130 CMR 403.000: HOME HEALTH AGENCY

Section

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403.401: Introduction

All home health agencies participating in MassHealth must comply with MassHealth regulations including, but not limited to, 130 CMR 403.000 and 130 CMR 450.000: *Administrative and Billing Regulations*. Home health agencies that provide Continuous Skilled Nursing (CSN) services must also comply with 130 CMR 438.000: *Continuous Skilled Nursing Agency*.

403.402: Definitions

The following terms used in 130 CMR 403.000 have the meanings given in 130 CMR 403.402, unless the context clearly requires a different meaning. The reimbursed services defined in 130 CMR 403.402 are not determined by these definitions, but by the application of regulations elsewhere in 130 CMR 403.000 and 130 CMR 450.000: *Administrative and Billing Regulations.*

Accountable Care Organization (ACO) – an entity that enters into a population-based payment model contract with EOHHS as an accountable care organization, wherein the entity is held financially accountable for the cost and quality of care for an attributed or enrolled member population. ACOs include Accountable Care Partnership Plans, Primary Care ACOs, and MCO-administered ACOs.

Activities of Daily Living (ADL) – activities related to personal care, specifically bathing, grooming, dressing, toileting/continence, transferring/ambulation, and eating.

Branch Office – a location or site from which a home health agency provides services within a portion of the total geographic area served by the parent home health agency. The parent home health agency must provide supervision and administrative control of any branch office on a daily basis.

Calendar Week – seven consecutive days beginning Sunday at midnight and ending Saturday at 11:59 P.M.

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Capitated Program – an ICO, SCO, ACO, or PACE organization, or any other entity that, according to a contract with EOHHS, covers home health and other medical services for members on a capitated basis.

Certification Period – a period of no more than 60 days in which the member's physician or ordering non-physician practitioner certified that the plan of care is medically appropriate and necessary.

Complex-care Member – a MassHealth member whose medical needs, as determined by the MassHealth agency or its designee, are such that he or she requires a nurse visit of more than two continuous hours of nursing services to remain in the community.

Continuous Skilled Nursing (CSN) Services – skilled nursing care provided by a licensed nurse to complex-care members who require more than two continuous hours of nursing services per day.

Home Health Agency – a public or private organization that provides nursing and other therapeutic services to individuals whose place of residence conforms to the requirements of 42 CFR 440.70(c). Home health agency providers are governed by 130 CMR 403.000.

Home Health Aide – a person who is employed or contracted by a home health agency and meets the qualifications of a Home Health Aide to perform certain personal-care and other health-related services as described in 130 CMR 403.416(B) and according to 42 CFR 484.80.

Homemaker – a person who performs light housekeeping duties (for example, cooking, cleaning, laundry) for the purpose of maintaining a household.

Integrated Care Organization (ICO) — an organization with a comprehensive network of medical, behavioral health care, and long-term services and supports providers that integrates all components of care, either directly or through subcontracts, and has contracted with EOHHS and the Centers for Medicare & Medicaid Services (CMS) and been designated as an ICO to provide services to dual eligible individuals under M.G.L. c. 118E. ICOs are responsible for providing enrolled members with the full continuum of Medicare- and MassHealth-covered services.

Intermittent Skilled Nursing Visits – nursing services provided by a licensed nurse that are necessary to provide targeted skilled nursing assessment for a specific member medical need, and/or discrete procedures and/or treatments, typically for less than two consecutive hours, and limited to the time required to perform those duties.

Long-term Services and Supports (LTSS) – certain MassHealth-covered services intended to enable a member to remain safely in the community. Such services include, but are not limited to, home health, durable medical equipment, oxygen and respiratory equipment, personal-care attendant, and other health-related services as determined by the MassHealth agency or its designee.

Managed Care Organization (MCO) – any entity with which the MassHealth agency contracts under its MCO program to provide, arrange for, and coordinate care and certain other medical services to members on a capitated basis, and is approved by the Massachusetts Division of Insurance as a health maintenance organization (HMO), and is organized primarily for the purpose of providing health care services.

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Maintenance Program – repetitive services, required to maintain or prevent the worsening of function, that do not require the judgment and skill of a licensed therapist for safety and effectiveness.

Marketing – any communication from a home health agency provider, or its agent, to a member, or his or her family or caregivers, that can reasonably be interpreted as intended to influence the member's choice of home health agency provider, whether by inducing that member

(1) to retain that home health agency provider to provide home health agency services to the member;

(2) not to retain home health agency services from another home health agency provider; or

(3) to cease receiving home health agency services from another home health agency provider.

Medical History – a component of the member's medical record that provides a summary of all health-related information about the member. A history includes, but is not limited to, medical and nursing care histories.

Medical Record – documentation, maintained by the home health agency, that includes medical history, diagnoses, physician or ordering non-physician practitioner orders, discipline-specific progress notes, member assessments, the member's plan(s) of care, and other information related to the member in accordance with 130 CMR 403.419(C).

Medical Records Release Form – a signed authorization from the member or the member's parent or legal guardian, if the member is a minor, that allows the designated releasee to access the member's confidential health information from other health-care providers.

Medication Administration Visit – a nursing visit for the sole purpose of administration of medications where the targeted nursing assessment is medication administration and patient response only, and when the member is unable to perform the task due to impaired physical, cognitive, behavioral, and/or emotional issues, no able caregiver is present, the member has a history of failed medication compliance resulting in a documented exacerbation of the member's condition, and/or the task including the route of administration of medication requires a licensed nurse to provide the service. A medication administration visit may include administration of oral, intramuscular, and/or subcutaneous medication or administration of medications other than oral, intramuscular and/or subcutaneous medication, but does not include intravenous administration.

Nurse – a person licensed as a registered nurse or a licensed practical nurse by a state's board of registration in nursing of the state in which they practice.

Nursing Services – the assessment, planning, intervention, and evaluation of goal-oriented nursing care that requires specialized knowledge and skills acquired under the established curriculum of a school of nursing approved by a board of registration in nursing. Such services include only those services that require the skills of a nurse.

Occupational Therapist – a person who is currently licensed by and in good standing with the Massachusetts Division of Professional Licensure, Board of Allied Health Professionals, and is qualified in accordance with 42 CFR 484.4.

Occupational Therapy – therapy services, including diagnostic evaluation and therapeutic intervention, designed to improve, develop, correct, rehabilitate, or prevent, maintain, or slow the worsening of functions that affect the activities of daily living that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Occupational therapy programs are designed to improve quality of life by recovering competence, preventing further injury or disability, and to improve the individual's ability to perform tasks required for independent functioning, so that the individual can engage in activities of daily living.

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Occupational Therapy Assistant – a person who is currently licensed and in good standing with the Massachusetts Division of Professional Licensure, Board of Allied Health Professionals, must work under the supervision of a licensed occupational therapist as described in 130 CMR 432.404(B), and is qualified in accordance with 42 CFR 484.4.

Ordering Non-physician Practitioner – a nurse practitioner, physician's assistant, or clinical nurse specialist who is licensed in the state of Massachusetts to perform medical services according to their scope of practice. Ordering non-physician practitioners are also allowed to conduct face-to-face encounters. Nurse midwives are not allowed to order home health services.

Physical Therapist – a person who is currently licensed by and in good standing with the Massachusetts Division of Professional Licensure, Board of Allied Health Professionals, and is qualified in accordance with 42 CFR 484.4.

Physical Therapy – therapy services, including diagnostic evaluation and therapeutic intervention, designed to improve, develop, correct, rehabilitate, or prevent, maintain, or slow the worsening of physical functions that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Physical therapy emphasizes a form of rehabilitation focused on treatment of dysfunctions involving neuromuscular, musculoskeletal, cardiovascular/pulmonary, or integumentary systems through the use of therapeutic interventions to optimize functioning levels.

