



# Home Health Care High Acuity Guide

# Contents

**Descriptive Narrative** \_\_\_\_\_ 3

**Eligibility** \_\_\_\_\_ 4

    Tier 1 \_\_\_\_\_ 4

    Tier 2 \_\_\_\_\_ 9

    Tier 3 \_\_\_\_\_ 12

    Billing, Claims, and Reimbursement: \_\_\_\_\_ 16

    Coding Examples \_\_\_\_\_ 18

    Additional Information: \_\_\_\_\_ 23

## Descriptive Narrative

**The Home Health Care High Acuity** opportunity aims to support Iowa Medicaid members recently hospitalized or assessed by a provider as needing high-acuity home care. It includes three (3) tiers based on care level, with higher payments requiring specific diagnosis codes for each tier.

Home Health Care Services provide short-term medical and non-medical support to help members recover at home and reduce hospital stays. Medical services include wound care, IV medications, medication management, and education on complex conditions. Non-medical support includes help with transitions and personal care, like bathing. A provider orders a personalized plan of care (POC), which nursing staff update through collaboration. Iowa Medicaid reimburses providers for medically necessary services.

Providers are continuously monitoring if Home Health Care Service is the appropriate LOC for a member. This Acuity reimbursement opportunity does not eliminate the need to evaluate if the client/member should stay in their own home environment. If Home Care Services are not the appropriate LOC, refer to a higher LOC.

*The High Acuity Home Health Care reimbursement opportunity allows providers to be reimbursed when providing care to a member requiring services of a higher acuity.*

**Acuity** is determined by a member's diagnosis and personalized plan of care (POC). Higher acuity levels reflect more complex needs and care requirements. Since needs can be subjective, providers must document services thoroughly to justify higher reimbursement for high-acuity care.

Iowa Medicaid reimburses a home health care provider for the services provided that meet a medical necessity. The increase in reimbursement for services provided must meet the identified Tier Level necessity.

Iowa Medicaid and the Managed Care Organizations (MCOs) will be completing documentation reviews and/or audits to make sure the care provided met the requirements of the acuity Tier Level requested reimbursement rate. (see Billing, Claims, and Reimbursement section of this guide). If the review/audit of the documentation does not meet the requirement of the Tier Level, the increased reimbursement will be denied initially or recouped.

## Eligibility

Iowa Medicaid Home Health Care Providers meeting eligibility requirements can receive increased reimbursement for high-acuity care. Members qualify based on specific diagnosis codes per tier and documented home care activities. Although the 485 specifies the ordering provider care orders, the ordering provider does not specify which Tier level should be submitted for receipt of payment for the services rendered.

### Tier 1

#### Members requiring daily visits:

This requirement needs clear documentation as to **why** the member needs daily visits. The purpose of each discipline's daily visit must be explicit in the documentation to clearly explain the seven days a week visits. The decision for a PT visits one day, HCA visits three days a week, RN visits two days, and a speech therapy visit one day does not satisfy the requirements. Clearly document why is it necessary to space out these services over seven days.

#### Documentation should include:

HHA: Documentation from the Plan of Care

- Type of bathing, toleration, how much of bath did patient complete alone, the amount of required assistance or complete dependance, oxygen use, patient positioning, ambulation toleration, skin care.
- What is difference in the self-care ability now, then before
- Provider order must specify on the 485
- Services provided for four to seven days per week, not to exceed 28 hours per week

PT/OT/ST Document according to the POC.

- The preference is restorative care. The POC will identify the modalities of treatment.
  - The documentation will identify the condition(s) being treated, the restorative potential, and the progress notes.
- If maintenance care is necessary, what is the plan to achieve a specific goal.
  - Once the specific goal is met, then the discharge from therapy will be completed.

**Members with Chronic Obstructive Pulmonary Disease (COPD):**

Must have had a hospitalization or provider visit within the past 14 days due to a deterioration in status, indicating the potential for improvement, not a chronic condition.

