Home Health Care Acuity FAQ

May 2025

IOWA Health and Human Services

Iowa Medicaid
Iowa HHS

When does the high acuity reimbursement begin?

Starting July 1, 2025, Iowa Medicaid will begin a high acuity reimbursement opportunity. Members who fulfill the Home Health Care High Acuity Guide's standards and provide the supporting documentation should be eligible for increased agency reimbursement.

(See Home Health Care High Acuity Guide located in the Iowa Medicaid Website, under Home Health Services.) (https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-medicaid-programs/home-health)

Example: To begin billing on July 1, 2025, a member must have been admitted in the hospital or have seen a provider reporting a change in condition, between June 17, 2025, through June 30, 2025. Although the agency may have served the member before July 1, 2025, billing with the modifiers cannot begin until July 1, 2025.

Can this acuity reimbursement be used with a Third-Party Liability reimbursement?

This Home Health Care Acuity reimbursement opportunity is not available to members with other health insurance coverage.

Does this funding include the original visits of admitting to home care service agencies?

The first visits would be included if the members' diagnosis, care needs and documentation identify the eligibility.

How long can a home care provider submit the higher reimbursement?

The acute episode of the disease process, identified by the specific reimbursable codes, is improved within the first home health care certification. After those 60 days, the disease process is considered stable with interventions in place. That does not mean home care services are not needed, but the interventions are stabilized in the care routine. Clear documentation must always identify the activities to prove the need for increased reimbursement.

How does this work with Home Care Prior Authorizations? Does the home care provider need to request the tier level modifier with the PA?

The prior authorizations and plan of care should not have Tier Modifiers discussed. Only the reimbursement document identifies the tier level by the added modifier.

Do RNs and LPNs receive the same percentage increase in the Tier Level reimbursement?

Yes, the RNs and LPNs do receive the same percentage increase in the Tier Level reimbursement?

(See Home Health Care High Acuity Guide: Pages 9,16)

Can you clarify if the recent hospitalization or exacerbation needs to be for that diagnosis?

Within the Home Health Care High Acuity Guide, each tier level explains the standard and specific diagnosis codes with the code description. The services provided by the agency staff must relate back to the specific diagnosis codes.

Example: A person has a diagnosis of E66.2 described as morbid (severe) obesity with alveolar hypoventilation and was hospitalized with cellulitis due to obesity. The Home Health referral and POC will reflect cellulitis and E66.2. The POC diagnosis list should also include the E66.2 code as cellulitis is not on the approved list. The reimbursement submission allows for 25 codes so each of these codes needs to be included for reimbursement.

Example: A person has a diagnosis of E66.2 described as morbid (severe) obesity with alveolar hypoventilation and was hospitalized with cellulitis due to obesity. The Home Health referral and POC will reflect cellulitis and E66.2. The Home Health Aide may be needed to assist in bathing, dressing, and other personal cares. The Home Health Aide services would be submitted with a U1, indicating a Tier 1.

Example: The client was hospitalized with a cerebral infarction due to thrombus of right middle cerebral artery (163.311) resulting in hemiplegia and hemiparesis (169.35). The Home Health Team is assisting in the transition to home, bathing, training, and therapies. The 163.311 would be the billing code for which the modifier is effective, but the 169.53 would also be used on the Plan of Care.

If upon documentation review, the claim is denied for higher reimbursement, will the provider need to submit a new claim without the modifiers to be paid the basic rate?

Yes, the claim will need to be resubmitted.

Will the home health provider agency know the reimbursement amount prior to admitting the client?

The provider agency could calculate the amount expected. Identified on the Iowa Medicaid Home Health Services Website; “The per visit rate is a fee schedule that is based on the low utilization payment adjusted (LUPA) methodology.” The services provided would meet the acuity identified by the diagnosis codes and documentation. The provider could calculate what each service would be submitted for reimbursement.

When the member is receiving the services, the Higher reimbursement amount is covered by this acuity. The Provider will submit the claim that includes the billed charges equal to or higher than the anticipated reimbursement amount.

Example: The RN visit is typically at a LUPA rate of $100. The RN is completing an assessment, filling the medication box, and providing education to a person with the diagnosis code E10.42, described as type 1 diabetes mellitus with diabetic polyneuropathy (a Tier 1 diagnosis). The agency would submit this visit as a Tier 2 reimbursement level, raising the typical LUPA rate by 30%. At the very least, the agency would submit the claim for $130. The documentation must clearly identify the care the RN provided during the specific visit.