Physical Therapy Assistant – a person who is currently licensed by and in good standing with the Massachusetts Division of Professional Licensure, Board of Allied Health Professionals, and must work under the supervision of a licensed physical therapist as described in 130 CMR 432.404(A), and is qualified in accordance with 42 CFR 484.4.

Primary Caregiver – the individual, other than the nurse or home health aide, who is primarily responsible for providing ongoing care to the member.

Programs of All-inclusive Care for the Elderly (PACE) – the Programs of All-inclusive Care for the Elderly (PACE), as described in 42 CFR 460, and 130 CMR 519.007(C): *Program of All-inclusive Care for the Elderly (PACE)*.

Provider Portal – the online site by which LTSS providers, as applicable, submit all MassHealth LTSS prior authorization requests to a MassHealth designated vendor.

Request and Justification for Nursing and Home Health Aide Services Form – the form describing the nursing and home health aide needs of a member that a home health agency is required to submit to the MassHealth agency or its designee, when requesting prior authorization (PA) for intermittent nursing service through a paper PA.

Request and Justification for Therapy Services and Home Health Aide Services Form – the form describing the therapy and home health aide needs of a member that a home health agency may submit to the MassHealth agency or its designee, when requesting prior authorization for therapy services.

Respite Services – a range of services provided on a short-term or intermittent basis in response to the need for relief of those persons who normally provide this care.

Senior Care Organization (SCO) – a managed care organization that participates in MassHealth under a contract with the MassHealth agency to provide coordinated care and medical services through a comprehensive network to eligible members 65 years of age or older. SCOs are responsible for providing enrolled members with the full continuum of MassHealth-covered services, and for dual eligible members, the full continuum of MassHealth and Medicare-covered services.

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Skilled Nursing Visit – a nursing visit that is necessary to provide targeted skilled nursing assessment for a specific member medical need, and/or discrete procedures and/or treatments, typically for less than two consecutive hours, and limited to the time required to perform those duties.

Speech/Language Therapist (Speech/Language Pathologist) – a person who is currently licensed by and in good standing with the Massachusetts Board of Registration in Speech-language Pathology and Audiology and is qualified in accordance with 42 CRF 484.4.

Speech/Language Therapy – therapy services, including diagnostic evaluation and therapeutic intervention, that are designed to improve, develop, correct, rehabilitate, or prevent, maintain, or slow the worsening of speech/language communication and swallowing disorders that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Speech and language disorders are those that affect articulation of speech, sounds, fluency, voice, swallowing, and those that impair comprehension, spoken, written, or other symbol systems used for communication.

Unfair or Deceptive Acts or Practices – any unfair or deceptive acts or practices, as that term is defined in M.G.L. c. 93A, § 2, and the regulations promulgated thereunder by the Massachusetts Attorney General.

Visit – a personal contact in the member's home or other non-institutional setting, for the purpose of providing a covered service by a registered or licensed nurse, home health aide, or physical, occupational, or speech/language therapist employed by, or contracting with, the home health agency.

403.404: Eligible Members

(A) MassHealth Members. MassHealth pays for home health services for eligible members, subject to the restrictions and limitations described in 130 CMR 450.105: *Coverage Types* which specifically states, for each MassHealth coverage type, which services are covered and which members are eligible to receive those services.

(B) Recipients of the Emergency Aid to the Elderly, Disabled and Children Program. For information on covered services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program, *see* 130 CMR 450.106: *Emergency Aid to the Elderly, Disabled and Children Program*.

(C) For information on verifying member eligibility and coverage type, *see* 130 CMR 450.107: *Eligible Members and the MassHealth Card*.

403.405: Provider Eligibility: In-state

To participate in MassHealth, a Massachusetts home health agency must

(A) be certified as a provider of home health services under the Medicare program by the Massachusetts Department of Public Health and meet all requirements within the Medicare Conditions of Participation for home health agency services;

(B) obtain a MassHealth provider number before providing home health services;

(C) agree to periodic inspections, by the MassHealth agency or its designee, that assess the quality of member care and ensure compliance with 130 CMR 403.000;

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(D) participate in any Home Health Agency provider orientation required by the Executive Office of Health and Human Services (EOHHS);

(E) submit to the MassHealth agency or its designee a statement of fiscal soundness attesting to the financial viability of the home health agency provider supported by documentation to demonstrate that the provider has adequate resources to finance the provision of services in accordance with 130 CMR 403.000 and as specified in 130 CMR 403.419(D)(1);

(F) notify the MassHealth agency in writing within 14 days of any change in any of the information submitted in the provider application in accordance with 130 CMR 450.223(B): *Provider Contract: Execution of Contract* including, but not limited to, change of ownership, change of address, change in status of Medicare Certification and/or reaccreditation, and additional home health agency branch office;

(G) accept MassHealth payments as payment in full for all home health services;

(H) agree to comply with all the provisions of 130 CMR 403.000 and 450.000: *Administrative and Billing Regulations*, and all other applicable MassHealth rules and regulations; and

(I) meet all provider participation requirements described in 130 CMR 403.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

403.406: Provider Eligibility: Out of State

(A) To participate in MassHealth, an out-of-state home health agency located within 50 miles of the Massachusetts border must

(1) ensure that the agency and each participating branch is certified as a provider of home health services under the Medicare program;

(2) participate in the Medicaid program in its state and meet all requirements within the Medicare Conditions of Participation for home health agency services;

(3) provide home health services to a member who resides in a Massachusetts community near the border of the home health agency's state;

(4) obtain a MassHealth provider number before providing home health services; and

(5) notify the MassHealth agency in writing within 14 days of any change in any of the information submitted in the provider application in accordance with 130 CMR 450.223(B): *Provider Contract: Execution of Contract* including, but not limited to, change of ownership, change of address, change in status of Medicare Certification and/or reaccreditation, and additional home health agency branch office.

(B) To participate in MassHealth, an out-of-state home health agency located beyond 50 miles of the Massachusetts border must

(1) be certified as a provider of home health services under the Medicare program by the Medicare-certifying agency in its state;

(2) participate in the Medicaid program in its state;

(3) obtain a MassHealth provider number before providing home health services;

(4) provide services to a member in accordance with 130 CMR 450.109: *Out-of-state Services*;

(5) notify the MassHealth agency in writing within 14 days of

(a) any change in any of the information submitted in the provider application in accordance with 130 CMR 450.223(B): *Provider Contract: Execution of Contract* including, but not limited to, change of ownership, change of address, change in status of Medicare Certification and/or reaccreditation, and additional home health agency participating branch office.

(b) In addition, out-of-state providers also need to

1. accept MassHealth payments as payment in full for all home health services;

2. agree to comply with all the provisions of 130 CMR 403.000 and 130 CMR 450.000: *Administrative and Billing Regulations*, and all other applicable MassHealth rules and regulations; and

3. meet all provider participation requirements described in 130 CMR 403.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

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3. meet all provider participation requirements described in 130 CMR 403.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

403.407: Services Provided under Contract

(A) Introduction. A home health agency may provide home health services directly or through contractual arrangements made by the home health agency. Whether the services are provided directly or through contracts, the home health agency is responsible for submitting claims for services and for meeting the requirements in 130 CMR 403.000 and all other applicable state and federal requirements. A home health agency may provide services through contracts in the following situations:

(1) when a home health agency, in order to be approved to participate in MassHealth, makes arrangements with another agency or organization to provide the nursing, home health aide, or other therapeutic services that it does not provide directly; or

(2) when a home health agency that is already approved for participation in MassHealth makes arrangements with others to provide services it does not provide.