Relevant codes:

Code	Description
J44.0	Chronic obstructive pulmonary disease with (acute) lower respiratory infection
J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation

**Members with Cerebral Vascular Accident (CVA):**

Must have a hospitalization or a provider visit within the past 14 days with the provider direction of decline or complication in status. This should be a member who could benefit from improvement rather than a chronic level.

Relevant codes:

Code	Description
G46.4	Cerebellar stroke syndrome
I60.7	Nontraumatic subarachnoid hemorrhage from unspecified intracranial artery
I61.0	Nontraumatic intracerebral hemorrhage in hemisphere, subcortical
I61.5	Nontraumatic intracerebral hemorrhage, intraventricular
I63.311	Cerebral infarction due to thrombosis of right middle cerebral artery
I63.50	Cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery
I63.511	Cerebral infarction due to unspecified occlusion or stenosis of right middle cerebral artery
I63.512	Cerebral infarction due to unspecified occlusion or stenosis of left middle cerebral artery
I63.541	Cerebral infarction due to unspecified occlusion or stenosis of right cerebellar artery
I63.81	Other cerebral infarction due to occlusion or stenosis of small artery

### Members with Diabetes:

Must have had a hospitalization or provider visit within the past 14 days due to a deterioration in status, indicating the potential for improvement, not a chronic condition.

Relevant codes:

Code	Description
E08.22	Diabetes mellitus due to underlying condition with diabetic chronic kidney disease
E08.3519	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, unspecified eye
E08.65	Diabetes mellitus due to underlying condition with hyperglycemia
E09.65	Drug or chemical induced diabetes mellitus with hyperglycemia
E10.10	Type 1 diabetes mellitus with ketoacidosis without coma
E10.21	Type 1 diabetes mellitus with diabetic nephropathy
E10.22	Type 1 diabetes mellitus with diabetic chronic kidney disease
E10.39	Type 1 diabetes mellitus with other diabetic ophthalmic complication
E10.42	Type 1 diabetes mellitus with diabetic polyneuropathy
E10.43	Type 1 diabetes mellitus with diabetic autonomic (poly)neuropathy
E10.49	Type 1 diabetes mellitus with other diabetic neurological complication
E10.51	Type 1 diabetes mellitus with diabetic peripheral angiopathy without gangrene
E10.59	Type 1 diabetes mellitus with other circulatory complications
E10.621	Type 1 diabetes mellitus with foot ulcer
E10.628	Type 1 diabetes mellitus with other skin complications
E10.65	Type 1 diabetes mellitus with hyperglycemia
E10.69	Type 1 diabetes mellitus with other specified complication
E11.00	Type 2 diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
E11.10	Type 2 diabetes mellitus with ketoacidosis without coma
E11.21	Type 2 diabetes mellitus with diabetic nephropathy
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease

E11.29	Type 2 diabetes mellitus with other diabetic kidney complication
E11.311	Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema
E11.41	Type 2 diabetes mellitus with diabetic mononeuropathy
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy
E11.43	Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy
E11.44	Type 2 diabetes mellitus with diabetic amyotrophy
E11.49	Type 2 diabetes mellitus with other diabetic neurological complication
E11.51	Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene
E11.52	Type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene
E11.610	Type 2 diabetes mellitus with diabetic neuropathic arthropathy
E11.618	Type 2 diabetes mellitus with other diabetic arthropathy
E11.621	Type 2 diabetes mellitus with foot ulcer
E11.622	Type 2 diabetes mellitus with other skin ulcer
E11.628	Type 2 diabetes mellitus with other skin complications
E11.65	Type 2 diabetes mellitus with hyperglycemia
E11.69	Type 2 diabetes mellitus with other specified complication
E13.311	Other specified diabetes mellitus with ketoacidosis with coma
E13.42	Other specified diabetes mellitus with diabetic polyneuropathy
E13.621	Other specified diabetes mellitus with foot ulcer
E23.2	Diabetes insipidus

**Members with Severe Morbid Obesity:**

Must have had a hospitalization or provider visit within the past 14 days due to a deterioration in status, indicating the potential for improvement, not a chronic condition.

