

Home Health Workshop Handouts

September 2006



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GENERAL COVERAGE GUIDELINES

Home Health Care

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

Under group contracts, the employer decides what maximum benefit limit they want for their employees. 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.)

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



Home Health Care coverage includes skilled nursing services, physical, occupational, speech and respiratory therapy and social worker services. Home health aides and Hourly Private Duty Nursing services are covered when prior approved and determined to be medically necessary.

Prescription drugs and supplies are provided to the member by the licensed pharmacy or the Durable Medical Equipment company.

Private Duty Nursing

Private Duty Nursing benefits are standard benefits in our member contracts and usually have a benefit limitation of \$1500. Self-funded or Administrative Services Only (ASO) groups can decide whether to include this benefit and at what level. These benefits can sometimes be utilized by case management when no home health benefit exists in the member contract.



Private Duty Nursing coverage includes 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.

When this benefit is used to provide home skilled services in lieu of a home health benefit, the services are authorized as a per visit service and are reimbursed at the providers per visit home health maximum allowable payment.

In atypical situations there may be a need for the home health agency to provide hourly private duty nursing. Those services must also be prior authorized through case management.

Covered Home Health Care and Private Duty Nursing services include:

- a. Nursing care provided in the Member's home by:
 1. A registered nurse
 2. A licensed practical nurse
 3. A licensed vocational nurse
- b. Physical, occupational or speech therapy provided in the Member's home by:
 1. A licensed physical therapist
 2. A licensed occupational therapist
 3. A licensed speech therapist
- c. Medically necessary services provided in the Member's home by a licensed social worker.

Covered services do not include services:

- a. Provided by a member 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.

Homebound

The homebound status of the patient must be documented in the medical record along with the reason for being homebound. If the patient is using medical equipment that makes mobility difficult or impossible, make sure your documentation states such.



A member is considered homebound if they have a condition or illness which restricts their ability to leave their place of residence and/or leaving the residence is medically contraindicated. Blue Cross and Blue Shield of Kansas has the right to determine whether the patient is home bound.

Physical Medicine Rider

The physical medicine rider is pretty much standard in all our contracts. These services may be subject to the member's deductible and coinsurance and may be limited by visits or by a dollar maximum.

Applicable outpatient services include:

- a. Physical medicine modalities, including but not limited to: correction or adjustment by manual, mechanical, electrical or physical means (including the use of light, heat, water, or exercise) of structural imbalance, distortion, subluxation or misplaced tissue of any kind of nature of the human body.
- b. Physical Therapy
- c. Occupational Therapy (not to include materials)
- d. Speech Therapy
- e. Respiratory Therapy
- f. Cardiac Rehabilitation *
- g. Pulmonary Rehabilitation *

***Note:** Only when provided by a provider whose program has been approved by Blue Cross and Blue Shield of Kansas

Prior Authorization

All home health care and private duty nursing requires prior authorization. Even if a self-insured group does not require it in their member policy, it is a provision of the provider's contract that prior authorization applies to all service provided to Blue Cross and Blue Shield of Kansas (BCBSKS) members receiving home health services.

If prior authorization is not obtained, BCBSKS has the right to request medical records to review and determine whether services are eligible under the members contract. Services are not automatically denied due to lack of prior authorization. All services not prior authorized will be reviewed for medical necessity.

If upon review the service is deemed medically necessary but no prior authorization was done, the services are paid at a 25% penalty up to \$250 per episode.



A treatment episode is defined as the treatment period for that diagnosis and that plan of care. It begins when the physician orders home health care and the home health agency agrees to care for the patient. The treatment episode 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.

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 not, a payment reduction will be assessed. The authorization process continues when additional or continuing services are ordered by the physician.

At times you may need to provide services to a patient after business hours or on the weekend. In these situations, you will need to call BCBSKS and leave a message with us describing the patient's condition and the services in which you are requesting prior authorization. Then contact us the next business day to complete the prior authorization process.

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.

Out of State Members

When you provide services to a patient that is covered by a Blue Plan other than BCBSKS, you must prior authorize services through the patient's home plan. You will also need to call that other Plan to verify member benefits for home health services.

You will know if the member has an out of state plan by viewing their Blue Cross identification card.

BILLING AND PAYMENT

Type of Bill

The type of bill you submit to Medicare may or may not be the same as the type of bill you submit to Blue Cross. However, we will accept a Medicare type of bill on secondary claims for most lines of business. In rare cases, the Federal Employee Program has rejected a particular type of bill. In those situations and when the claim is Blue Cross primary the bill type will need to be as reflected below.

