental/investigational unless the member was notified prior to the services being provided. Refer to section titled PRIOR AUTHORIZATION/PRECERTIFICATION of ADMISSIONS/SERVICES for complete details about the Notice of Personal Financial Obligation.
- C. Claims will be submitted within 15 months from the date of outpatient service. Some groups may impose alternate timely filing and claim assessment requirements. Failure to meet those requirements will result in claim denial.
- If BCBSKS requests additional information or clarification about a claim before it can be processed, the provider will submit this information within 15 months of the date of service or discharge.
- Corrected claims of adjustment requests must also be filed within 15 months of the date of service or discharge.
- D. Reimbursement for skilled and therapeutic visits is the providers charge up to the maximum allowable payment amount.

Supplies used during home health visits are included as part of the global allowance for the visit. When applicable, suppliers may be reimbursed for billable supplies or durable medical equipment.

Charges for prescription drugs are submitted by the participating pharmacy to BCBSKS and are not reimbursed as part of the home health provider contract.

Reimbursement for IV therapy visits to include teaching will be limited to the MAP for a skilled visit.

- E. When requested, complete medical record information will be provided in a format that can be utilized by BCBSKS.

The members' contract allows BCBSKS to request and receive medical record information without the need for additional authorization.

III. Case Management

Case management is a process that identifies and coordinates alternative treatment plans to enhance care through effective administration of available health care resources in the most cost efficient manner.

The process is accomplished through the development of a treatment plan by the patient or legal representative, the physician, other health care providers, and the BCBSKS case manager.

The services may include both covered services and non-covered services with the exception of specifically stated exclusions. Total benefits paid for such services shall not exceed the total benefits to which the member would otherwise be entitled under the terms of their contract.

Participation in case management is voluntary. The member may withdraw at any time and return to the stated benefits of their contract.

If a member's care is being handled through the case management process, our medical staff may negotiate reimbursement rates different than the established home health maximum allowable payments.

IV. Home Care Benefits

A Home Care Benefit Rider can be purchased by local Blue Cross and Blue Shield of Kansas groups and adds home health and hospice benefits to the group's basic health insurance plan.

Maximum Benefits Limit The group decides what maximum benefit limit they want for their members. The limit can be either a maximum dollar amount (i.e.: \$2,500, \$5,000, etc.) or a visit limit (i.e.: 40 visits per calendar year, 50 visits per calendar year etc.)

Allowed Charge The provider's charge or the maximum allowable payment (MAP), whichever is less.

Home Health services Covered home health services include services provided by a Medicare certified home health agency for medically necessary services provided to an member who is homebound.

Private Duty Nursing Covered private duty nursing services include services provided by a state licensed nursing agency or state licensed nurse for medically necessary services provided on an hourly basis to a homebound member.

Definition of Homebound A member will be considered homebound if they have a condition due to illness or injury for which leaving the home is medically contraindicated. The Plan has the right to determine whether the patient is home bound.

No payment will be made for services provided to a patient that does not meet the homebound definition. These charges are the patient's responsibility.

Prior Authorization All home health care and private duty nursing requires prior authorization.

V. Covered Services

1. Covered home health services include services provided by a Medicare certified home health agency for medically necessary services provided a member who is homebound.
2. Covered private duty nursing services include those services provided by a state licensed nursing agency or state licensed nurse for medically necessary services provided on an hourly basis to a homebound member.
3. A member will be considered be homebound if they have a condition due to illness or injury for which leaving the home is medically contraindicated. The Plan has the right to determine whether the patient is homebound. More information about determining if a patient is homebound appears later in this section.
4. All home health care and private duty nursing require prior authorization by the Blue Cross and Blue Shield of Kansas in order to be eligible for benefits. If prior approval is not obtained, Blue Cross and Blue Shield of Kansas has the right to request medical records to review to determine whether services are eligible under the contract.

Note: Call 1-800-782-4437 to pre-authorize home health services.