Relevant codes:

Code	Description
E66.01	Morbid (severe) obesity due to excess calories
E66.2	Morbid (severe) obesity with alveolar hypoventilation

**Members with Traumatic Brain Injury:**

Must have had a hospitalization or provider visit within the past 14 days due to a deterioration in status, indicating the potential for improvement, not a chronic condition.

Relevant codes:

Code	Description
S06.2X0D	Diffuse traumatic brain injury without loss of consciousness, subsequent encounter
S06.2X1D	Diffuse traumatic brain injury with loss of consciousness of 30 minutes or less, subsequent encounter
S06.2X9D	Diffuse traumatic brain injury with loss of consciousness of unspecified duration, subsequent encounter
S06.2X9S	Diffuse traumatic brain injury with loss of consciousness of unspecified duration, sequela
S06.300A	Unspecified focal traumatic brain injury without loss of consciousness, initial encounter
S06.309A	Unspecified focal traumatic brain injury with loss of consciousness of unspecified duration, initial encounter
S06.309D	Unspecified focal traumatic brain injury with loss of consciousness of unspecified duration, subsequent encounter



## Tier 2

All the Tier 1 diagnosis codes identified above would be classified as a Tier 2 for clients needing:

- **2 person transfers, - clearly documented why** - the proof supporting the care provided **must** be present in the documentation records.
- **RN or LPN in person visit (not telehealth),**
- **Multiple visits the same day -clearly documented why** - the proof supporting the care provided **must** be present in the documentation records.

Code	Description
F02.B2	Dementia in other diseases classified elsewhere, moderate, with psychotic disturbance
F02.B3	Dementia in other diseases classified elsewhere, moderate, with mood disturbance
F02.B4	Dementia in other diseases classified elsewhere, moderate, with anxiety
G31.83	Neurocognitive disorder with Lewy bodies
G80.0	Spastic quadriplegic cerebral palsy
G82.51	Quadriplegia, C1-C4 complete
G82.52	Quadriplegia, C1-C4 incomplete
G82.53	Quadriplegia, C5-C7 complete
G82.54	Quadriplegia, C5-C7 incomplete
R53.2	Functional quadriplegia

- HHA: Documentation from the Plan of Care:
  - Type of bathing, toleration, how much of bath did patient complete alone, the amount of required assistance or complete dependance, oxygen use, patient positioning, ambulation toleration, skin care.
  - What is difference in the self-care ability now vs before
  - Provider order must specify on the 485
  - Services provided for four to seven days per week, not to exceed 28 hours per week
- PT/OT/ST Document according to the POC.
  - The preference is restorative care. The POC will identify the modalities of treatment.
    - The documentation will identify the condition(s) being treated, the restorative potential, and the progress notes.
    - Evaluate if this is the correct level of care for this person, if not start referrals.
  - If maintenance care is necessary, what is the plan to achieve a specific goal.
    - Once the specific goal is met, then the discharge from therapy will be completed

- **RN:** According to the POC, the documentation needs to match the patient's needs specific to what was completed at the present visit – the proof supporting the care must be present in the documentation records.
  - Depending on the situation, the RN may revise and record a POC based on the circumstances.
    - (Assess, Plan {including teaching – response to teaching}, implementation, Evaluation.) Was the provider notified, if not, why was the provider not notified of this visit, etc. (Always following Nurse Practice Act Iowa Administrative Code 655 – 6.1-6.9.)
- **LPN:** According to the POC, the documentation needs to match the patients' needs specific to what was completed at the present visit – the proof supporting the care must be present in the documentation records.
  - After the initial RN assessment, the LPN will:
    - clarify new orders,
    - fill a Med box, explain the process of filling the med box and evaluate the understanding by the person receiving the explanation,
    - complete a medication review, contact providers to refill if needed,
    - promptly notify and collaborate with those involved in the patients care,
    - complete treatments per the POC,
    - if interventions are not completed, document why, and who was notified etc.
    - clearly document all that was provided at each visit,
    - LPN services are based on the Nurse Practice Act of the Iowa Administrative Code Chapter 655 – 6.3(1)-6.3(14).

## Pain

Must have had a hospitalization or provider visit within the past 14 days due to a deterioration in status, indicating the potential for improvement, not a chronic condition.