(B) Contract Requirements.

(1) If the home health agency contracts with another provider participating in MassHealth (*e.g.*, hospital, nursing facility, another home health agency, or hospice), a written contract must document the services to be provided and the corresponding financial arrangements.

(2) If the home health agency contracts with a provider that does not participate in MassHealth, the written contract must include

(a) a description of the services to be provided;

(b) the duration of the agreement and how frequently it is to be reviewed;

(c) a description of how personnel are supervised;

(d) a statement that the contracting organization will provide its services in accordance with the plan of care established by the member's physician in conjunction with the home health agency's staff;

(e) a description of the contracting organization's standards for personnel, including qualifications, functions, supervision, and in-service training;

(f) a description of the method of determining reasonable costs and payments by the home health agency for the specific services to be provided by the contracting organization; and

(g) an assurance that the contracting organization will comply with Title VI of the Civil Rights Act and all relevant MassHealth provider requirements.

403.408: Administrative Requirements

Whether services are provided by the home health agency directly or through contractual arrangements made by the agency, the agency must

(A) accept the member for treatment in accordance with its admission policies;

(B) maintain a complete medical record as defined at 130 CMR 403.402 relating to all services provided in accordance with 130 CMR 403.419(C)(3)(b);

(C) obtain from the physician or ordering non-physician practitioner the required certifications and recertifications of the plan of care in accordance with 130 CMR 403.420(C); and

(D) ensure that the home health agency's staff or designated review group review the medical necessity of services and the physician and ordering non-physician practitioner certification on a regular basis.

403.409: Clinical Eligibility Criteria for Home Health Services

(A) Member Must Be under the Care of a Physician or Ordering Non-physician Practitioner. The MassHealth agency pays for home health services only if the member's physician or ordering non-physician practitioner certifies the medical necessity for such services and establishes an individual plan of care in accordance with 130 CMR 403.420. A member may receive home health services only if he or she is under the care of a physician or ordering non-physician practitioner. (A podiatrist may be considered a physician for the purposes of meeting 130 CMR 403.409(A).) The physician or ordering non-physician practitioner providing the certification of medical necessity and submitting the plan of care for home health services must not be a physician or ordering non-physician practitioner on the staff of, or under contract with, the home health agency.

(B) Limitations on Covered Services. The MassHealth agency pays for home health services to a member who resides in a non-institutional setting, which may include, without limitation, a homeless shelter or other temporary residence or a community setting. In accordance with 42 CFR 440.70(c), the MassHealth agency does not pay for home health services provided in a hospital, nursing facility, intermediate care facility for the intellectually or developmentally disabled, or any other institutional facility providing medical, nursing, rehabilitative, or related care.

(C) Medical Necessity Requirement. In accordance with 130 CMR 450.204: *Medical Necessity*, and MassHealth Guidelines for Medical Necessity Determination for Home Health Services, the MassHealth agency pays for only those home health services that are medically necessary. Home health services are not to be used for homemaker, respite, or heavy cleaning or household repair.

(D) Availability of Other Caregivers. When a family member or other caregiver is providing services, including nursing services, that adequately meet the member's needs, it is not medically necessary for the home health agency to provide such services.

(E) Least Costly Form of Care. The MassHealth agency pays for home health agency services only when services are no more costly than medically comparable care in an appropriate institution and the least costly form of comparable care available in the community.

(F) Safe Maintenance in the Community. The member's physician or ordering non-physician practitioner and home health agency must determine that the member can be maintained safely in the community.

(G) Prior Authorization. Home health services require prior authorization. *See* 130 CMR 403.413 for requirements.

(H) Continuous Skilled Nursing (CSN) Services. For clinical eligibility criteria for CSN services, *see* 130 CMR 438.000: *Continuous Skilled Nursing Agency*.

403.410: Prior Authorization Requirements

(A) General Terms.

(1) Prior authorization must be obtained from the MassHealth agency or its designee as a prerequisite to payment after certain limits are reached, as described in 130 CMR 403.410. Without such prior authorization, the MassHealth agency will not pay providers for these services.

(2) Prior authorization determines only the medical necessity of the authorized service, and does not establish or waive any other prerequisites for payment such as member eligibility or resort to health insurance payment.

(3) Approvals for prior authorization specify the number of hours, visits, or units for each service that are medically necessary and payable each calendar week and the duration of the prior authorization period. The authorization is issued in the member's name and specifies frequency and duration of care for each service approved per calendar week.

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(4) The home health agency must submit all prior authorization requests in accordance with the MassHealth agency's administrative and billing regulations and instructions and must submit each such request to the appropriate addresses listed in Appendix A of the Home Health Agency Manual.

(5) In conducting prior authorization review, the MassHealth agency or its designee may refer the member for an independent clinical assessment to inform the determination of medical necessity for home health services.

(6) If authorized services need to be adjusted because the member's medical needs have changed, the home health agency must submit an adjustment request to the MassHealth agency or its designee.

(7) MassHealth only pays for services up to the amount authorized in the PA.

(B) Skilled Nursing and Medication Administration Visits for MassHealth Members Not Enrolled in a Capitated Program.

(1) The home health agency must obtain prior authorization for the provision of skilled nursing and medication administration visits beyond the amounts set forth in 130 CMR 403.410(B)(5). *See* 130 CMR 403.410(C) for prior authorization requirements relative to home health aide services. *See* 130 CMR 403.410(D) for prior authorization requirements relative to home health therapy services.

(2) To obtain prior authorization for skilled nursing and/or medication administration visits, the home health agency must submit to the MassHealth agency or its designee written physician or ordering non-physician practitioner orders that identifies the member's admitting diagnosis, frequency, and, as applicable, duration of nursing services, and a description of the intended nursing intervention.

(3) The home health agency must complete a prior authorization request through the Provider Portal or by using the Request and Justification for Nursing and Home Health Aide Services Form, if paper submission is necessary, in accordance with 130 CMR 403.410(B)(1) and 403.415, as applicable. This must be submitted to the MassHealth agency or its designee for all prior authorization requests for skilled nursing, medication administration, and home health aide services, as applicable.

(4) Prior authorization for any and all home health skilled nursing and medication administration visits is required whenever the services provided exceed more than 30 intermittent skilled nursing and/or medication administration visits in a calendar year.

(5) Any verbal request for changes in service authorization must be followed up in writing to the MassHealth agency or its designee within two weeks of the date of the verbal request.

(C) Home Health Aide Services for MassHealth Members Not Enrolled in a Capitated Program.

(1) The home health agency must obtain prior authorization for the provision of home health aide services beyond the amounts set forth in 130 CMR 403.410(C)(5).

(2) To obtain prior authorization for home health aide services, the home health agency must submit to the MassHealth agency or its designee written physician or ordering non-physician practitioner orders that identifies the member's admitting diagnosis, frequency of services, and, as applicable, duration of home health aide services, and a description of the intended interventions.

(3) The home health agency must complete a prior authorization request through the Provider Portal or by using the Request and Justification for Nursing and Home Health Aide Services Form, if paper submission is necessary, in accordance with 130 CMR 403.410(C)(1) and 403.416. This must be submitted to the MassHealth agency or its designee with all prior authorization requests for skilled nursing, medication administration visits, therapy, or home health aide services as applicable.

(4) Prior authorization for home health aide services is required whenever services provided exceed more than 240 home health aide units in a calendar year.

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(D) Therapy Services for All Members for Whom Therapies Are a Covered Service.