The bill types that should be reported for home health claims submitted on the UB-92 are:

- 331 Admit through Discharge Claim
- 332* Interim – First Claim
- 333* Interim – Continuing Claim
- 334* Interim – Final Claim
- 337 Relacement Claim
- 338 Cancelled Claim

*Interim billing is accepted but not required

Revenue and CPT Codes

Revenue Code	CPT Code	Description
410	94799	Unlisted pulmonary service or procedure
421	G0151	Services of a physical therapist in home health setting , each 15 minutes
431	G0152	Services of occupational therapist in home health setting, each 15 minutes
441	G0153	Services of speech and language pathologist in home health setting, each 15 minutes
551	G0154	Services of skilled nurse in home health setting, each 15 minutes
561	G0155	Services of clinical social worker in home health setting, each 15 minutes
571	G0156	Services of home health aide in home health setting, each 15 minutes

581	Not Required (if reported, use either 36415 or S9529)	Other visits (Home Health) Visits for the sole purpose of providing a peripheral blood draw
989	Not Required	Private Duty Nursing (Private Duty Nursing 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 989. It is not appropriate to bill private duty nursing services under revenue code 551)

Units

Units are billed based on the definition of the CPT code you submit. If the code states that services are measured each 15 minutes, you will list units in increments of time (ie. 1 hr = 4 units).

If there is no indication of how to code units based on the definition of the CPT, you default to billing one unit (ie. 36415 – collection of venous blood by venipuncture)

Reimbursement for skilled and therapeutic visits is one map per date of service unless Medical Review has prior authorized multiple visits per day. In these situations, you must bill a separate line item for each approved service provided on the same day.

Rev	HCPC/CPT	Date of Service	Total Charge	Allowed	Paid Amount
551	G0154	8/1/06	\$80.00	\$75.00	\$75.00
551	G0154	8/1/06	\$80.00	\$75.00	\$75.00

Line Item Date of Service

Line item dates of service are to be reported for each line where a HCPC code is reported. The line item date of service must fall within the ‘from’ and ‘through’ date of the claim.

If multiple services of the same discipline (i.e. occupational therapy) are billed without line item dates of service, it will be assumed that all services happened on the same day.

Billing Provider Numbers

Home Health and Hospice claims follow different pricing strategies. When the incorrect provider number is used the payment issued will be in error and the claim will need to be adjusted.

Hospital or hospice claims are being billed using the home health provider number and visa versa. Please double check the provider number in box 51 prior to submitting the claim to make sure you are using the correct provider number.

Likewise, if claims are received without a provider number, the processor will look to Box 1 to see who is billing the claim. If you are a combination home health and hospice facility, the processor will look to see what services are being billed to determine which provider number to use. This method is not always accurate. Adjustments will be prevented when the provider number is on the claim and the correct provider number is being used.

NOTE: Remember, you may begin using your NPI number on your Blue Cross claim as soon as October of this year. This will allow us the opportunity to perform testing prior to the required date for NPI submission.

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.

Examples of prior authorization letters and medical record request 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 letter below

demonstrate scenarios where the member has a home health benefit and where the members 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 551 and HCPC G0154.

Home Health Prior Authorization Letter
(Private Duty Nursing Benefit)

Date

PreCert #: AC 2006-01-0111111

Facility Name

Facility Address

RE: Member Name

Identification Number

Group #

Physician

Facility

Facility Admission Date

Dear :

On January 1, 2006 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, 2006 through January 15, 2006 according to the **Private Duty Nursing benefit** 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 approved 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, extension XXXX. 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 Benefit Prior Authorization Letter
(Home Health Benefit)

Date

PreCert #: AC 2006-01-0111111

Facility Name

Facility Address

RE: Member Name

Identification Number

Group #

Physician

Facility

Facility Admission Date

Dear :

On January 1, 2006 we received a request for precertification for **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, 2006 through January 15, 2006 according to the **Home Health benefit** 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 approved 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, extension XXXX. 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 2006-01-0111111

Member Name

Member Address

RE: Member Name
Identification Number

Group #

Physician

Facility

Facility Admission Date

Dear :

On January 1, 2006 we received a request for precertification of **physical, occupational, 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, 2006 through January 15, 2006 according to the **Physical Medicine benefit** 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 benefit** 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 approved 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, extension XXXX. 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.

Additional Information Request Letters

Date

Facility Name

Facility Address

Identification:

Relationship:

Patient:

Date of Birth:

Service Date:

Control #:

Dear :

Our office has received a claim for services provided to this patient. Before we can complete the processing of the claim, we will need some additional information. Please obtain needed information and return this form along with a claim to us as soon as possible.

Please resubmit with Drs orders, and notes from the visits to include the home bound status to review for medical necessity.

As soon as you return the needed information, we will resume processing your claim.

Thank You.

