Home Health Care High Acuity Guide

(Updated 06/30/2025)

Iowa Medicaid
Iowa HHS

IOWA
Health and
Human Services

Contents

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. The 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.

Starting on July 1, 2025, Iowa Medicaid reimburses a home health care agency for the services provided that meet a medical necessity. The increase in reimbursement for services provided must meet the identified Tier Level necessity and documentation requirements.

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 Agencies 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 summited for receipt of payment for the services rendered.

The maximum "Period of Consideration" for high-acuity tier billing is the 60 days certification period from the date of the OASIS Start of Care ("SOC"). A Period of Consideration for high-acuity tier services may be initiated with an OASIS Resumption of Care ("ROC"), or OASIS Significant Change of Condition ("SCC") if eligibility requirements are met. The Period of Consideration for any tier payment initiates only for those SOCs, ROCs, or SCCs occurring within 14 days of a hospital discharge or provider visit and for a tier diagnosis or condition being directly addressed as a result of that discharged hospitalization or provider visit. This does not mean that home health care services are no longer needed, but the acuity is likely stabilized.

Documentation must be reflective of the tier reimbursement request.

Tier billing should not occur following recognized patient improvement in the tier-related condition, i.e. health or functional goals for the tier diagnosis are completed.

*Members who are **eligible for reimbursement** from a primary payer are **not eligible** for the High Acuity Home Health Care reimbursement.*

Tier 1

The Home Health Aide (HHA) claims should be submitted at a Tier 1 level for **all relevant diagnosis codes in this guide**. If the HHA is providing services, the Tier 1 level is used for the claim submission.

HHA: Documentation as per 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.
- The provider must order HHA services on the 485.
- Services may be provided for up to seven days per week, not to exceed 28 hours per week.

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 had a hospitalization or a provider visit within the past 14 days with the provider direction of decline or complication in status. This member should be able to improve rather than one who is at 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:

- **RN or LPN in person visit (not telehealth) is always a Tier 2 unless providing cares for a Tier 3 diagnosis,** (If the RN or LPN are providing services for a Tier 1 diagnosis, submit as U2)
- **2 person transfers, - clearly documented why 2 persons are required -** the proof supporting the care provided **must** be present in the documentation records.
- **Multiple visits the same day -clearly documented why -** the proof supporting the care provided **must** be present in the documentation records.

- **RN Documentation for all visits regardless of Tier level:** 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 Documentation for all visits regardless of Tier level:** 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, as needed:
        - 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).

Members with Dementia, Neurocognitive Disorders, Quadriplegia
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
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

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.

Relevant codes:

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). Report on the patient response to teaching. Always remember: the proof supporting 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.

For all Diagnosis Codes in Tier 3, the patient 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
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

Billing, Claims, and Reimbursement:

Tier	Description	Billing Guidance
Basic	Services performed were considered "standard"	Provider submits claim normally
Tier 1	Receiving a 10% increase to the LUPA rate	Provider submits the claim with the U1 modifier
Tier 2	Receives a 30% increase to the LUPA rate	Provider submits the claim with the U2 modifier
Tier 3	Receives a 60% increase to the LUPA rate	Provider submits the claim with the U3 modifier

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.

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 Tier 3. The U3 modifier would need to be billed with the appropriate procedure code and 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 (and not Tier 3) 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 members 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 the 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.*****

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.