5. Covered services include nursing care provided in the member's home by:
 - a) A registered nurse
 - b) A licensed practical nurse
 - c) A licensed vocational nurse
6. Covered services do not include services:
 - a) Provided by an individual of the member's immediate family;
 - b) Provided by a person who normally lives in the member's home; or

- c) Which are custodial or maintenance care. The company has the right to determine which services are custodial/maintenance.
- 7. Physical, occupational or speech therapy provided in the member's home by:
 - a) A licensed physical therapist
 - b) A licensed occupational therapist
 - c) A licensed speech therapist
- 8. Medically necessary services provided in the member's home by a licensed social worker.
- 9. PERIPHERAL BLOOD DRAWS FOR LABORATORY SERVICES

Sometimes a home health agency is asked to visit a home patient and the only scheduled service is a peripheral blood draw for laboratory services. Peripheral blood draws will be handled as follows:

- a) This service is subject to a maximum allowable payment.
- b) The home health agency will bill revenue code 0581 – Home Health/Other Visit. No HCPCS code is required but if you report one, it should be 36415 or S9529.
- c) Home health visits for peripheral blood draws only must be prior authorized.
- d) The 25% payment reduction applies if the service is not prior authorized.
- e) Peripheral blood draws done in conjunction with a scheduled home health visit will not be separately billed or reimbursed.

VI. Determining If A Patient Is Homebound

Blue Cross and Blue Shield of Kansas offers the following information to assist providers in determining a patient's homebound status:

BCBSKS does not follow Medicare's definition of homebound.

Homebound is defined in the member contract as:

An Insured will be considered to be Homebound if they have a condition due to illness or injury for which leaving the home is medically contraindicated. The Plan has the right to determine whether the patient is homebound.

When determining if a patient is deemed homebound consider the following questions:

1. Is there a medical reason why the person can not be transported to the place where the service can be provided?
2. Is it medically contraindicated for the person to leave their home or residence?

There are some situations where a patient may routinely leave the home for doctor visits, outpatient visits or other outings. In those cases, the patient may not meet the definition of homebound as defined above.

However, this should not be confused with the patient that is absent from the home to attend doctor visits for continued evaluation of their home health diagnosis, to receive outpatient dialysis services, outpatient chemotherapy or radiation therapy when these visits occur infrequently and/or are of short duration.

So both the reason the patient is leaving the home and the duration and frequency has to be evaluated to determine if the patient meets the homebound status.

At time patients may require certain types (ie. Suction machines, portable ventilator, infusion pumps, etc.) or more than one type of medical equipment that would make it difficult to leave the home for a doctor's visit. Likewise consideration has to be given as to whether leaving the home

would result in medical compromise of the patient's condition ie. The patient would require several hours to return to their normal vital signs such as heart rate, blood pressure and/or respiratory rate, etc.

A patient that has a documented immunodeficiency disease may be placed at risk of undo exposure to pathogens if they left the home. All these examples have to be considered when determining homebound status.

- The doctor ordering the services must state the reason they believe the patient is homebound.
- If the patient is not deemed homebound, the provider should provide the Notice of Personal Financial Obligation to the patient advising them of their financial responsibility.

VII. Prior Authorization

The Blue Cross and Blue Shield of Kansas provides medical necessity determinations.

Precertification- 1-800-782-4437

Detailed information relating to the prior authorization process and requirements is located in Section 6 of this manual. (Section 6: Prior Authorization/Precertification of Admission/Services)

- A. The Policies and Procedures Payment Attachment for home health agencies, allows Blue Cross and Blue Shield of Kansas (BCBSKS) to assess a payment reduction when an agency fails to prior authorize services. The contract language reads:

Failure to preauthorize will result in a 25 percent reduction in payment with a maximum penalty of \$250 per treatment episode.

The payment reduction:

- Applies to medically necessary services that are not prior authorized,
- Will be applied to services that are initiated outside of normal business hours. The provider can however avoid the penalty on these cases by notifying BCBSKS by the end of the first business day following the service(s).

- Is applied per treatment episode,
- Can only be assessed once per treatment episode, and
- Is a provider write-off

A treatment episode:

- Is defined as the treatment period for that diagnosis and that plan of care,
- Begins when the physician orders home health care and the home health agency agrees to care for the patient,
- Ends when the patient stops receiving home health services. This could be because the patient's condition improves and they no longer need home health care, because the patient is admitted for inpatient care, or because the patient or the family chooses not to continue. (This is not an all-inclusive list.)