Claims Department:

Cc:

Additional information requests occur when you provide more services than you are authorized OR when you do not prior authorize any services. For claims processing reasons, if you provide services in addition to those prior authorized and submit them on the same claim, the claim will be held until we receive the medical records to determine if the additional services can be paid.

If no attempt is made to prior authorize services and if upon review of the medical record the services are found to be medically necessary, a 25% payment reduction will apply.

Claim Examples



Example 1:

The HHA calls BCBSKS and receives authorization for 1 skilled nursing visit per week for 2 weeks during the time period of August 1 through August 11, 2006.

Rev	HCCP/CPT	Date of Service	Total Charge	Allowed	Paid Amount
551	G0154	8/1/06	\$80.00	\$75.00	\$75.00
551	G0154	8/8/06	\$80.00	\$75.00	\$75.00

The initial order from the physician is written for skilled services one time a week for one month. In this situation, you will need to call BCBSKS after you have made the first two visits to provide an update on the patient's condition and seek authorization for the additional two visits.

If the follow-up phone call is not made for the additional three visits, medical records will be requested upon submission of the claim. The other services on the claim will be pended until we receive the records. If the last three visits of the month are found to be medically necessary, the claim payment will look like this.

Rev	HCCP/CPT	Date of Service	Total Charge	Allowed	Paid Amount
551	G0154	8/1/06	\$80.00	\$75.00	\$75.00
551	G0154	8/8/06	\$80.00	\$75.00	\$75.00
551	G0154	8/15/06	\$80.00	\$75.00	\$56.25
551	G0154	8/22/06	\$80.00	\$75.00	\$56.25
551	G0154	8/29/06	\$80.00	\$75.00	\$56.25



Example 2:

The HHA receives prior authorization from BCBSKS for 1 skilled visit per week for four weeks during the month of August. The HHA provides a total of five visits during the month.

Rev	HCPC/CPT	Date of Service	Total Charge	Allowed	Paid Amount
551	G0154	8/7/06	\$80.00	\$75.00	\$75.00
551	G0154	8/14/06	\$80.00	\$75.00	\$75.00
551	G0154	8/21/06	\$80.00	\$75.00	\$75.00
551	G0154	8/24/06	\$80.00	\$75.00	*\$56.25
551	G0154	8/28/06	\$80.00	\$75.00	\$75.00

* this assumes the visit was deemed medically necessary after review of records

One visit per week is allowed and upon review of the additional visit, it is deemed medically necessary and paid at a rate of \$56.25.

NOTE: Refer to the newsletter on our Web site dated July 10, 2006, titled, "Prior Authorization of Services" and the newsletter dated November 3, 2004, titled, "Home Health Agency Contract and Procedure Update" for additional information.

Fetal Monitoring

Prior authorization is performed to seek approval for a home health visit. The services you perform during that visit may impact the medical necessity of the visit so it is important to relay to the medical review nurse all the services you will provide during that visit.

However, it is not necessary to code out all the services you perform on your home health claim. You only need to code for the skilled visit. Therefore, if fetal monitoring is provided in the home setting, it should be billed as a skilled nursing visit when prior authorized.

Rev	HCPC/CPT	Date of Service	Total Charge	Allowed	Paid Amount
551	G0154	8/7/06	\$80.00	\$75.00	\$75.00

Peripheral Blood Draws

When the only reason for the home health visit is to perform a peripheral blood draw, the claim will reflect revenue code 581. A HCPCs code is optional. Valid codes are 36415 or S9529. Reimbursement will reflect the maximum allowable payment (MAP) assigned to revenue code 581 which is \$26 for 2006. You may not bill a skilled visit in addition if a blood draw was the only reason for the visit.

Rev	Description	HCPC/CPT	Service Date	Service Units	Total Charge
581	Other Home Health Visit	36415	8/16/06	1	\$28.00

If the purpose of the visit is to provide skilled nursing care and a peripheral blood draw is done during that visit, you may bill for the skilled nursing visit.

Rev	Description	HCPC/CPT	Service Date	Service Units	Total Charge
551	Skilled Nursing Visit		8/17/06	1	\$ 80.00

Routine and Non-Routine Supplies

Payment for routine supplies used during a skilled or therapy visit is included in the reimbursement for the skilled visit billed under revenue code 551.

Effective January 1, 2005, providers are no longer required to bill separately for non-routine supplies using revenue code 270. This includes surgical dressing supplies billed under revenue code 623. The Durable Medical Equipment (DME) / Home Medical Equipment (HME) supplier is responsible for submitting these charges to Blue Cross and Blue Shield of Kansas using their DME/HME provider number.