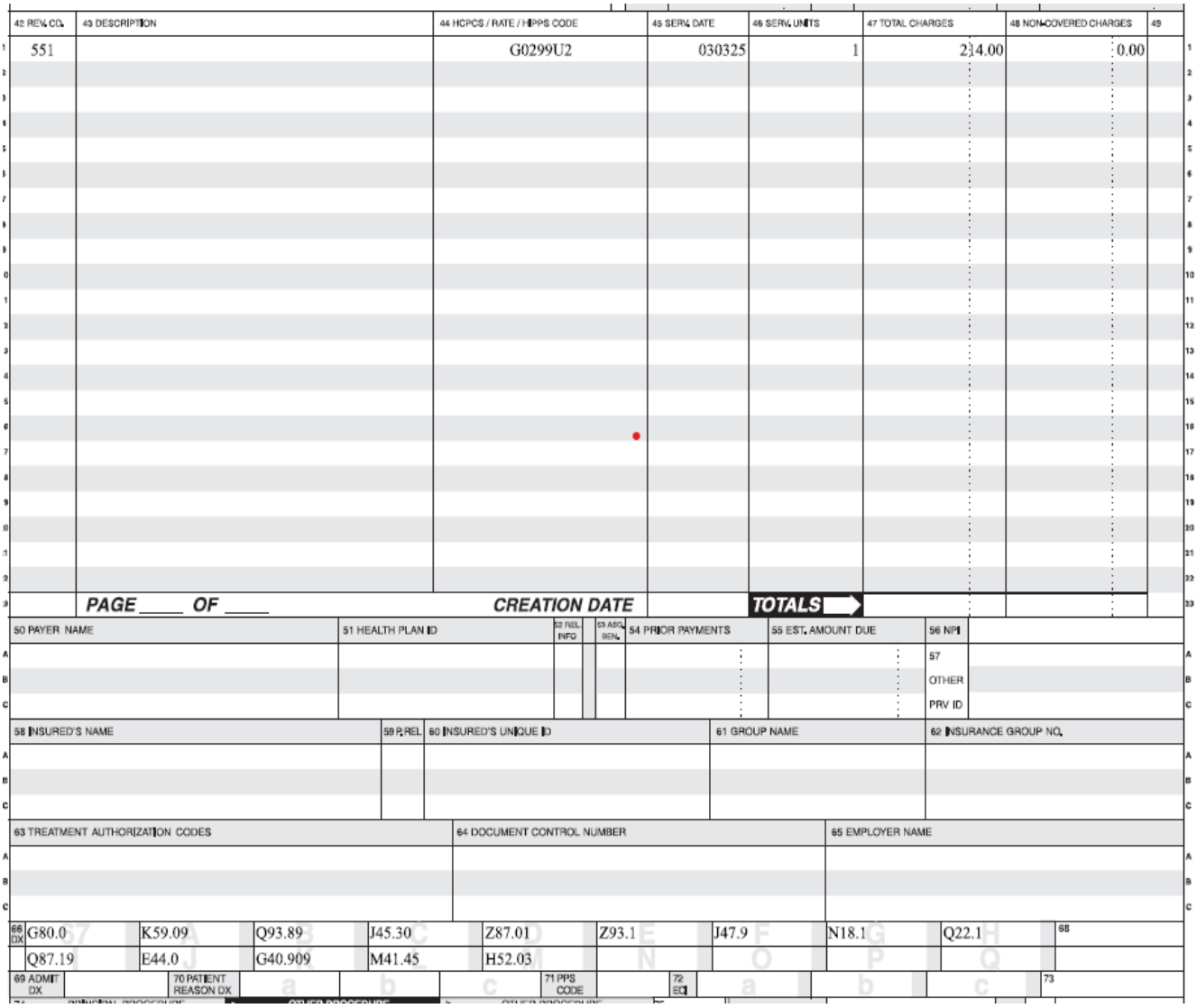
The Corrected Claim timeline is 365 from the Date of Adjudication up to 2 years from the date of service.

Coordination of Benefits
Members who are eligible for reimbursement from a **primary payer are not eligible** for the High Acuity Home Health Care reimbursement.

Documentation
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.

Coding Examples

A 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*. The claim submitted will be a U2.



42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
551		G0299U2	030325	1	214.00	0.00	
	PAGE ____ OF ____	CREATION DATE		TOTALS			