Code	Description
G89.11	Acute pain due to trauma
G89.12	Acute pain due to other external causes
G89.18	Other Acute pain
G89.21	Chronic pain due to trauma
G89.22	Chronic pain due to other external causes
G89.29	Other chronic pain
G89.3	Neoplasm-related pain
M79.1	Myalgia (muscle pain)
M54.5	Low back pain
M25.5	Pain in join (for specific joints)

- Acute pain codes are used for pain that has a sudden onset and is typically associated with injury or surgery.
- Chronic pain codes are used for pain that persists over a longer period, often beyond the expected recovery time from an injury or illness.
- Neoplasm-related pain is used for pain associated with malignancies, either due to the cancer itself or as a side effect of cancer treatment.
- Pain in a joint code is used when pain is linked to a specific condition or anatomical site, such as muscle pain or joint pain.
- RN: Document Thoroughly: Detailed documentation to include information on the pain's onset, location, severity, and any associated conditions. If pain is a symptom of another condition, such as a chronic disease or injury, describe this information. Describe patient teaching, (potentially medication use, tolerance, dose or frequency changes, why there are no changes needed at this visit) always remember: the proof supporting the care must be present in the documentation records.

## Tier 3

The Plan of Care with recognized diagnosis codes determines the needed services, including stage-specific pressure ulcers and other non-pressure chronic ulcers.

Overall, the guiding principle for documentation is that it must be thorough and reflective of the care provided, aligning with the needs outlined in the Plan of Care.

Code	Description
L89.023	Pressure ulcer of left elbow, stage 3
L89.142	Pressure ulcer of left lower back, stage 2
L89.152	Pressure ulcer of sacral region, stage 2
L89.153	Pressure ulcer of sacral region, stage 3
L89.154	Pressure ulcer of sacral region, stage 4
L89.156	Pressure-induced deep tissue damage of sacral region
L89.212	Pressure ulcer of right hip, stage 2
L89.213	Pressure ulcer of right hip, stage 3
L89.214	Pressure ulcer of right hip, stage 4
L89.222	Pressure ulcer of left hip, stage 2
L89.223	Pressure ulcer of left hip, stage 3
L89.224	Pressure ulcer of left hip, stage 4
L89.312	Pressure ulcer of right buttock, stage 2
L89.313	Pressure ulcer of right buttock, stage 3
L89.314	Pressure ulcer of right buttock, stage 4
L89.322	Pressure ulcer of left buttock, stage 2
L89.323	Pressure ulcer of left buttock, stage 3
L89.324	Pressure ulcer of left buttock, stage 4
L89.43	Pressure ulcer of contiguous site of back, buttock and hip, stage 3
L89.44	Pressure ulcer of contiguous site of back, buttock and hip, stage 4
L89.512	Pressure ulcer of right ankle, stage 2
L89.523	Pressure ulcer of left ankle, stage 3
L89.612	Pressure ulcer of right heel, stage 2

L89.613	Pressure ulcer of right heel, stage 3
L89.614	Pressure ulcer of right heel, stage 4
L89.616	Pressure-induced deep tissue damage of right heel
L89.622	Pressure ulcer of left heel, stage 2
L89.623	Pressure ulcer of left heel, stage 3
L89.626	Pressure-induced deep tissue damage of left heel
L97.112	Non-pressure chronic ulcer of right thigh with fat layer exposed
L97.128	Non-pressure chronic ulcer of left thigh with other specified severity
L97.212	Non-pressure chronic ulcer of right calf with fat layer expose
L97.222	Non-pressure chronic ulcer of left calf with fat layer exposed
L97.312	Non-pressure chronic ulcer of right ankle with fat layer exposed
L97.322	Non-pressure chronic ulcer of left ankle with fat layer exposed
L97.412	Non-pressure chronic ulcer of right heel and midfoot with fat layer exposed
L97.413	Non-pressure chronic ulcer of right heel and midfoot with necrosis of muscle
L97.418	Non-pressure chronic ulcer of right heel and midfoot with other specified severity
L97.422	Non-pressure chronic ulcer of left heel and midfoot with fat layer exposed
L97.423	Non-pressure chronic ulcer of left heel and midfoot with necrosis of muscle
L97.424	Non-pressure chronic ulcer of left heel and midfoot with necrosis of bone
L97.428	Non-pressure chronic ulcer of left heel and midfoot with other specified severity
L97.512	Non-pressure chronic ulcer of other part of right foot with fat layer exposed
L97.515	Non-pressure chronic ulcer of other part of right foot with muscle involvement without evidence of necrosis
L97.516	Non-pressure chronic ulcer of other part of right foot with bone involvement without evidence of necrosis
L97.518	Non-pressure chronic ulcer of other part of right foot with other specified severity
L97.522	Non-pressure chronic ulcer of other part of left foot with fat layer exposed
L97.523	Non-pressure chronic ulcer of other part of left foot with necrosis of muscle

