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Home Health Benefits

Introduction
Home health is defined as services provided in a member's home by a home health agency. Home health services include skilled nurse visits, occupational therapy, physical therapy and speech therapy. It also includes intravenous (IV) therapy, total parenteral nutrition (TPN) and home phototherapy.

Filing a Home Health Claim
The following are guidelines for filing a home health claim:
- Preferred Home Health agencies that supply infusion and nursing services must submit one claim for all services provided per member
- Providers should only bill the member for the copayment and/or deductible amount
- Home health drug pricing and filing information can be accessed through the Interactive Voice Response (IVR) system, 24 hours a day, at 1-800-216-9920. To access the system, enter your three-digit plan code followed by your five-digit provider identification (ID) and follow the menu prompts
- The initial nursing visit is included in the per diem. Fees include all supplies (i.e., syringes, bandages, etc.) that are normally used. Nursing visits must be billed as a separate line item from the per diem charges
- Members are held harmless for services denied post-payment due to lack of medical necessity

Conditions of Coverage for All Contracts
All contracts require the following conditions for coverage:
- Patients must be under the care of a licensed physician who establishes the plan of treatment and certifies the medical necessity for home health services;
- Services must be provided by a home health agency that has a contractual agreement with Blue Cross and Blue Shield of Alabama; and
- Services must be provided under a treatment plan for a specific diagnosis or diagnoses established by the physician.

Note: Specific group coverage may vary and payment of benefits is always contingent at the time services are provided. Be sure to verify benefits for each member. Providers have access to online benefit information through ProviderAccess at www.bcbsal.com.

Reimbursement
Home health services are reimbursed at a contractual per visit rate. The member’s benefits must include coverage for home health services and conditions for coverage must be met.

Contract Exclusions
Most home health contracts exclude the following services or care:
- Services provided by a person who resides with or is related by blood or marriage to the patient
- Non-skilled care such as aides and custodial care (some contract’s provide coverage)
- Dietician services
- Maintenance therapy that is not restorative in nature
- Food or home delivered meals
Physical Therapy, Occupational Therapy and Speech Therapy

Paper claims for physical therapy, speech therapy and occupational therapy require the agency’s National Provider Identifier (NPI) and a separate legacy number to identify the type service provided. If a provider number for these types of services is needed, e-mail our Credentialing department at credentialing@bcbsal.org or call 205-220-6765.

Electronic claims require the agency’s NPI and the taxonomy code for the service provided. Claims for these services must be filed independent of other home health services.

Home Infusion Services

For a drug to be considered for reimbursement under the home health benefit, it must be infused in the patient’s home. With the exception of Procrit® and Synagis®, drugs administered by any other method is not eligible for coverage under the home health benefit.

The per diem for home infusion services should be submitted with the appropriate Healthcare Common Procedure Coding System (HCPCS) code depending on the frequency of medication administration. The HCPCS codes are available on ProviderAccess under the Home Health Fee Schedule. The per diem fee includes administrative services, professional pharmacy services, care coordination as well as necessary supplies and equipment. The IV pole and fluids for infusing medications are considered as supplies and are included in the per diem.

Medications must be billed separately with the appropriate HCPCS code as well as the appropriate National Drug Code (NDC) number, prescription number and number of units administered. If more than one drug is administered on the same day, providers may submit the appropriate HCPCS code for additional IV drugs once per day when two or more IV drugs are administered. Do not bill each IV drug administered separately. Nursing visits should be billed separately, also.

As a reminder, with the exception of Procrit and Synagis, only those drugs infused in the home are eligible for reimbursement under the home health benefit. An infusion per diem should not be billed when administering Procrit or Synagis.

Drugs Administered Outside the Patient’s Home

Drugs administered outside the patient’s home are not eligible for reimbursement as a home health benefit. Home health/home infusion providers should not bill Blue Cross and Blue Shield of Alabama for drugs delivered to a physician’s office or other location for administration. Drugs administered in a physician’s office should be billed by the physician. The administration fee should be billed by the physician also.

Home health providers submitting charges to Blue Cross for drugs delivered to a physician’s office or other location for administration are in violation of the Preferred Home Health Network Agreement. Such providers will be subject to the denial of claims, collection of refunds and other measures that may include termination of the Preferred Provider Agreement with Blue Cross.

Compound Drugs

Compound drugs are not considered a home health/home infusion benefit. Home infusion companies may compound drugs for a physician’s office; however, the physician’s office must bill Blue Cross for the drugs. Home health/home infusion providers should not submit charges for drug compounds to Blue Cross.

Factor Drugs

Factor drugs used in the treatment of hemophilia should not be billed as a home health service. These drugs are considered a pharmacy benefit.
**Heparin Flush and Saline for Injection**

When administering home infusion therapy, heparin flushes, normal saline for injection and any other agents used to reconstitute a drug or flush an IV access line should not be billed separately. These items are included in the per diem or global payment for the infusion.

**Dakin’s Solution for Wound Care**

Dakin’s solution is a billable item when provided for wound care. Claims should be submitted with the appropriate HCPCS code for wound cleansers of any type or size. Dakin’s solution should not be billed as a drug with a NDC number.

**Wound Care Supplies**

HCPCS codes for wound care supplies may be billed by a Participating Home Health Agency. Routine wound care supplies such as tape, alcohol wipes, cotton balls, syringes and needles are not separately billable items to Blue Cross and Blue Shield of Alabama or to the member. These items are included in the global per diem and/or home health nursing visit.

**TPN**

Standard TPN formulas should be billed with the appropriate HCPCS codes according to the amount of TPN administered. The standard TPN formula includes all vitamins, electrolytes and trace elements. Nursing visits, lipids, specialty amino acid formulas and medications may be billed separately.