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
						57 OTHER PRV ID	

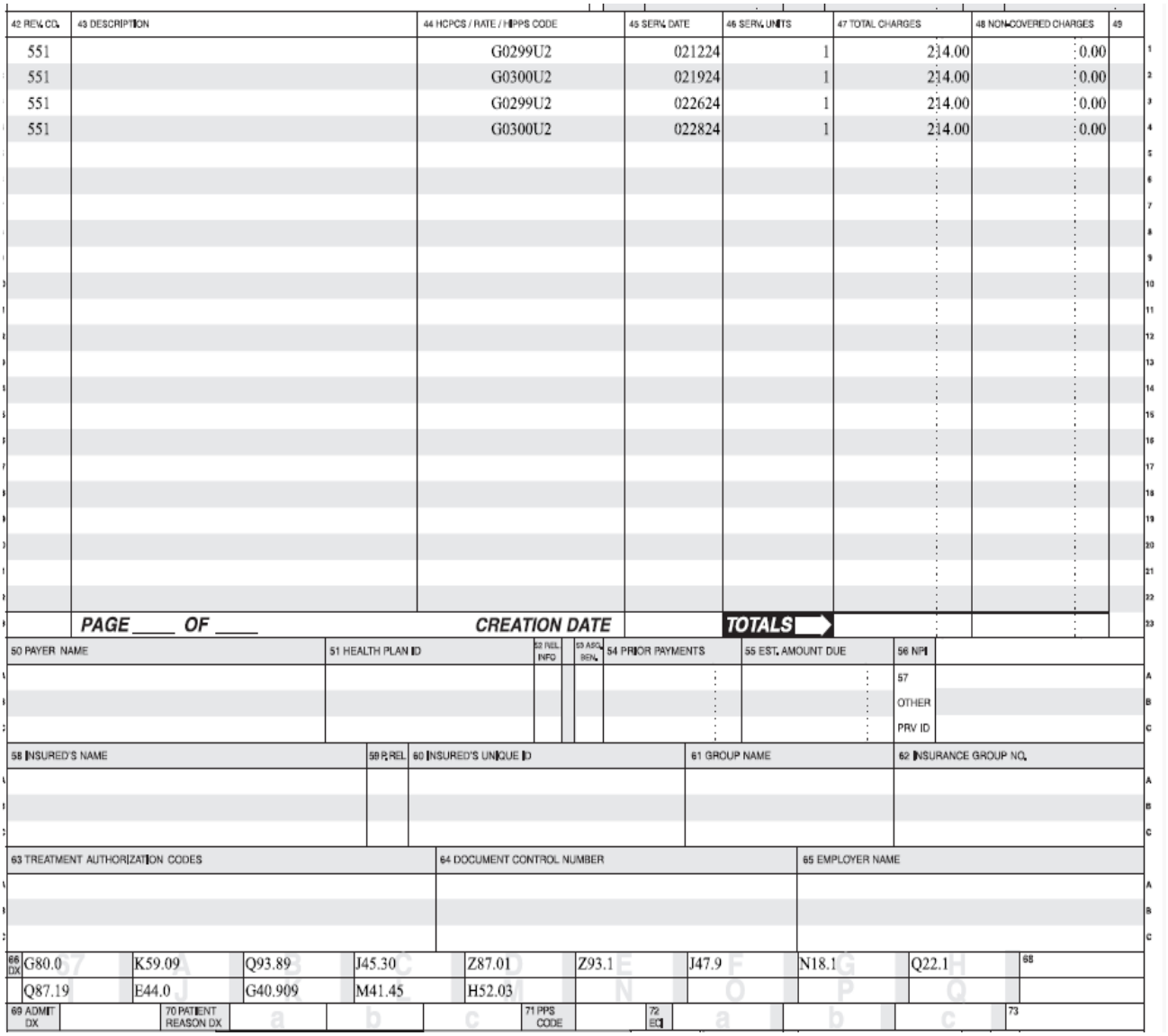
58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX											68
	G80.0	K59.09	Q93.89	J45.30	Z87.01	Z93.1	J47.9	N18.1	Q22.1		
	Q87.19	E44.0	G40.909	M41.45	H52.03						

69 ADMIT DX		70 PATIENT REASON DX				71 PPS CODE		72 ECI				73
			a	b	c				a	b	c	

This next claim identified a Medicaid member requiring assessment, teachings and med box filling on different days of the month. Note multiple claims on one form.



42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
551		G0299U2	021224	1	214.00	0.00	
551		G0300U2	021924	1	214.00	0.00	
551		G0299U2	022624	1	214.00	0.00	
551		G0300U2	022824	1	214.00	0.00	
	PAGE ____ OF ____	CREATION DATE		TOTALS			

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
						57	A
						OTHER	B
						PRV ID	C

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
					A
					B
					C

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
			A
			B
			C

66 DX											67	67A	67B	67C	67D	67E	67F	67G	67H	67I	67J	67K	67L	67M	67N	67O	67P	67Q	68
	G80.0	K59.09	Q93.89	J45.30	Z87.01	Z93.1	J47.9	N18.1	Q22.1																				
	Q87.19	E44.0	G40.909	M41.45	H52.03																								

69 ADMIT DX		70 PATIENT REASON DX		a	b	c	71 PPS CODE		72 ECI	a	b	c	73

The Physical Therapist does not receive any acuity increase.

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
421		G0151	011425	1	210.00	0.00		1
421		G0151	011625	1	210.00	0.00		2
421		G0151	012125	1	210.00	0.00		3
421		G0151	012325	1	210.00	0.00		4
421		G0151	013025	1	210.00	0.00		5
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	PAGE ____ OF ____	CREATION DATE		TOTALS				23

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
						57	A
						OTHER	B
						PRV ID	C