If a treatment episode ends and the patient later needs additional services, this starts a new treatment episode and the services must be prior authorized. If they're not, a payment reduction will be assessed.

A copy of the prior authorization of services must accompany the claim.

B. Prior Authorization Letters

Upon completion of the prior authorization the provider will receive a letter showing approval of the authorized visits. This letter must accompany the claim when submitted. Electronic claims must include the prior authorization number in the treatment authorization field.

Examples of prior authorization letters you may receive are contained on the following pages. Because some parts of the letters are written freestyle, you will experience variations in the way the approvals are notated. Here are some common remarks:

- Approved one physical therapy evaluation
- Approved two additional physical therapy visits
- Approved physical therapy visits two times per week times two weeks
- One occupational therapy visit evaluation
- Approve 1 skilled nurse visit

- Seven skilled nursing visits
- Three skilled nursing visits approved

With regards to home health services, some member contracts do not have a separate home health benefit. In these cases, the Private Duty Nursing benefit can sometimes be 'flexed' to allow for skilled visits in the home. The authorization letter will state when the member's Private Duty Nursing is being flexed for home health services.

When home health services are paid under the Private Duty Nursing benefit, the manner in which you bill services is not affected. You will continue to bill skilled services using the revenue code 0551 and HCPC G0154.

Home Health Prior Authorization Letter
(Private Duty Nursing Benefit)

Date

PreCert #: AC 20XX-01-0111111

Facility Name
Facility Address

RE: Member Name
Identification Number

Group#
Physician
Facility
Facility Admission Date

Dear _____:

On January 1, 20XX, we received a request for precertification of skilled nursing services for the above patient.

It has been determined that medical necessity has been supported and the following benefits will be provided from January 1, 20XX through January 15, 20XX according to the Private Duty Nursing benefits provisions of their Blue Cross and Blue Shield of Kansas contract.

Five skilled nursing visits

All services will be subject to the Private Duty Nursing maximum of this member's contract. Any services provided above this benefit maximum will be non-covered and the member's responsibility.

The above decision was based on the information available to us today and is subject to the terms of the contract in force on the date the services were actually provided. Actual payment is subject to any deductible, coinsurance, specified dollar maximums, or benefit period limitations of this member's contract. Any additional services exceeding those provided above, should be prior authorized for medical necessity to be eligible for reimbursement.

ALL CLAIMS SHOULD BE SUBMITTED WITH A COPY OF THIS LETTER ATTACHED IN ORDER THAT BENEFITS WILL BE PAID AS APPROVED ABOVE.

If you have questions regarding this medical necessity determination, please call 1-800-782-4437. Any questions related to the benefits of this member's contract should be directed to Customer Service at 1-800-432-3990 or 785-291-4180.

Home Health Prior Authorization Letter
(Home Health Benefit)

Date

PreCert #: AC 20XX-01-0111111

Facility Name
Facility Address

RE: Member Name
Identification Number

Group#
Physician
Facility
Facility Admission Date

Dear _____:

On January 1, 20XX, we received a request for precertification of skilled nursing services for the above patient.

It has been determined that medical necessity has been supported and the following benefits will be provided from January 1, 20XX through January 15, 20XX according to the Home Health benefits provisions of their Blue Cross and Blue Shield of Kansas contract.

Five skilled nursing visits

All services will be subject to the Home Health maximum of this member's contract. Any services provided above this benefit maximum will be non-covered and the member's responsibility.

The above decision was based on the information available to us today and is subject to the terms of the contract in force on the date the services were actually provided. Actual payment is subject to any deductible, coinsurance, specified dollar maximums, or benefit period limitations of this member's contract. Any additional services exceeding those provided above, should be prior authorized for medical necessity to be eligible for reimbursement.

ALL CLAIMS SHOULD BE SUBMITTED WITH A COPY OF THIS LETTER ATTACHED IN ORDER THAT BENEFITS WILL BE PAID AS APPROVED ABOVE.