(1) The home health agency must obtain prior authorization from the MassHealth agency or its designee as a prerequisite for MassHealth payment as primary payer of the following services to eligible MassHealth members:

(a) more than 20 occupational-therapy or 20 physical-therapy visits, including any initial patient assessment or observation and evaluation or reevaluation visits, for a member within a calendar year;

(b) more than 35 speech-language therapy visits, including any initial patient assessment or observation and evaluation or reevaluation visits, for a member within a calendar year; and

(c) If a member requires home health aide services in addition to therapy services, prior authorization is required whenever the services provided exceed any of the limits set forth for therapy or home health aide services. The prior authorization request for home health aide services will need to include the request for physical, occupational, or speech/language therapy services.

(2) The home health agency must complete a prior authorization request through the Provider Portal or by using the Request and Justification for Therapy and Home Health Aide Services Form, if paper submission is necessary, in accordance with 130 CMR 403.410(D)(1) and 403.417. This form must be submitted to the MassHealth agency or its designee with all prior authorization requests.

(E) MassHealth Members Enrolled in a Capitated Program. For those members who are enrolled in a MassHealth-approved capitated program, the home health agency must follow the authorization procedures of the capitated program where applicable for home health services. For those members in a capitated program whose nursing service needs are more than two hours in duration and are not covered by the capitated program, the home health agency must comply with 130 CMR 403.438.

403.411: Notice of Approval or Denial of Prior Authorization

(A) Notice of Approval. For all approved prior authorization requests for home health services, the MassHealth agency or its designee sends written notice to the member and the home health agency about the frequency, duration, and intensity of care authorized, and the effective date of the authorization.

(B) Notice of Denial or Modification and Right of Appeal.

(1) For all denied or modified prior authorization requests, the MassHealth agency or its designee notifies both the member and the home health agency of the denial or modification, and the reason. In addition, the member will receive information about the member's right to appeal, and appeal procedure.

(2) A member may request a fair hearing if the MassHealth agency or its designee denies or modifies a prior authorization request. The member must request a fair hearing in writing within 30 days after the date of receipt of the notice of denial or modification. The Office of Medicaid Board of Hearings conducts the hearing in accordance with 130 CMR 610.000: *MassHealth: Fair Hearing Rules*.

403.412: Scope of Home Health Services

The MassHealth agency pays for the following home health services for eligible MassHealth members, subject to the restrictions and limitations described in 130 CMR 403.000 and 450.000: *Administrative and Billing Regulations*:

(A) nursing;

(B) home health aide; and

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(C) physical, occupational, and speech/language therapy.

403.413: Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services

The MassHealth agency pays for all medically necessary home health agency services for EPSDT-eligible members in accordance with 130 CMR 450.140: *Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services: Introduction* with prior authorization.

403.415: Nursing Services

(A) Conditions of Payment. Nursing services are payable only if all of the following conditions are met:

(1) there is a clearly identifiable, specific medical need for nursing services;

(2) the services are ordered by the member's physician or ordering non-physician practitioner and are included in the plan of care;

(3) the services require the skills of a registered nurse or of a licensed practical nurse under the supervision of a registered nurse, in accordance with 130 CMR 403.415(B);

(4) the services are medically necessary to treat an illness or injury in accordance with 130 CMR 403.409(C); and

(5) prior authorization is obtained where required in compliance with 130 CMR 403.410.

(B) Clinical Criteria.

(1) A nursing service is a service that must be provided by a registered nurse, or by a licensed practical nurse under the supervision of a registered nurse, to be safe and effective, considering the inherent complexity of the service, the condition of the member, and accepted standards of medical and nursing practice.

(2) Some services are nursing services on the basis of complexity alone (for example, intravenous and intramuscular injections, or insertion of catheters). However, in some cases, a service that is ordinarily considered unskilled may be considered a nursing service because of the patient's condition. This situation occurs when only a registered nurse or licensed practical nurse can safely and effectively provide the service.

(3) When a service can be safely and effectively performed (or self-administered) by the average nonmedical person without the direct supervision of a registered or licensed practical nurse, the service is not considered a nursing service, unless there is no one trained, able, and willing to provide it.

(4) Nursing services for the management and evaluation of a plan of care are medically necessary when only a registered nurse can ensure that essential care is effectively promoting the member's recovery, promoting medical safety, or avoiding deterioration.

(5) Medical necessity of services is based on the condition of the member at the time the services were ordered, what was, at that time, expected to be appropriate treatment throughout the certification period, and the ongoing condition of the member throughout the course of home care.

(6) A member's need for nursing care is based solely on his or her unique condition and individual needs, whether the illness or injury is acute, chronic, terminal, stable, or expected to extend over a long period.

(7) Medication Administration Visit. A nursing visit for the sole purpose of administering medication and where the targeted nursing assessment is medication administration and patient response only may be considered medically necessary when the member is unable to perform the task due to impaired physical, cognitive, behavioral, and/or emotional issues, no able caregiver is present, the member has a history of failed medication compliance resulting in a documented exacerbation of the member's condition, and/or the task of the administration of medication, including the route of administration, requires a licensed nurse to provide the service. A medication administration visit may include administration of oral, intramuscular, and/or subcutaneous medication or administration of medications other than oral, intramuscular and/or subcutaneous medication

403.416: Home Health Aide Services

(A) Conditions of Payment. Home health aide services are payable only if all of the following conditions are met:

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(1) home health aide services are medically necessary to
(a) directly support curative, rehabilitative, or preventative aspects of nursing or therapy services provided by the home health agency; and/or
(b) provide hands-on assistance throughout the task or until completion, with at least two activities of daily living (ADLs) defined as: bathing, grooming, dressing, toileting/ continence, transferring/ambulation, and eating.
(2) the frequency and duration of the home health aide services must be ordered by the physician or ordering non-physician practitioner and must be included in the plan of care for the member;
(3) the services are medically necessary to provide personal care to the member, to maintain the member's health, or to facilitate treatment of the member's injury or illness;
(4) prior authorization, where applicable, has been obtained where required in compliance with 130 CMR 403.410;
(5) the home health aide is supervised by a registered nurse or therapist for nursing services or therapy services, respectively, employed or contracted by the same home health agency as the home health aide. In the event that the home health agency contracts for, rather than directly employs, home health aides, such aides must be supervised in accordance with 42 CFR § 484.80(h), and 130 CMR 403.419(C);
(6) all services provided by the home health aide must be delivered at the direction of the registered nurse or therapist supervising the home health aide. The individualized patient care instructions must be included in the member's plan of care or attached to the member's plan of care; and
(7) the home health aide has completed a training and competency evaluation program as specified in 42 CFR 484.80(a)(b)(c) and the servicing home health agency has documented the home health aide's competency in all subject areas as described in 42 CFR 484.80(b)(3) within the last 12 months.

(B) Payable Home Health Aide Services Provided Pursuant to Nursing or Therapy Services. Payable home health aide services when home health aide services are provided pursuant to nursing or therapy services include, but are not limited to,
(1) personal-care services; such as bathing, dressing, grooming, caring for hair, nail, and oral hygiene, which are needed to facilitate treatment or to prevent deterioration of the member's health, changing the bed linen, shaving, deodorant application, skin care with lotions and/or powder, foot care, ear care, feeding, assistance with elimination, routine catheter care, and routine colostomy care;
(2) simple dressing changes that do not require the skills of a registered or licensed nurse;
(3) medication reminders for medications that are ordinarily self-administered and that do not require the skills of a registered or licensed nurse;
(4) assistance with activities that are directly supportive of skilled therapy services; and
(5) routine care of prosthetic and orthotic devices.