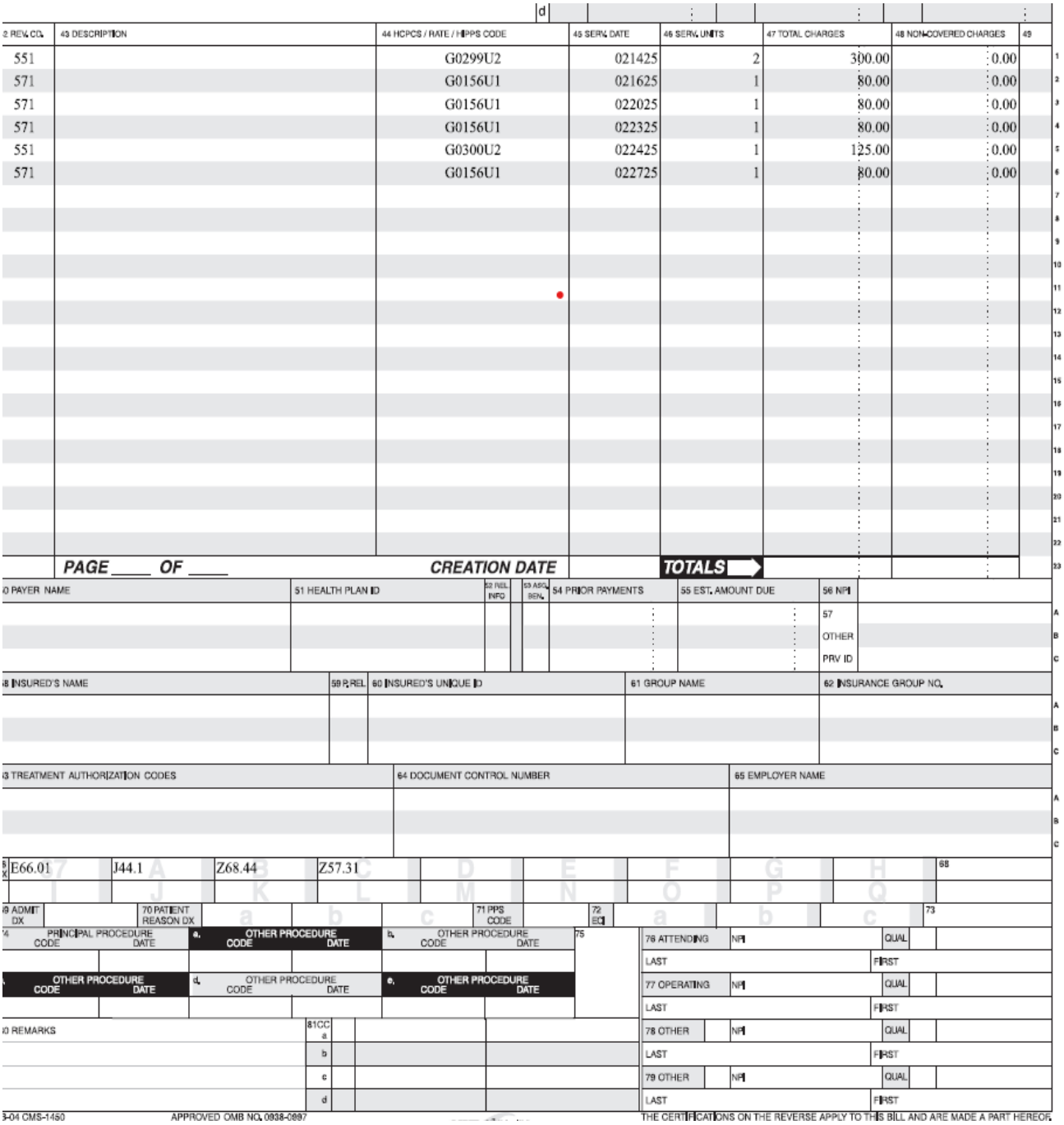
58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
					A
					B
					C

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
			A
			B
			C

66 DX											68
	G89.29	M25.512	G12.1	M25.511	E43						
	I	J	K	L	M	N	O	P	Q		

69 ADMIT | 70 PATIENT | 71 PPS | 72 | 73

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



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42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED 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
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	PAGE ____ OF ____	CREATION DATE		TOTALS			23

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
						57	A
						OTHER	B
						PRV ID	C

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
					A
					B
					C

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
			A
			B
			C

67	A	B	C	D	E	F	G	H	66
E66.01	J44.1	Z68.44	Z57.31						
I	J	K	L	M	N	O	P	Q	

69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 PPS CODE		72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI	QUAL.	
LAST		FIRST	
77 OPERATING	NPI	QUAL.	
LAST		FIRST	
78 OTHER	NPI	QUAL.	
LAST		FIRST	
79 OTHER	NPI	QUAL.	
LAST		FIRST	

80 REMARKS	81CC		
	a		
	b		
	c		
	d		

3-04 CMS-1450 APPROVED OMB NO. 0938-0997 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 by 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 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 pertain to Home Health Services.

All provider manuals specific to Polices 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 members' comprehensive needs are met, the HHS POC must include all services, regardless of funding source, and unpaid support(s) 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.