L97.525	Non-pressure chronic ulcer of other part of left foot with muscle involvement without evidence of necrosis
L97.528	Non-pressure chronic ulcer of other part of left foot with other specified severity
L97.812	Non-pressure chronic ulcer of other part of right lower leg with fat layer exposed
L97.818	Non-pressure chronic ulcer of other part of right lower leg with other specified severity
L97.821	Non-pressure chronic ulcer of other part of left lower leg limited to breakdown of skin
L97.822	Non-pressure chronic ulcer of other part of left lower leg with fat layer exposed
L97.912	Non-pressure chronic ulcer of unspecified part of right lower leg with fat layer exposed
L97.918	Non-pressure chronic ulcer of unspecified part of right lower leg with other specified severity
L97.922	Non-pressure chronic ulcer of unspecified part of left lower leg with fat layer exposed
T31.10	Burns involving 10-19% of body surface with 0% to 9% third degree burns
T31.21	Burns involving 20-29% of body surface with 10-19% third degree burns
Z48.03	Encounter for change or removal of drains
T21.35XD	Burn of third degree of buttock, subsequent encounter
T24.302S	Burn of third degree of unspecified site of left lower limb, except ankle and foot, sequela
T24.311D	Burn of third degree of right thigh, subsequent encounter
T25.312D	Burn of third degree of left ankle, subsequent encounter
Z48.00	Encounter for change or removal of nonsurgical wound dressing
Z48.01	Encounter for change or removal of surgical wound dressing
J95.03	Malfunction of tracheostomy stoma
J95.09	Other tracheostomy complication
Q32.0	Congenital tracheomalacia
Z43.0	Encounter for attention to tracheostomy
Z93.0	Tracheostomy status
Z99.11	Dependence on respirator [ventilator] status

- HHA: Documentation from the Plan of Care:
  - Type of bathing, toleration, how much of bath did patient complete alone, the amount of required assistance or complete dependance, oxygen use, patient positioning, ambulation toleration, skin care.
  - What is difference in the self-care ability now vs before
  - Provider order must specify on the 485
  - Services provided for four to seven days per week, not to exceed 28 hours per week
- PT/OT/ST Document according to the POC.
  - The preference is restorative care.
  - This should be a member who could benefit from improvement rather than chronic level of care
  - Evaluate if this is the correct level of care for this person, if not start referrals.
  - If maintenance care is necessary, what is the plan to achieve a specific goal.
  - Once the specific goal is met, then the discharge from therapy will be initiated.
  - The POC will identify the modalities of treatment, the conditions being treated, the restorative potential, and the progress notes.
  - The POC will identify the modalities of treatment, the conditions being treated, the restorative potential, and the progress notes.
  - Once the specific goal is met, then the discharge from therapy will be initiated.
- RN: According to the POC, the documentation needs to match the patients' needs specific to what was completed at the present visit
  - Depending on the situation, the RN may revise and record a POC based on the circumstances.
    - (Assess, Plan {including teaching – response to teaching}, implementation, Evaluation.) Was the provider notified, if not, why was the provider not notified of this visit, etc. (Always following Nurse Practice Act Iowa Administrative Code 655 – 6.1-6.9.)
  - Specify the wound care
  - Instruct the patient and care giver of the wound, process of healing and the response from who was taught.