**Enteral Feeding**

Enteral feeding supplies and nutrients may be billed by a Participating Home Health Agency. When billing for enteral formulas, the number of units is based on 100 calories per unit of service.

An IV pole needed for enteral feeding is limited to a 10-month rental and will be considered purchased in full after 10 months.

**Anodyne® Photo-Therapy**

Anodyne photo-therapy is considered investigational which means it does not meet Blue Cross’ medical criteria for coverage.

**Filing Home Health Drug Charges Electronically**

All home health drug charges can now be filed electronically using the Health Insurance Portability and Accountability Act (HIPAA) compliant ANSI 837 ASC X12N 004010X098A1 format as long as the following criteria are met:

- You are registered with Blue Cross and Blue Shield of Alabama as a preferred provider of the home health nursing specialty.
- The NDC number must be present in the 2410 Drug Identification Loop, LIN segment.
- The submitted NDC number must contain 11 numerics and be a current and valid number according to the Medi-Span Drug file.
- The prescription number must be present in the 2410 Drug Identification Loop, REF segment.

The NDC number and prescription number should contain only numbers; no dashes or prefixes are necessary.
Health Management Updates

Blue Cross and Blue Shield of Alabama updates the criteria for coverage on an as-needed basis. Coverage criteria is reviewed frequently in relation to the following conditions:

- Changes in current medical practice;
- Input from our Quality Assurance Committee;
- Availability of new therapies and technologies;
- Utilization trends; and
- New surgical and treatment modalities.

When new or updated criteria is required, information is gathered from a review of medical literature and expert clinical advisors. This information is given to our Medical Directors for review. Changes are made based on the Medical Director’s approval.

Precertification of Home Health Services

When precertification of nursing services is required by the member’s contract, home health providers must verify any requirements. All requests for precertification of skilled nursing services must be reviewed for medical necessity. Private duty nursing is not a covered service within the Preferred Home Health benefit and is not part of the Preferred Home Health fee schedule for reimbursement.

To submit a precertification, call the Health Management Program at 1-800-821-7231 or 205-733-7067 and follow the auto-attendant instructions. Written requests should be faxed to 205-220-9852 within five business days of the initiation of care. Be sure to include the patient’s name, contract number, provider’s name and telephone number, the initial assessment, the physician’s order and any other pertinent information.

When a physician recommends home healthcare for a member, follow the procedures outlined below:

- The Home Health Services Request for Certification Form must be completed by the member or responsible party, the physician or the nursing agency.
- The form must be submitted to Blue Cross and Blue Shield of Alabama via the address or fax number printed on the form within five business days prior to the start of the care.
- The completed form will be evaluated to assess the medical necessity of the proposed skilled nursing services and for their duration and frequency.
- Proposed services will be approved by assigning hours per day/week(s) or visits based on the information submitted on the Home Health Services Request for Certification Form necessary for skilled nursing care.
- Telephone notification will be made to the nursing agency or nurse. Notification letters containing the authorization number will be mailed to the member, nursing agency and physician.
- All recertifications require nurses’ notes, a new nursing plan of treatment and a new certification signed by the attending physician. The recertification form must be received within five business days after the ending date of each certification period. Nurses’ notes from the proceeding certification period must be attached.
- Services for skilled nursing care may not be certified if the nursing agency or nurse does not follow the precertification/recertification process.
- Do not submit the Home Health Services Request for Certification Form, nurses’ notes or the nursing plan of treatment with the claim.
- The “From” and “To” dates on your claim must match the dates of the certification period.
**FEP Home Health Services**

**Overview**
The Federal Employee Program (FEP) covers home nursing care for 2 hours per day up to 25 visits per calendar year, when provided by a registered nurse (RN) or licensed practical nurse (LPN) provided and ordered by a physician.

Under the FEP Standard Option Plan, covered visits while a member meets his or her calendar year deductible count toward the annual visit limit. Under the FEP Basic Option Plan, all home nursing care must be provided by a Preferred Provider to be eligible for benefits.

**Non-Covered Services**
- Nursing care requested by, or for the convenience of, the patient or the patient’s family
- Services primarily for bathing, feeding, exercising, moving the patient, homemaking, giving medication, or acting as a companion or sitter
- Services provided by a nurse, nursing assistant, health aide, or other similarly licensed or unlicensed person that are billed by a skilled nursing facility, extended care facility or nursing home
- Private duty nursing

**References**
Please refer to the [Service Benefit Plan Brochure](#) for specific benefit information available to Standard and Basic Option plan members. Contact the Customer Service Department at 1-800-492-8872 if assistance is needed. All benefits are subject to the definitions, limitations and exclusions listed in the brochure and are payable only when determined to be medically necessary.

**NASCO**
The National Accounts Service Company (NASCO) is a claims processing system implemented for many of our national contracts. The NASCO system serves as a dedicated central processor for these contracts in Alabama. NASCO was designed to ensure nationally uniform administration of healthcare benefits for enrollees of the National Accounts involved.

Claims are processed according to current contract provisions. For benefit information, call 1-800-634-7592.

**System Overview**
The NASCO system is an automated system supported by a dedicated claims processing staff and dedicated customer service unit. Providers must follow the established procedures when submitting claims, requesting adjustments and predetermination requests to Blue Cross and Blue Shield of Alabama. Claims will process using the contract number on the identification card.

**Payments/Vouchers**
All providers will receive a separate voucher reflecting payments made by the NASCO system. Providers will receive a separate payment by check and not an electronic funds transfer (EFT) for these claims. An explanation of each column is provided on the voucher.

**Adjustments**
Payment for adjustments will be reflected on a new provider check voucher.
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