(C) Payable Home Health Aide Services for ADL Supports Only. Home health aide services for ADL supports are only reimbursable if the member has two or more ADL needs that require hands-on assistance. This service requires a non-skilled nursing visit for assessment of the member and assessment and supervision of the home health aide care plan once every 60 days. Payable home health aide services for ADL supports only include:
(1) hands-on assistance with ADLs as described in 130 CMR 403.402;
(2) IADL support services provided incidental to hands-on ADL assistance;
(3) monitoring or supervision provided incidental to or concurrently with hands-on ADL support;
(4) personal care services as described in 130 CMR 403.416(B)(1) if provided in addition to hands-on ADL support as described in 130 CMR 403.402.

(D) Nonpayable Home Health Aide Services. The MassHealth agency does not pay for homemaker, respite, or chore services provided to any MassHealth member in the absence of ADL needs. It is not permissible for home health agencies to bill MassHealth for home health aide services for the primary purpose of providing nonpayable home health aide services, or incidental services as described in 130 CMR 403.416(E). Additionally, home health aide services are nonpayable for monitoring of anticipatory and unpredictable services.

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(E) Incidental Services. When a home health aide visits a member to provide a health-related service, the home health aide may also perform some incidental services that do not meet the definition of a home health aide service (for example, light cleaning, preparing a meal, removing trash). However, the purpose of a home health aide visit must not be to provide these incidental services and home health aide visits are not reimbursable if used to primarily conduct incidental services, since they are not health-related services.

403.417: Physical, Occupational, and Speech/Language Therapy

(A) Physical Therapy. The MassHealth agency pays for up to 20 visits within a calendar year for physical therapy without prior authorization when provided to an eligible MassHealth member, if the services are

(1) prescribed by a physician or an ordering non-physician practitioner;
(2) directly and specifically related to an active treatment regimen;
(3) of such a level of complexity and sophistication that the judgment, knowledge, and skills of a licensed physical therapist are required;
(4) performed by a licensed physical therapist, or by a licensed physical therapy assistant under the supervision of a licensed physical therapist;
(5) considered under accepted standards of medical practice to be a specific and effective treatment for the member's condition;
(6) medically necessary for treatment of the member's condition. Services related to activities for the general good and welfare of members (for example, general exercises to promote overall fitness and flexibility, and activities to provide diversion or general motivation) do not constitute physical therapy services for purposes of MassHealth payment; and
(7) certified by the physician or an ordering non-physician practitioner every 60 days.

(B) Occupational Therapy. The MassHealth agency pays for up to 20 visits within a calendar year for occupational therapy without prior authorization when provided to an eligible MassHealth member, if the services are

(1) prescribed by a physician or an ordering non-physician practitioner;
(2) performed by a licensed occupational therapist, or by a licensed occupational therapy assistant under the supervision of a licensed occupational therapist;
(3) considered under accepted standards of medical practice to be a specific and effective treatment for the member's condition;
(4) medically necessary for treatment of the member's illness or injury. Services related to activities for the general good and welfare of the member (for example, general exercises to promote overall fitness and flexibility, and activities to provide diversion or general motivation) do not constitute occupational therapy services for purposes of MassHealth payment; and
(5) certified by the physician or an ordering non-physician practitioner every 60 days.

(C) Speech/Language Therapy. The MassHealth agency pays for up to 35 visits within a calendar year for speech and language therapy without prior authorization when provided to an eligible MassHealth member, if the services are

(1) prescribed by a physician or an ordering non-physician practitioner;
(2) performed by a licensed speech and language therapist;
(3) medically necessary for treatment of the member's illness or injury; and
(4) certified by the physician or an ordering non-physician practitioner every 60 days.

(D) Maintenance Program.

(1) The MassHealth agency pays for the establishment of a maintenance program and the training of the member, member's family, or other persons to carry it out, as part of a regular treatment visit, not as a separate service. The MassHealth agency does not pay for performance of a maintenance program, except as provided in 130 CMR 403.417(D)(2).

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(2) In certain instances, the specialized knowledge and judgment of a licensed therapist may be required to perform services that are part of a maintenance program, to ensure safety or effectiveness that may otherwise be compromised due to the member's medical condition. At the time the decision is made that the services must be performed by a licensed therapist, all information that supports the medical necessity for performance of such services by a licensed therapist, rather than a non-therapist, must be documented in the medical record.

403.418: Medical Supplies

Home health agencies must submit prescriptions and orders for medical supplies only to vendors who are participating in MassHealth. Medical supplies, equipment, and appliances must be prescribed or ordered by the member's physician or non-physician practitioner and must be provided and claimed directly by appropriate vendors in accordance with MassHealth regulations governing drugs, restorative therapy services, rehabilitative services, and durable medical equipment.

403.419: Provider Responsibilities

In addition to meeting all of the qualifications set forth in 130 CMR 403.000 and 450.000: *Administrative and Billing Regulations*, home health agencies must meet all of the following requirements.

(A) Policies and Procedures. Each home health agency must develop, maintain, review, update, and comply with comprehensive policies and procedures governing the delivery of home health services which at a minimum must contain the following as applicable for the services the agency delivers:

(1) administrative policies and procedures including, but not limited to:
- (a) human resource and personnel;
- (b) staff and staffing requirements;
- (c) backup staff in the event coverage is required due to illness, vacation, or other reasons;
- (d) staff education and training;
- (e) home health agency staff evaluation and supervision;
- (f) emergencies including fire, safety and disasters, including notifying the fire department and police in emergencies;
- (g) member rights;
- (h) human rights and nondiscrimination;
- (i) incident and accident reporting;
- (j) staff and member grievances;
- (k) staff cultural competency;
- (l) quality assurance and improvement;
- (m) home health aide training;
- (n) emergency services and plans;
- (o) recognizing and reporting abuse (physical, sexual, emotional, psychological), neglect, self-neglect and financial exploitation;
- (p) Health Insurance Portability and Accountability Act (HIPAA); and
- (q) procedures to be followed if a member is missing or lost.

(2) clinical policies and procedures including, but not limited to:
- (a) clinical evaluations;
- (b) privacy and confidentiality;
- (c) documentation of visits and progress notes;
- (d) medication management;
- (e) infection control and communicable disease;
- (f) discharge criteria;
- (g) coordination of home health with other services the member is receiving; and
- (h) first aid and cardiopulmonary resuscitation requirements.

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(B) Teaching Activities. During a home health nursing or therapy treatment visit, the nurse or therapist must teach the member, family member, or caregivers how to manage the member's treatment regimen as applicable. Ongoing teaching is required when there is a change in the procedure or the member's condition, and all teaching activities must be documented in the member's record.

(C) Visit Verification. Home health agencies that provide home health aide services must:

(1) ensure the member completes home health aide visit verification, which must minimally include:

(a) the date of service rendered;

(b) the number of hours provided; and

(c) the signature of the member or the member's legal representative.

(2) Store the completed visit verification in the member's record.

(D) Recordkeeping.

(1) Administrative Records. Home health agencies must maintain administrative records in compliance with the record retention requirements set forth in 130 CMR 450.205: *Recordkeeping and Disclosure*. All records including, but not limited to, the following must be accessible and made available on-site for inspection by the MassHealth agency:

(a) payroll and staff records, including evidence of completed staff orientation and training;

(b) financial records;

(c) staffing levels;

(d) complaints and grievances;

(e) contracts for subcontracted services, including a description of how the home health agency will supervise the subcontracted services;

(f) contracts for independent contractor services, including a description of how the home health agency will supervise the independent contractors and their services; and

(g) job descriptions that include titles, reporting authority, qualifications, and responsibilities.