- LPN: According to the POC, the documentation needs to match the patients' needs specific to what was completed at the present visit.
  - After the initial RN assessment, the LPN will:
    - clarify new orders,
    - fill a Med box, explain the process of filling the med box and evaluate the understanding by the person receiving the explanation,
    - complete a medication review, contact providers to refill if needed,
    - promptly notify and collaborate with those involved in the patients care,
    - complete treatments per the POC,
    - if interventions are not completed, document why, and who was notified etc.
    - clearly document all that was provided at each visit,
    - LPN services are based on the Nurse Practice Act of the Iowa Administrative Code Chapter 655 – 6.3(1)-6.3(14).

### Billing, Claims, and Reimbursement:

Tier	Description	Billing Guidance
Basic	Services performed were considered “standard”	Provider submits claim normally
Tier 1	Receives a 10% increase	Provider submits the claim with the <b>U1</b> modifier
Tier 2	Receives a 30% increase	Provider submits the claim with the <b>U2</b> modifier
Tier 3	Receives a 60% increase	Provider submits the claim with the <b>U3</b> modifier

The claims must include the modifier that corresponds with the acuity tier level/diagnosis for that visit. Examples include the following scenarios:

#### Scenario 1: Diagnosis relates to one Tier

A member has one diagnosis that is a Tier 1 Diagnosis. Visits directly related to the care of that condition would need to be billed with a U1 modifier for that visit and the documentation should meet the requirements listed in the Tier 1 section of this manual. The reimbursement would be a 10% increase to the LUPA rate.



## **Scenario 2: Diagnoses relating to more than one Tier Level**

The member has diagnosis codes that relate to both Tier 2 (RN visit) and Tier 3. The RN visit is due to a need under the Tier 3. The U3 modifier would need to be billed with the appropriate procedure code the LUPA rate would be increased by 60%. All documentation for that visit would need to indicate the services related to that diagnosis as outlined in the Tier 3 section. If a RN does a visit later that week for the same member and does care that relates to the Tier 2 diagnosis/condition, the modifier would be U2 and the documentation should reflect care done per the requirements listed in the Tier 2 section of this manual. The reimbursement would be a 30% increase to the LUPA rate. All visits unrelated to the specific high acuity needs of the member should be billed per normal billing guidelines and will be reimbursed at the LUPA rate.

For the submission of the UB04 form, the diagnosis codes identified in each tier are the ONLY codes available for High Acuity Reimbursement. If any other code(s) is submitted with the modifier that is not on the list of approved codes, the claim line indicating a high acuity visit will be denied. The claim line would need to be resubmitted correctly to be reimbursed. Multiple visits for same day billing and or other dates of visits may be submitted on the same claim form. If there are diagnosis codes that do not meet the High Acuity Reimbursement program, they may be submitted on the same UB04 form and would be reimbursed as per the usual process. Nothing is changed regarding other 'code lines' as previously submitted for the EVV process.

**\*\*\*Code updates may result in changes to the diagnosis codes. If this the case, this guide will be revised, the High Acuity Code List posted on the website will be updated, and an Informational Letter will be sent out.\*\*\***

For the submission of the 837I, One or more of the diagnosis codes identified in each tier must be included for High Acuity Reimbursement. If any claim line is submitted with a High Acuity modifier, and the claim does not include one or more of the identified diagnosis codes for that tier, the claim line will be denied. The claim and/or claim line would need to be resubmitted correctly to be reimbursed for High Acuity Home Health.

For purposes of determining whether a High Acuity service has the appropriate diagnosis code, the code(s) can be included in any appropriate diagnosis code segment within the Loop 2300 of the 837I.

**Prior Authorizations:** The prior authorization process will remain unchanged. The visit(s) will be authorized following the current procedure, the high acuity add on will not be separately authorized.

## **Coordination of Benefits**

Member's claims who are eligible for reimbursement from a primary payer, are not eligible for the High Acuity Home Health Care reimbursement.