If you have questions regarding this medical necessity determination, please call 1-800-782-4437. Any questions related to the benefits of this member's contract should be directed to Customer Service at 1-800-432-3990 or 785-291-4180.

Therapy Prior Authorization Letter

Date

PreCert #: AC 20XX-01-0111111

Member Name
Member Address

RE: Member Name
Identification Number

Group#
Physician
Facility
Facility Admission Date

Dear _____:

On January 1, 20XX, we received a request for precertification of physical, occupations, and/or speech therapy services for the above patient.

It has been determined that medical necessity has been supported and the following benefits will be provided from January 1, 20XX through January 15, 20XX according to the Physical Medicine benefits provisions of their Blue Cross and Blue Shield of Kansas contract.

Approved two physical therapy visits

All services will be subject to the Physical Medicine maximum of this member's contract. Any services provided above this benefit maximum will be non-covered and the member's responsibility.

The above decision was based on the information available to us today and is subject to the terms of the contract in force on the date the services were actually provided. Actual payment is subject to any deductible, coinsurance, specified dollar maximums, or benefit period limitations of this member's contract. Any additional services exceeding those provided above, should be prior authorized for medical necessity to be eligible for reimbursement.

ALL CLAIMS SHOULD BE SUBMITTED WITH A COPY OF THIS LETTER ATTACHED IN ORDER THAT BENEFITS WILL BE PAID AS APPROVED ABOVE.

If you have questions regarding this medical necessity determination, please call 1-800-782-4437. Any questions related to the benefits of this member's contract should be directed to Customer Service at 1-800-432-3990 or 785-291-4180.

VIII. Appeals

Refer to Section 7: Compliance and Appeals

IX. Billing and Reimbursement

UB-04 Claim Form

Home health agencies submit claims for authorized services using the UB-04 claim-billing format. A copy of the prior authorization must accompany the claim.

Coding requirements specific for home health agencies are outlined in this manual section. Refer to the UB-04 section of this manual for a complete description of the UB-04 form locators.

Type of Bill

UB-04 Form Locator 4

The bill type is a code indicating the specific type of bill (outpatient, adjustment). This is a four-position field and is mandatory for all outpatient bills submitted to Blue Cross.

The bill types that should be reported for home health claims submitted on the UB-04 are:

032X	Home Health – Inpatient (plan of treatment under Part B only)
033X	Home Health – Outpatient (plan of treatment under Part A, including DME under Part A)
034X	Home Health – Other (for medical and surgical services not under a plan of treatment)

The fourth digit defines the frequency:

XXX1	Admit through Discharge Claim
XXX2	Interim – First Claim
XXX3*	Interim – Continuing Claim
XXX4*	Interim – Final Claim
XXX7	Replacement Claim
XXX8	Cancelled Claim

*Interim billing is accepted but not required

Providers must use the correct provider number/NPI and type of bill on the claim. BCBSKS will return the claim to the provider if the type of bill does not match the provider number/NPI on the claim.

Revenue Code

UB –92 Form Locator 42 – this is a general category code used to report the services

HCPCS/CPT

UB-04 Form Locator 44 – This is a detailed code used to report the specific service provided

Units

UB-04 Form Locator 46 – The number of times the service or procedure was performed according to the HCPCS/CPT code definition

Line Item Date of Services

UB-04 Form Locator 45 – Is reported for each line item to reflect the actual date the service was provided.

Billing Blue Cross and Blue Shield of Kansas for Home Health Services

Description of Service	Revenue Code	HCPCS Code	Units	Line Item Date of Services
Respiratory Therapy	0410	94799	1	Required
Physical Therapy Visit	0421	G0151	1= 15 minutes	Required
Occupational Therapy Visit	0431	G0152	1= 15 minutes	Required
Speech Therapy Visit	0441	G0153	1= 15 minutes	Required
Skilled Nursing Visit	0551	G0154	1=15 minutes	Required
Medical/Social Worker Visit	0561	G0155	1= 15 minutes	Required
Home Health Aide Visit	0571	G0156	1= 15 minutes	Required
Home Health/Other Services (Used when scheduled visit is for a peripheral blood draw)	0581	Not Required (if reported, use either 36415 or S9529)	Number of Services	Required
*Hourly Private Duty Nursing	0989	Not Required	1	Required