(2) Incident and Accident Records. Home health agencies must maintain an easily accessible record of member and staff incidents and accidents. The record may be kept within the individual member medical record or employee record or within a separate, accessible file.

(a) The home health agency must submit to the MassHealth Program Manager or their designee an incident or accident report within five days of having knowledge of the incident and under the following circumstances.

1. An incident or accident that occurred during a home health service visit that results in serious injury to the member.

2. An incident or accident resulting in the member's death even if the home health agency was not involved in the incident or accident.

3. An incident of abuse or neglect involving a staff member of the home health agency and the member.

4. An incident of abuse or neglect committed by another provider supporting the member concurrently as the home health agency (if known).

(b) The incident or accident report must include at least the following information.

1. general information including, but not limited to, member name and member identification;

2. general nature of incident or accident; and

3. any action that was taken as a result of the incident or accident including all outcomes.

(3) Member Records. In order for a medical record to completely document a service to a member, the record must describe fully the nature, extent, quality, and necessity of the care furnished to the member. When the information contained in a member's record does not provide sufficient documentation for the service, the MassHealth agency may disallow payment (*see* 130 CMR 450.205: *Recordkeeping and Disclosure*).

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(a) The record maintained by a home health agency for each member must conform to 130 CMR 450.000: *Administrative and Billing Regulations*. Payment for any service listed in 130 CMR 403.000 requires complete documentation in the member's medical record. The home health agency must maintain records for each member to whom services are provided.

(b) The home health agency must maintain an up-to-date medical record of services provided to each member. The medical record must contain at least the following in addition to the information defined at 130 CMR 403.402:

1. the member's name, address, phone number, date of birth, and MassHealth ID number;
2. the name and phone number of the member's ordering physician or ordering non-physician practitioner prescribing home health services;
3. the primary caregiver's name, phone number, and relationship to the member;
4. the name and phone number of the member's emergency contact person;
5. a copy of all verbal orders, properly authenticated;
6. accessible and legible progress notes for each visit, signed by the person providing the service that includes the following information:
   a. the full date of service and time that each visit began and ended;
   b. for nursing and therapy visit notes, treatments and services ordered by the physician or ordering non-physician practitioner that were provided by the clinician during the visit and the member's response;
   c. for home health aide visit notes, documentation of which treatments and services in the plan of care or directed/supervised by a nurse/therapist that were provided during the visit and the member's response, including documentation of medication administration as described in 130 CMR 403.419(D)(3)(b)8.;
   d. any service or treatment the member declined during visit and explanation of denial;
   e. the member's vital signs and any other required measurements as appropriate;
   f. when applicable, progress toward achievement of goals as specified in the plan of care, including an explanation of why goals are not achieved as expected;
   g. a pain assessment, as appropriate;
   h. the status of any equipment maintenance and management, as appropriate; and
   i. any contacts with physicians or other health-care providers about the member's needs or change in plan of care, as applicable;
7. a current medication-administration list or other documentation, such as nursing notes, and as applicable, that includes the timing of administration as ordered, drug identification and dose, route of administration, the member's response to the medication being administered, and the signature of the person administering the medication;
8. documentation on the teaching provided to the member, member's family, or caregiver by the nurse or therapist on how to manage the member's treatment regimen, any ongoing teaching required due to a change in the procedure or the member's condition, and the response to the teaching; or as applicable, documentation indicating that teaching was unsuccessful or unnecessary and why further teaching is not reasonable;
9. visit verification as described in 130 CMR 403.419(C);
10. any clinical tests and their results, as applicable; and
11. a signed medical records release form, as applicable.

(4) Copies of Records. Upon the request of the member or the member's representative, the home health agency must provide a copy of the medical record to the person or entity that the member or the member's representative designates.

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(E) Statement of Fiscal Soundness.

(1) Submission Requirements. Under 130 CMR 403.405(E), home health agencies must submit annually and at enrollment to MassHealth or its designee a statement of fiscal soundness attesting to the financial viability of the home health agency. To satisfy the fiscal soundness requirement, the home health agency must demonstrate a cash reserve sufficient to meet one month of financial obligations in the operation of the provider's home health program including, but not limited to, timely payment of staff wages and the agency's general and professional liability insurance coverage and workers' compensation insurance coverage. If using a line of credit to meet the cash reserve requirement, the agency must demonstrate the line of credit has been approved by a financial institution.

(2) Submission Due Date. The home health agency must submit to MassHealth or its designee a statement of fiscal soundness annually and by the end of May each year.

(3) Attestation. The home health agency must attest that its available cash reserve will meet the average monthly cost at all times during the subsequent year.

(4) Noncompliance. For home health agencies that fail to meet the fiscal soundness requirement pursuant to 130 CMR 403.405(E) and 403.419(E), MassHealth may take further action, such as imposing sanctions in accordance with 130 CMR 450.238: *Sanctions: General* including, but not limited to, termination of the organization as a MassHealth home health agency.

403.420: Plan-of-care Requirements

All home health services must be provided under a plan of care established individually for the member.

(A) Providers Qualified to Establish a Plan of Care.

(1) The member's physician or ordering non-physician practitioner must establish a written plan of care in consultation with the home health agency. The physician or ordering non-physician practitioner must review, sign and date the plan of care and revise it, as applicable:

(a) no less than every 60 days from the start of home health services;

(b) more frequently as the member's condition or needs require. The plan of care or other medical notes in the member record must document that a face-to-face encounter related to the primary reason the member requires home health services occurred no more than 90 days before or 30 days after the start of home health services. *See* 130 CMR 403.420(E).

(c) in accordance with verbal order requirements described in 130 CMR 403.420(D).

(2) A home health agency nurse or skilled therapist may establish an additional, discipline-oriented plan of care, when appropriate. These plans of care may be incorporated into the plan of care, or be prepared separately, but do not substitute for the plan of care.

(B) Content of the Plan of Care. The orders on the plan of care must specify the service type and frequency of the services to be provided to the member, and the type of professional who must provide them. The physician or ordering non-physician practitioner must sign and date the plan of care before the home health agency submits its claim for those services to the MassHealth agency for payment, or must comply with the verbal-order provisions at 130 CMR 403.420(D). Any increase in the frequency of services or any addition of new services must be authorized in advance by the physician or ordering non-physician practitioner with verbal or written orders and authorized by the MassHealth agency or its designee as appropriate. If the member is enrolled in the Primary Care Clinician (PCC) Plan, the home health agency must communicate with the member's PCC both when the goals of the care plan are achieved and when there is a significant change in a member's health status. The plan of care must contain

(1) all pertinent diagnoses, including the member's mental, psychosocial, and cognitive status;

(2) the types of services, supplies, and equipment ordered;

(3) the frequency of the visits to be made;

(4) the prognosis, rehabilitation potential, functional limitations, permitted activities, nutritional requirements, medications, and treatments;

(5) any safety measures to prevent injury;

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(6) a description of the member's risk for emergency department visits and hospital readmission, and all necessary interventions to address the underlying risk factors;
(7) any teaching activities to be conducted by the nurse or therapist, to teach the member, family member, or caregiver how to manage the member's treatment regimen (ongoing teaching may be necessary where there is a change in the procedure or the member's condition);
(8) the discharge plans;
(9) any additional items the home health agency or physician or ordering non-physician practitioner chooses to include;
(10) all patient care orders, including a record of verbal orders and/or initial referral to home health services; and
(11) member-specific home health aide care instructions created by the RN or therapist supervising the home health aide, as applicable (may be attached to the plan of care).