## Coding Examples

48-year-old Iowa Medicaid member. He has Type 1 Diabetes and just returned home from the hospital after having toes removed. He is to walk with a knee scooter. His surgical site requires dressing changes every 3 days. The dressing was changed in the hospital yesterday. Today's visit is for the RN to assess and start the plan of care.

42 REV. CL	43 DESCRIPTION	44 HCPCS / RATE / ICD-10 CODE	45 SER# DATE	46 SER# UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	551	G0299U2	030325	1	214.00	0.00	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
PAGE ____ OF ____		CREATION DATE		TOTALS			
50 PAYER NAME		51 HEALTH PLAN ID		52 REL INFO	53 ASG REL	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
							56 NPI
							57 OTHER
							PRV ID
58 INSURED'S NAME		59 REL	60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER				65 EMPLOYER NAME	
66 DX	G80.0	K59.09	Q93.89	J45.30	Z87.01	Z93.1	J47.9
	Q87.19	E44.0	G40.909	M41.45	H52.03		N18.1
69 ADMIT DX		70 PATIENT REASON DX			71 PPS CODE		72
							73

This next claim identified a Medicaid member requiring assessment, teachings and med box.

42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / ICDPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NONCOVERED CHARGES	49
551		G0299U2	021224	1	234.00	0.00	1
551		G0300U2	021924	1	234.00	0.00	2
551		G0299U2	022624	1	234.00	0.00	3
551		G0300U2	022824	1	234.00	0.00	4
							5
							6
							7
							8
							9
							10
							11
							12
							13
							14
							15
							16
							17
							18
							19
							20
							21
							22
PAGE ____ OF ____		CREATION DATE		TOTALS			23
50 PAYER NAME		51 HEALTH PLAN ID	52 REL INFG	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
							57
							OTHER
							PRV ID
58 INSURED'S NAME		59 REL	60 INSURED'S UNIQUE ID		61 GROUP NAME	62 INSURANCE GROUP NO.	
63 TREATMENT AUTHORIZATION CODES			64 DOCUMENT CONTROL NUMBER			65 EMPLOYER NAME	
66 DX	G80.0	K59.09	Q93.89	J45.30	Z87.01	Z93.1	J47.9
	Q87.19	E44.0	G40.909	M41.45	H52.03		N18.1
							Q22.1
69 ADMIT DX		70 PATIENT REASON DX			71 PPS CODE	72 EST	73

The Physical Therapist does not receive any acuity increase.

42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / ICDPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NONCOVERED CHARGES	49
421		G0151	011425	1	230.00	0.00	1
421		G0151	011625	1	230.00	0.00	2
421		G0151	012125	1	230.00	0.00	3
421		G0151	012325	1	230.00	0.00	4
421		G0151	013025	1	230.00	0.00	5
							6
							7
							8
							9
							10
							11
							12
							13
							14
							15
							16
							17
							18
							19
							20
							21
							22
PAGE ____ OF ____		CREATION DATE		TOTALS			23
50 PAYER NAME		51 HEALTH PLAN ID	52 REL INFO	53 ADDL BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
							57
							OTHER
							PRV ID
58 INSURED'S NAME		59 REL	60 INSURED'S UNIQUE ID		61 GROUP NAME	62 INSURANCE GROUP NO.	
63 TREATMENT AUTHORIZATION CODES			64 DOCUMENT CONTROL NUMBER			65 EMPLOYER NAME	
66	G89.29	M25.512	G12.1	M25.511	E43	D	E
67						F	G
68						H	I
69	ADMIT	70 PATIENT		71 PPS	72		73

This example identifies the monthly submission of a claim with multiple disciplines.

