High Acuity Home Care Patients

IOWA Health and Human Services

High Acuity Home Care

History

Billing & Coding

Claim Examples

History

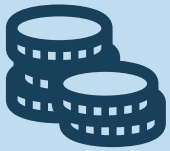
The severity of a disease or medical condition is referred to as ‘patient acuity’

Higher acuity Medicaid Members may be more challenging to place with an agency and serve, due to reimbursement

Appropriation funding was received by Iowa Medicaid to reimburse providers for higher-acuity Home Health Care clients

History (p.2)

The funding has been appropriated on an annual basis at $1.5 million state dollars unless the legislature changes.



The $1.5M will be assumed in the Medicaid budget in future SFY Medicaid budgets

Home Health Care High Acuity Guide

- This guide provides the details of this reimbursement opportunity.
- We will be reviewing all the details in this guide today.
- Please hold your questions or write in the chat until the end of the presentation today.
- The guide will be accessible on the website.
- Home Health Services | Health & Human Services

Tier Levels

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 **U1** modifier
Tier 2	Receives a 30% increase	Provider submits the claim with the **U2** modifier
Tier 3	Receives a 60% increase	Provider submits the claim with the **U3** modifier

Tier	Service Categories	Percent Increase
Tier 1	Specific Codes related to: Clients with: • COPD • CVA • Diabetes • Morbid Obesity • TBI • Clients needing services 7 days/week	10%
Tier 2	Clients needing: • 2 person transfers • LPN or RN in person visit • Multiple visits the same day • IV Infusions Specifics Codes related to Clients with: • Advanced Dementia • Quadriplegia Clients that are total care/bed-bound	30%
Tier 3	Specific codes related to: Clients needing: • Trach and/or Vent care • Complex wound care • Clients having more than 1 wound • Wound care that takes more than an hour • Clients that are post-surgery with drains, pain management, or wounds • Pain management chronic and acute	60%

Tier 1 Review

Regarding the specific codes listed for diagnosis:

- COPD: respiratory infection, exacerbation,
- CVA: recent needing assist with recovery
- Diabetes: uncontrolled needing assist
- Morbid Obesity: HCA required to assist in personal cares
- TBI

Regarding services 7 days a week, does this include a combination of any discipline during the week?

It is any combination RN, LPN, HHA, PT, OT, ST with explanation as to why this needs to meet the clients need.

Tier 2 Review

What does it mean to have “Multiple Visits” on the same day?

- This is any combination that may be needed - maybe an LPN and HCA at the same time for bathing – but why?

Make sure the requirement for the multiple visits on the same day is **documented** as the cause or justification.

All staff records who visit on the same day must have the documentation in the member’s visit notes as to the reason why.

Tier 2 Review (p.2)

An additional suggestion for documentation:

- Does the client **use** specialized equipment such as a - Hoyer lift – dialysis machine – trach equipment – oxygen concentrator – ventilator – lift bed – specialized adaptive toilet- knee scooter?

If so, document everything the client and care team do with this equipment!

Tier 2 Review (p.3)

Pain Management

May be a diagnosis on its own or related to the dressing changes, surgical site, etc.

Would require:

- The assessment of pain
- Evaluating the current treatment (POC)
- Calling a provider for adjustments in POC if needed
- Teaching regarding medications, positioning, other comfort measures, etc.

Documentation

- Documentation must identify the care/services rendered under the tier level requested for the higher amount of that tier to be reimbursed.

- To be reimbursed for the higher amount of each tier level, the documentation must support the care provided.

- Documentation must validate the care provided is at the tier level for the requested amount to be reimbursement

If it is not documented – it was not done

- Without the documentation the reimbursement process could be interrupted.

ICD-10 Diagnosis Codes

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

Billing Requirements

	Requirements
Modifier	• Modifiers U1, U2 or U3 must be appended to the claim line in any position. • The modifier billed must align with the level of acuity indicated by the specific Diagnosis Code and visit notes. • If multiple tier services are submitted on the same claim, each tier must be billed on separate claim lines with the appropriate modifier in the first modifier position.
Diagnosis Code/s	When billing High Acuity Home Health, one or more of the high acuity diagnosis codes must be billed in any diagnosis position on the claim (1-25) that relate to the tier being billed based on the modifier.

Billing

- Provider is paid based on the highest tier billed on the claim line based on the modifier billed
- Visit notes will be included in the claim submission for FFS
- MCOs will be performing post pay audits where visit notes may be requested
- Tier level is chosen based on what was done at the visit that day
  - One visit may qualify for 60% increase, but the next visit may only qualify for a 10% increase or no increase
- High acuity claims should contain the appropriate HCPCS code, modifier and diagnosis code that align with the tier being billed
- All existing guidelines for billing Home Health Services are applicable to the Home Health High Acuity.
- Claims that require submission to a primary insurance are not eligible for High Acuity reimbursement.

EVV Home Health Care Codes

G0299	RN Direct Care, Home Health or Hospice Setting
G0300	LPN Direct Care, Home Health Setting or Hospice Setting
G0158	OT Assistant, Home Health Setting or Hospice Setting
G0159	PT, Home Health Setting
G0160	OT, Home Health Setting
G2168	PT Assistant, Home Health Setting
G2169	OT Assistant, Home Health Setting
G0151	PT, Home Health Setting or Hospice
G0152	OT, Home Health Setting or Hospice
G0153	SLP or ST, Home Health Setting or Hospice
G0156	Home Health Aide, Home Health or Hospice Setting
G0161	SLP, Home Health Setting

Example

J.R. is a 48-year-old 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. Today's visit is for the RN to assess and complete the wound care.

Example (p.2)

What Tier Level should be submitted for this visit's acuity reimbursement?

- Visit 2 for J.R. is needing assistance with balance and bathing. The Physical therapist and Home Care Aide are present together.

What Tier Level should be submitted for this visit's acuity reimbursement?

- Visit 3 for J.R. is for is wound care, dressing change. The LPN meets with J.R. in his home and changes his complex dressing change.

What Tier Level should be submitted for this visit's acuity reimbursement?

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