(C) Certification Period. Both the plan of care, required under 130 CMR 403.420(A)(1), and the discipline oriented plan of care, described in 130 CMR 403.420(A)(2), must be reviewed, signed, and dated by a physician or ordering non-physician practitioner at least every 60 days, unless the provider follows the verbal order provisions at 130 CMR 403.420(D).

(D) Verbal Orders.
(1) Notwithstanding the requirements of 130 CMR 403.420(A), services that are provided from the beginning of the certification period (*see* 130 CMR 403.420(C)) and before the physician or ordering non-physician practitioner signs the plan of care are considered to be provided under a plan of care established and approved by the physician or ordering non-physician practitioner if
(a) the clinical record contains a documented verbal order from the ordering physician or ordering non-physician practitioner for the care before the services are provided; and
(b) the physician or ordering non-physician practitioner signature is on the 60-day plan of care either before the claim is submitted or within 45 days after submitting a claim for that period.
(2) If the member has other health insurance (whether commercial or Medicare), the provider must comply with the other insurer's regulations for physician or ordering non-physician practitioner signature before billing the MassHealth agency.
(3) The home health agency must obtain prior authorization for verbal orders where required.

(E) Face-to-face Encounter Requirements.
(1) A face-to-face encounter between the member and an authorized practitioner is required for initial orders for home health services. A face-to-face encounter is not required when the plan of care is reviewed and revised as required at 130 CMR 403.420(C) or at resumption of home health services.
(2) Authorized practitioners include:
(a) the ordering physician or ordering non-physician practitioner. In order to be an ordering physician or ordering non-physician practitioner, the physician or ordering non-physician practitioner must be enrolled in MassHealth;
(b) the physician or ordering non-physician practitioner who cared for the member in an acute or post-acute care facility (acute/post-acute care attending physician or non-physician practitioner) from which the member was directly admitted to home health; or
(c) certain authorized non-physician practitioners, which include one of the following in a home health context:
1. a nurse practitioner or clinical nurse specialist who is working in collaboration with the ordering physician or the acute/post-acute care attending physician;
2. a certified nurse midwife; or
3. a physician assistant under the ordering or acute/post-acute care attending physician.
(3) Documenting the Face-to-face Encounter in the Member's Record.
(a) The face-to-face encounter must be documented in the member's record either on the plan-of-care or in other medical notes sufficient to make the link between the individual's health conditions, the services ordered, an appropriate face-to-face encounter, and actual service provision.

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(b) The ordering or acute/post-acute-care attending physician or ordering non-physician practitioner may write the plan of care. When the acute/post-acute-care attending physician or ordering non-physician practitioner writes the plan of care, such practitioners must document that the face-to-face encounter is related to the primary reason the patient requires home health services and that the encounter with an authorized practitioner occurred within the required timeframes. The plan of care or the medical notes must include which authorized practitioner conducted the encounter and the date of the encounter.

(c) If the face-to-face encounter was not provided by the ordering physician or ordering non-physician practitioner, the authorized practitioner who did conduct the face-to-face encounter is required to communicate the clinical findings of the face-to-face encounter to the ordering physician or ordering non-physician practitioner. This requirement is necessary to ensure that the ordering physician or ordering non-physician practitioner has sufficient information to determine the need for home health services in the absence of conducting the face-to-face encounter himself or herself.

(d) The home health agency must maintain a copy of the face-to-face documentation.

(4) Well Mom and Baby Visits. Face-to-face encounters must be conducted prior to home health services that arise from well mom and baby visits. If, in the course of such a visit, an authorized practitioner determines that home health services are required to address the condition of the mother or child, such a visit may be the basis for a documented face-to-face encounter to the extent that the visit involves examining the condition of the mother or child for whom services are being ordered.

(5) Dual-eligible Members. If the source of payment for the member's care has changed from Medicare to Medicaid, and a face-to-face encounter was performed at the start of Medicare-authorized home health services, a new face-to-face encounter is not required.

403.421: Quality Management and Utilization Review

(A) A home health agency must participate in any quality management and program integrity processes as required by the MassHealth agency including making any necessary data available and providing access to visit the home health agency's place of business upon request by MassHealth or its designee.

(B) A home health agency must submit requested documentation to the MassHealth agency or its designee for purposes of utilization review and provider review and audit, within the MassHealth agency's or its designee's time specifications. The MassHealth agency or its designee may periodically review a member's plan of care and other records to determine if services are medically necessary in accordance with 130 CMR 403.409(C). The home health agency must provide the MassHealth agency or its designee with any supporting documentation the MassHealth agency or its designee requests, in accordance with M.G.L. c. 118E, § 38, and 130 CMR 450.000: *Administrative and Billing Regulations*.

403.422: Transfers and Discharge Planning

(A) Discharge Procedures.

(1) A member shall be discharged by the home health agency provider under the following conditions:

(a) upon the member's request;

(b) if the member ceases to benefit from home health services;

(c) if the member no longer meets the clinical eligibility for home health services;

(d) if the member selects another MassHealth service that is duplicative of the home health the member is receiving, including MassHealth services that provide assistance with personal care;

(e) if the member transitions completely to another home health provider or CSN provider or combination of providers; or

(f) if the home health agency ceases operations.

(2) A member may be discharged by the home health agency provider if the home health agency cannot safely serve the member in the home in accordance with 42 CFR 484.50(d)(5).

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(B) Safe Discharge Planning When Other Community Services Needed. Home health agencies must

(1) begin to develop a discharge and transition plan for members during the admission process/start of care;

(2) coordinate community long-term services that are most appropriate for the member's needs at discharge and refer to other community services accordingly;

(3) provide assistance to the member in identifying and locating other community long-term services;

(4) document coordination with community resources and keep documentation of referrals to other community resources in the member's record;

(5) coordinate the discharge and transition with the member, member's family/caregiver, and the staff of the provider, program or agency to which the member is to be transferred; and

(6) make best efforts to ensure the continuity of care until the new service has commenced.

(C) Discharge Planning Requirements for Members over 21 Years of Age Utilizing Home Health Aide Services for ADL Supports Only. In addition to complying with the discharge requirements established in 130 CMR 403.422(A) and 130 CMR 403.422(B), home health agencies providing home health aide services for ADL supports only must also

(1) complete a Member Connection Form as designated by the MassHealth agency, and send to the member's waiver program (as applicable) or to the member's local ASAP for evaluation or options counseling;

(2) establish an individualized discharge plan at the start of services. The member's discharge plan must be reviewed and updated as the member's discharge from home health services approaches; and

(3) assist the member in locating and securing long-term personal care services, if needed.

(D) Members 60 Years of Age or Older. Home health agencies must complete a Member Connection Form for those MassHealth members 60 years of age or older within 15 days of a planned discharge from home health services or whenever the agency determines that the MassHealth member could benefit from ASAP services. *See* 651 CMR 14.00: *Aging Services Access Points*, for a description and definition of ASAP. Home health agencies shall forward the completed referral form to the ASAP serving the area in which the member resides and must keep a copy of the completed ASAP referral form in the member's record.

(E) Transfers of Members to Alternate Home Health Agencies.

(1) When a member transfers from one home health agency to an alternate home health agency, the transferring home health agency must inform MassHealth within ten days of the transfer. When informing the MassHealth agency of the transfer, the transferring home health agency must include the following information in the form and format required by the MassHealth agency and maintain this information in the member's record:

(a) Member Name;
(b) Member ID;
(c) Member care plan;
(d) Receiving home health agency;
(e) Date of transfer; and
(f) Reason for transfer.

(2) The receiving home health agency must complete an initial member assessment and must obtain prior authorization. The new agency must collaborate with the transferring agency in regards to the prior authorization timeline, number of visits completed, and must ensure that there are no overlapping dates of service.