What is the requirement for the members’ services to be eligible for acuity reimbursement?

The member must have been hospitalized or been seen by a provider within the past 14 days, to report a condition change. The member focus will be through SMART goals identifying improvement, not attention on chronic level of needs.

What is the requirement of the MCOs for billing to be separated by modifiers?

Claim submission includes the ability to submit multiple visits on a single UB04. Each visit line will have the modifier indicating the higher reimbursement.

See Home Health Care High Acuity Guide: page 21.

If a recoupment occurs, will that be the total amount for the visit or just the percent of increase?

It could be either depending about the recoupment.

How does this apply to the individual with long-term and intense conditions and service needs?

It is recognized some of the individuals served with the diagnosis' present in the guide could have chronic needs. The acuity opportunity is to support them in transition from a change in condition to an improvement in status or to help the person to the chronic level of functioning. The chronic level of functioning becomes the routine care.

CareBridge Updates: For applicable EVV services, visits either being sent to or captured in CareBridge will require the necessary modifier(s) and the appropriate corresponding rate. EVV claims will continue to be generated out of CareBridge for the MCOs, this includes eligible EVV services with the high acuity modifiers (U1, U2, or U3).

CareBridge Users: CareBridge is updating the Provider Portal to enable functionality that allows providers to add a high acuity modifier to a visit. It is critical that providers also set the appropriate rate for the high acuity service and modifier in the CareBridge Provider Portal.

Third-Party EVV Users: CareBridge is updating the *CareBridge EVV Integration Guide and Technical Specifications* to include the high acuity modifiers. It is critical that providers also send the appropriate rate for the high acuity service and modifier in the EVV Visit File that is transmitted to CareBridge via their third-party EVV solution.

Note: CareBridge will not implement any validations related to the required diagnosis codes in relation to the tier or modifiers as part of this process. It is the providers' responsibility to ensure that high acuity services are being captured with the correct diagnosis code associated with the visit and that this diagnosis code is being transmitted to CareBridge if using a third-party EVV solution.

a. CareBridge is working with the MCOs and Iowa Medicaid to develop training materials on how to add modifiers for qualifying visits. This information will be shared with providers prior to the July 1st, 2025 implementation date and will be available in the CareBridge Iowa Resource Library.

b. CareBridge is actively collaborating with the MCOs and Iowa Medicaid to ensure complete alignment on requirements. The current target date for final approval and sign-off is May 1, 2025. Upon approval, the technical specifications will be updated accordingly.

What is the time frame for post pay audits?

The MCO post pay reviews are explained on page 22 of The Home Health Care High Acuity Guide. Post pay reviews may be completed up to 2 years since the claim was last finalized.

How is Iowa Medicaid FFS billing process changing?

Please see page 22 of The Home Health Care High Acuity Guide.

What happens if funding runs out for this program?

The funding for this project will be monitored closely. If there are any concerns regarding the funds, notification will occur.

Will this additional reimbursement include supplies?

The Tier Reimbursement is for what is specified within The Home Health Care High Acuity Guide.

We have concerns with some of the codes identified in The Home Health Care High Acuity Guide. Can we change those codes?

The codes in the current Home Health Care High Acuity Guide will stay as they are at this time.

Looking at the requirements for a Level II Tier, does the patient have to have all care requirements listed or is it any of those to qualify?

It is any of those to qualify, along with the documentation.

Are Waiver Members eligible for the tiered Modifier?

If the member meets the criteria for the Tier Level explained in The Home Health Care High Acuity Guide, eligibility is present with the documentation.

Scenario 1

January 1: A patient is discharged from a hospital.

January 4: The patient is admitted to home health with qualifying conditions and diagnoses for tier payments.

Does the clock on the 14-day count start on the date of discharge from the hospital, the day after discharge from the hospital, or from the date of admittance to home health following a hospital stay?

Answer

In the scenario provided the response would be:

January 1: Hospital Day 0

January 2: Day 1

January 3: Day 2

January 4: Day 3

Scenario 2

The patient is admitted to home health on 01/04. The patient goes to the provider office on 01/12. The provider notes a worsening condition requiring home visits every day of the week. Does a new 14-day clock start because of the provider visit, meaning that the patient could potentially be eligible for 2 “series” of tier payments?

If you are changing your 485 plan of care and updating your OASIS, **YES.**

The signed 485 will need to be added to the documentation when requested.