- 94799 Unlisted pulmonary service or procedure
- 36415 Venipuncture
- G0151 Services of a physical therapist in home health setting, each 15 minutes
- G0152 Services of occupational therapist in home health setting, each 15 minutes

- G0153 Services of speech and language pathologist in home health setting, each 15 minutes
- G0154 Services of skilled nurse in home health setting, each 15 minutes
- G0155 Services of clinical social worker in home health setting, each 15 minutes
- G0156 Services of home health aide in home health setting, each 15 minutes
- Q0081 IV administration, nonchemotherapy agent (IV drip)
- S9529 Routine venipuncture for collection of specimen(s), single home bound, nursing home, or skilled nursing facility patient.

*Private Duty Nursing services should be billed to Blue Shield on a CMS 1500 claim form. If you do not have a Blue Shield provider number and the services have been prior approved, you may bill the services to Blue Cross using revenue code 0989. It is not appropriate to bill private duty nursing services under revenue code 551.

Services provided during a home health visit should be billed as a home health visit. If fetal monitoring is provided in the home setting, it should be billed as a home health visit when prior authorized. The CPT code for fetal monitoring should be used.

0410	RESPIRATORY THERAPY	Charges for administration of oxygen and certain potent drugs through inhalation, positive pressure or other forms of rehabilitative therapy by measuring of inhaled and exhaled gases, analysis of blood and evaluation of the patient's ability to exchange oxygen and other gases.
Category		Standard Abbreviation
Respiratory Therapy		RT
CPT required.		
94799 - Respiratory Therapy Visit		

0421-0424	Physical Therapy	Charges for therapeutic exercises, massage, and utilization of effective properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic, and other disabilities.
Subcategory		Standard Abbreviation
0421	Visit Charge	PHYS THERP/VISIT
0424	Evaluation or Reevaluation	PHYS THERP/EVAL
CPT/HCPC required. G0151 – PT in the Home Health Setting		

0431-0434	OCCUPATIONAL THERAPY	Charges for teaching manual skills and independence in personal care to stimulate mental and emotional activity on the part of patients.
Subcategory		Standard Abbreviation
0431	Visit Charge	OCCUP THERP/VISIT
0434	Evaluation or Reevaluation	OCCUP THERP/EVAL
CPT/HCPC required. G0152 – Occupational Therapy in the Home Health Setting		

0441-0444	SPEECH-LANGUAGE PATHOLOGY	Charges for services provided to persons with impaired functional communications skills.
Subcategory		Standard Abbreviation
0441	Visit Charge	SPEECH PATH/VISIT
0444	Evaluation or Reevaluation	SPEECH PATH/EVAL
CPT/HCPC required. G0153 – Speech Therapy in the Home Health Setting		

0551	SKILLED NURSING	Charges for nursing services that must be provided
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		under the direct supervision of a licensed nurse to assure the safety of the patient and to achieve the medically desired result. This code may be used for nursing home services or a service charge for home health billing.
Category		Standard Abbreviation
Visit Charge		RN VISIT
CPT/HCPCS required. G0154 – Skilled Nursing in the Home Health Setting		
0561	MEDICAL SOCIAL SERVICES	Charges for services (such as counseling patients, interviewing patients, and interpreting problems of social situations) rendered to patients on any basis.
Category		Standard Abbreviation
Visit Charge		MED SOC VISIT
CPT/HCPCS required. G0155 – Clinical Social Worker in the Home Health Setting		
0571	HOME HEALTH AIDE	Charges made by a home health agency for personnel that are primarily responsible for the personal care of the patient.
Category		Standard Abbreviation
Visit Charge		AIDE/HH/VISIT
CPT/HCPCS code required. G0156 – Home Health Aide in the Home Health Setting.		

0989	PRIVATE DUTY NURSING	<i>Note:</i> Indicate the number of hours in "Remarks" Form Locator 84.
Category		Standard Abbreviation
Private Duty Nurse		FEE/PVT NURSE
CPT/HCPCS code is not required.		