403.423: Conditions of Payment

The following conditions for payment apply to all home health services, in addition to conditions of payment described throughout 130 CMR 403.000.

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(A) The MassHealth agency pays for home health in accordance with the applicable payment methodology and rate schedule established by EOHHS.

(B) The home health provider must review each member in its care to ensure that the clinical eligibility criteria for home health continue to be met. A home health provider may not bill and the MassHealth agency will not pay for any member who does not meet the clinical criteria for home health.

(C) Initial Patient Assessments. The MassHealth agency pays for one initial member assessment visit by a home health agency with a physician or ordering non-physician practitioner's order. The MassHealth agency does not pay for any subsequent services provided to the member unless the physician or ordering non-physician practitioner has ordered the service prior to the continuation of care and includes them in the written plan of care.

(D) Observation and Evaluation Visits. The MassHealth agency pays for observation and evaluation (or reevaluation) visits when they are made by a registered nurse or physical, occupational, or speech/language therapist ordered by the physician or ordering non-physician practitioner, for the purpose of evaluating the member's condition and his or her continuing need for home health services.

(E) Supervisory Visits. The MassHealth agency does not pay for a supervisory visit made by a nurse or physical and occupational therapist for the purpose of evaluating the specific personal-care needs of the member, or reviewing the manner in which the personal-care needs of the member are being met by the home health aide. These visits are administrative and are, therefore, not payable.

(F) Nursing Visits for Members Receiving Home Health Services after 30 Calendar Days. The MassHealth agency pays a reduced rate for any additional nursing visit provided to the member on or after the 31st calendar day of the member's first home health service, even if some or all of those services were provided by a different home health agency or paid by a third-party insurer other than MassHealth. When billing the MassHealth agency for any nursing visit on or after the 31st calendar day, the service code and modifier must reflect the nursing visit. The MassHealth agency resumes the full nursing visit rate of one through 30 calendar days under the following conditions:

(1) Admission to a hospital for at least one overnight.
(2) Admission to a Crises Stabilization Unit of at least one overnight.
(3) Admission to a skilled nursing facility of at least three nights.
(4) Following a break in home health services of 60 days or more.

(G) Medication Administration Visit. The MassHealth agency pays a separate rate for nursing visits conducted for the purpose of medication administration, as defined in 130 CMR 403.402. Medication Administration Visits must include teaching on medication management to maximize independence, as applicable, documentation as specified in 130 CMR 403.419(C)(3)(b)9., and assessment of the member response to medication.

(H) Members for Whom Services Are Approved. The MassHealth agency does not pay for nursing services provided to any individual other than the member who is eligible to receive such services and for whom such services have been authorized by the MassHealth agency or its designee.

403.424: Intermittent or Part-time Requirement

The MassHealth agency pays for nursing visits and home health aide services provided pursuant to a need for skilled nursing services only on an intermittent or part-time basis, and only as described in 130 CMR 403.424(A), except as provided in 130 CMR 403.424(B). Services described in this section are paid for subject to any applicable prior authorization requirements as described at 130 CMR 403.410.

403.424: continued

(A) Intermittent and Part-time Services.

(1) Services are intermittent if up to eight hours per day of medically necessary nursing visits and home health aide services, combined, are provided seven days per calendar week for temporary periods of up to 30 days.

(2) Services are part-time if the combination of medically necessary nursing visits and home health aide services does not exceed 35 hours per calendar week, and those services are provided on a less-than-daily basis.

(3) To receive intermittent or part-time nursing care, the member must have a medically predictable recurring need for skilled nursing services at least once every 60 days, or the member must meet the conditions in 130 CMR 403.424(A)(4).

(4) In certain circumstances, the member needs infrequent, yet intermittent, nursing services. The following are nonexclusive examples of such services, which are payable.

(a) The member has an indwelling silicone catheter and generally needs a catheter change only at 90-day intervals.

(b) The member experiences a fecal impaction due to the normal aging process (that is, loss of bowel tone, restrictive mobility, and a breakdown in good health habits) and must be manually disimpacted. Although these impactions are likely to recur, it is not possible to predict a specific time frame.

(c) The member is diabetic and visually impaired. He or she self-injects insulin, and has a medically predictable recurring need for a nursing visit at least every 90 days. These nursing visits, which supplement the physician's contacts with the member, are necessary to observe and determine the need for changes in the level and type of care that have been prescribed.

(d) The need for intermittent or part-time nursing is medically predictable, but a situation arises after the first nursing visit that makes additional visits unnecessary (for example, the member becomes institutionalized or dies, or a primary caregiver has been trained to provide care). In this situation, the one nursing visit is payable.

(B) Exceptions. Nursing visits and home health aide services in excess of the intermittent or part-time limit, as described in 130 CMR 403.424(A), may be provided to members under any of the following conditions:

(1) the physician has documented that the death of the member is imminent, and the physician has recommended that the member be permitted to die at home;

(2) the home health agency has documented that the services are no more costly than medically comparable care in an appropriate institution (for example, long-term care or chronic disease and rehabilitation hospital care) and the least-costly form of comparable care available in the community, and the member prefers to remain at home;

(3) the home health agency has documented that it is seeking appropriate alternative modes of care, but has not yet found them;

(4) the physician has documented that the need for care in excess of 30 days or in excess of 35 hours per calendar week is medically necessary in accordance with 130 CMR 403.409(C);

(5) the member qualifies for CSN services; or

(6) for daily skilled nursing services for diabetics unable to administer their insulin (when there is no able and willing caregiver).

403.428: Maximum Allowable Fees

Home health agencies must accept MassHealth payment in full for home health services according to the rates and regulations established by EOHHS as set forth in 101 CMR 350.00: *Rates for Home Health Services*. Payments are subject to the conditions, exclusions, and limitations set forth in 130 CMR 403.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

403.429: Denial of Services and Administrative Review

(A) A failure or refusal by a home health agency to provide services that have been ordered by the member's attending physician and that are within the range of payable services is not an action by the MassHealth agency or its designee that a member may appeal; but such failure or refusal constitutes a violation of these regulations for which administrative sanctions may be imposed, with the exception of instances where the home health agency does not reasonably have staffing availability or cannot reasonably procure staffing to provide services. The MassHealth agency receives and acts upon complaints from physicians and ordering non-physician practitioners, continuing-care coordinators, and other social-services agencies, as well as from members and their families. A failure or refusal by a physician or ordering non-physician practitioner to order services or to certify their medical necessity is not an action by the MassHealth agency or its designee that a member may appeal.

(B) When a home health agency believes that services ordered by the physician or ordering non-physician practitioner are not payable under 130 CMR 403.000, the agency must refer the matter to the MassHealth agency for a payment decision. If and to the extent the MassHealth agency determines that the ordered services are payable, the agency must provide those services.

403.430: Prohibited Marketing Activities

A Home Health Agency provider must not:

(A) with the knowledge that a member is enrolled in a Capitated Program, engage in any practice that would reasonably be expected to have the effect of steering or encouraging the member to disenroll from the Capitated Program in order to retain the home health agency provider to provide home health services on a fee-for-service basis;

(B) offer to a member, or his or her family or caregivers, in-person or through marketing, any inducement to retain the home health agency provider to provide home health services, such as a financial incentive, reward, gift, meal, discount, rebate, giveaway, or special opportunity;

(C) pay a "finder's fee" to any third-party in exchange for referring a member to the home health agency provider; or

(D) engage in any unfair or deceptive acts or practices in connection with any marketing.

REGULATORY AUTHORITY

130 CMR 403.000: M.G.L. c. 118E, §§ 7 and 12.

NON-TEXT PAGE