This change was made budget neutral for home health providers in that payments for non-routine supplies were incorporated into the payment for the skilled visit that first year. This allowed time for home health providers to discontinue procedures to obtain these types of supplies for their patients. The purpose of this change was to ensure that the member's benefits were applied according to the member contract.

Home Health providers should not bill a revenue code 270 for supplies on their claim. If the revenue code 270 is billed, it will receive one cent reimbursement based on the number of units billed. It is not Blue Cross's intention to pay for supplies under both the revenue code 270 and the revenue code representing the skilled or therapeutic visit. System changes will be implemented in the near

future to allow zero reimbursement on revenue code 270 when billed with a skilled or therapeutic visit.

Rev	Description	HCPC/CPT	Service Date	Service Units	Total Charge
551	Skilled Visit	G0154	8/16/06	1	\$ 80.00
*270			8/16/06	1	\$.01

*billed by the DME/HME supplier to Blue Cross

If you are receiving non-routine supplies from your hospital to provide to the patient for patient convenience, the hospital may bill for these supplies using their assigned DME/HME provider number. If the base hospital does not have a separate DME/HME provider number, you will need to obtain supplies for home health visits from a licensed DME/HME supplier.

Pharmacy

Prescription drugs are dispensed by the licensed pharmacy and are billed by the pharmacy. Revenue code 25X should not be reported on a home health claim for prescription drugs.

Flu Vaccines and Vitamin K Injections

A skilled home health visit would not be deemed medically necessary for the sole purpose of providing a flu vaccine or a vitamin K shot. However, if the patient is considered homebound for another reason, and you provide the flu vaccine or vitamin K shot during an approved visit, the payment for administration is allowed in the skilled or therapeutic visit MAP. You may bill an additional charge for the flu vaccine and/or vitamin K shot under your home health provider number. These are the only drugs that may be billed under the home health provider number. All other drugs are to be billed by the licensed pharmacy providing the drug.

Rev	Description	HCPC/CPT	Service Date	Service Units	Total Charge
551	Skilled Visit	G0154	8/16/06	1	\$ 80.00
636	Flu Vaccine	90658	8/16/06	1	\$ 7.00
636	Vitamin K	J3430	8/16/06	1	\$ 7.00

Home Phototherapy

Home phototherapy is a covered service when deemed medically necessary in the treatment of physiologic hyperbilirubinemia. The blanket or light used to administer the therapy is billed by the durable medical equipment provider for the rental or purchase of the equipment.

While a skilled nursing visit will not be allowed for bilirubin levels blood draw, this may be billed as a peripheral blood draw.

Rev	Description	HCPC/CPT	Service Date	Service Units	Total Charge
581	Other Home Health Visit	36415	8/16/06	1	\$ 28.00

If your hospital supplies the bilirubin blanket and they have a DME provider number, they may bill Blue Cross for the rental or purchase of the blanket.

Home IV Therapy

Services associated with home IV Therapy to include prescription drugs, supplies and equipment are covered when prior authorized and deemed medically necessary. The home IV Therapy visit is billed as a skilled nursing visit. Supplies are reimbursed to the DME provider. When covered, prescription drugs are reimbursed to the pharmacy (parenteral nutritional supplements require prior authorization by BCBSKS).

The 2007 policies state that reimbursement for IV therapy visits to include teaching will be limited to the MAP for a skilled visit. If a home health agency is hospital based and receives their DME and pharmacy from that hospital, those services can be billed by the hospital only when the hospital has applied for and received a separate DME and pharmacy billing provider number. These services are not billed on the UB-92 claim form.

Rev	Description	HCPC/CPT	Service Date	Service Units	Total Charge
551	Skilled Visit	Q0081	8/16/06	1	\$ 80.00

*this service is billed using the home health provider number

Wound Vacuum Assisted Closure (VAC) Therapy

It is important that the home health agency is aware of the type of services and equipment a patient will require during home visits prior to accepting the patient. Wound VAC Therapy is a service that includes supplies and equipment provided by a DME or supplier. The home health agency nurse this equipment to provide services to the patient.

In order to bill for a skilled visit when providing wound VAC therapy, the home health nurse must have received or be scheduled to receive training prior to administration of the therapy in the patient's home and must have a thorough knowledge of the equipment required in delivery of the prescribed therapy.

During prior authorization, BCBSKS will verify that the agency has been trained in the use of this equipment before authorizing services. BCBSKS will look to the vendor to supply listings of trained home health agencies to assist us in this measure as well as information provided by your agency.

Proper training will give the home health provider with the knowledge to correctly use the equipment in promoting healing and may lessen the duration of therapies. If therapies continue for longer than the normal results reported when using the equipment, the home health agency should look to the vendor for additional assessment of the patient's condition with regards to the use of the equipment.