2 REN CD		43 DESCRIPTION		44 HCPCS / RATE / ICD-9 CODE		45 SERV DATE		46 SERV UNITS		47 TOTAL CHARGES		48 NONCOVERED CHARGES		49	
551				G0299U2		021425		2		300.00		0.00			1
571				G0156U1		021625		1		80.00		0.00			2
571				G0156U1		022025		1		80.00		0.00			3
571				G0156U1		022325		1		80.00		0.00			4
551				G0300U2		022425		1		125.00		0.00			5
571				G0156U1		022725		1		80.00		0.00			6
															7
															8
															9
															10
															11
															12
															13
															14
															15
															16
															17
															18
															19
															20
															21
															22
PAGE ____ OF ____		CREATION DATE				TOTALS									
9 PAYER NAME		51 HEALTH PLAN ID		52 REL INFO		53 PRIOR PAYMENTS		54 EST. AMOUNT DUE		56 NPI		57 OTHER		58	
8 INSURED'S NAME		59 REL		60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO.							
3 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME											
9 E66.01		J44.1		Z68.44		Z57.31								68	
9 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 EQ		73							
4 PRINCIPAL PROCEDURE CODE		a. OTHER PROCEDURE CODE		b. OTHER PROCEDURE CODE		c. OTHER PROCEDURE CODE		75		76 ATTENDING NPI		QUAL			
										LAST		FIRST			
5 OTHER PROCEDURE CODE		d. OTHER PROCEDURE CODE		e. OTHER PROCEDURE CODE		f. OTHER PROCEDURE CODE				77 OPERATING NPI		QUAL			
										LAST		FIRST			
10 REMARKS		81 CC								78 OTHER NPI		QUAL			
		a								LAST		FIRST			
		b								79 OTHER NPI		QUAL			
		c								LAST		FIRST			
		d								LAST		FIRST			
3-04 CMS-1450		APPROVED OMB NO. 0938-0897								THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF					

### Fee for Service:

The claim submission for Fee for Service will include the visit note. The provider is to upload the visit note to IMPA ATTACH for the 268 edits. The claim is held, and the documentation is reviewed per the QIO Team. Once the review is completed, the claim with the increase in reimbursement will be paid as submitted or will be denied if the documentation does not meet the criteria in the tier level.

### MCOs:

The claim associated visit note is not submitted to CareBridge for the Managed Care Organizations (MCOs). The MCOs will conduct Documentation/Medical Records reviews per a post pay review. These reviews will ensure that the documentation contained in the provider's medical records for a given service is in alignment with the information in this Home Care High Acuity Guide. If this documentation review does not identify the services provided met the Tier level reimbursed, a recoupment will occur. This will ensure consistency and adherence to established guidelines and the MCOs expect to utilize the following approaches for conducting these reviews:

- Random Sample Reviews: The MCOs teams plan to conduct random sample reviews to collect medical records, which will serve to document the rationale for the tier level billed. This method will help verify the appropriateness of services billed under each tier.
- Outlier Analysis: The MCO teams will perform outlier analyses to detect instances where a provider may frequently bill more than their peers for the same tier services, or overall, for the tier services. Identifying such outliers will warrant further review through requests for additional medical records.
- SIU Tips and Referrals: Standard Special Investigative Unit (SIU) tips and referrals will also be considered valid reasons to request and review records. This step ensures that potential issues are addressed comprehensively.

The MCOs believe that these measures will enhance the collaborative efforts in maintaining the integrity of high acuity home care services. The MCOs are committed to working closely with providers to ensure the success of this initiative.

## Additional Information

As per Title XVIII of the Social Security Act. The Home Health Services (HHS) program provides in home medical services by Medicare-certified home health agencies. A member does not have to be determined homebound to receive HHS services. HHS does not reimburse for medical needs that can be met by a family member, significant other, friend, neighbor, community or other unpaid resources.

The Sections of the Iowa Administrative Code: 441-77.9 and 441-78.9 pertains to Home Health Services.

All provider manual specific for Policies for Home Health Services Provider must be followed. Including but not limited to; a physician must certify that a member has a medical need for HHS through a face-to-face encounter. The physician must, also, review and sign the HHS plan. To prevent duplication of same or similar services and to ensure that the member's comprehensive needs are met, the HHS POC must include all services, regardless of funding source, and unpaid supports provided to the member.

These goals require that the HHS provider coordinate and communicate with caregivers, legal representatives or unpaid sources, providers of other services; and/or a DHS service worker or case manager, who may be assigned to a member. HHS providers are reimbursed per visit.