



An Independent Licensee of the Blue Cross and
Blue Shield Association

Guide to Billing Facility Services

Home Services

Preface

Summary of Changes

Table of Contents

Service Contacts

June 2011
Replaces: July 2010

Preface

The *Wellmark Provider Guide* and specialty guides are billing resources for providers doing business with Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Health Plan of Iowa, Inc., and Wellmark Blue Cross and Blue Shield of South Dakota. The guides are referenced in your provider agreement, and include information that applies to all benefit plans in Iowa and South Dakota unless specified within the text.

Explanation of Terminology

Wellmark	Throughout the guides, the term Wellmark indicates Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Health Plan of Iowa, Inc., and Wellmark Blue Cross and Blue Shield of South Dakota.
Member	Individuals with health coverage through Wellmark are referred to as members.

Provider Guide Updates

Wellmark's provider guides are continually updated to bring you the most current information. The following items identify when the guide or section was last changed.

- The most current date is printed on the front cover and inside pages. The date of the version replaced is also printed on the front cover.
- A *Summary of Changes* page lists all the substantial changes made in the most current update. The page(s) affected and a brief explanation of the change is linked from the *Summary of Changes* page to the change within the document.
- Changed text is in blue type.

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We invite you to print Wellmark's provider guides from the website. However, if you prefer to order a paper copy, simply complete a Provider Forms Order (IA: B-0002; SD: B-3001) found on [Wellmark.com > Provider > Communication & Resources > Forms](#), or in the Member and Service Information section of the *Wellmark Provider Guide*. If you do not have a forms order blank, contact a Provider/Customer Service representative for assistance. We will inform you of guide updates in the *Blue Ink* newsletter or on the Providers page of our website.

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Home Services Section—June 2011

Summary of Changes

Throughout:

Phone numbers have been updated as needed.

Page 8

Bill home health and hospice facility services with a single date of service on each claim line. If a claim line is billed with a date span, only one date of service will be paid.

Page 9

Added information to facilitate electronic claim submission for home health services.

Page 10

Added information to facilitate electronic claim submission for hospice services.

Home Services

Table of Contents

I. Benefits for Home Services	1
Home Health	1
Hospice	4
II. Precertification Process.....	6
Plan of Treatment/Patient Status Report	7
III. Billing for Home Health and Hospice.....	8
Home Health	9
Hospice	10

Scope Information in this guide applies to networks and products offered or administered by Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Blue Cross and Blue Shield of South Dakota, and Wellmark Health Plan of Iowa, Inc. The guidelines may also apply to Select First, the network administered by First Administrators, Inc., but as guidelines will vary, please check Select First coverage at <http://www.firstadministrators.com/> or call the phone number on the back of the member's ID card for details.

FAI

Use of terms

This section contains information about home health and hospice services provided to Wellmark members. All contracting providers must comply with the requirements identified below as a term of their provider contracts. Unless otherwise noted, in this section the word "facility" refers to a home health agency or hospice provider.

Federal Employee Program benefits

Note: Federal Employee Program (FEP) benefits vary slightly from Wellmark benefits. Exceptions are noted throughout this section. For more detailed information or assistance, call FEP Customer Service using the phone numbers listed on the back page.

I Benefits for Home Services

Home Health

Home health visit defined

A home health agency (HHA) is an agency or organization that provides skilled nursing care in a patient's home, and is approved by Medicare or The Joint Commission or the Community Health Accreditation Program (CHAP). Home health visit means a period of time, usually less than two hours, in which patient assessment, education, training, treatment and/or personal care is provided. Any other services rendered can be billed by the provider using the appropriate revenue and HCPCS codes.

Covered services

If a patient's benefit contract includes home health care, benefits for the following services are covered if prescribed by the patient's MD or DO and are medically necessary:

- skilled nursing services
- home health aide services
- medical social services
- physical therapy
- speech therapy
- occupational therapy
- medical supplies
- home medical equipment

The definition of medically necessary can be found in the Claims Filing section of the *Wellmark Provider Guide*.

Coverage criteria

Along with the criteria above, home health services covered by a member's benefit contract must also meet the following criteria to be eligible for coverage:

- An agency approved by Medicare or The Joint Commission or the Community Health Accreditation Program (CHAP) must provide the home health services.

Note: FEP benefits cover home nursing care, which must be provided by a registered nurse (RN) or a licensed practical nurse (LPN), and billed by the professional providing the service or by the home health agency, which must be approved by Medicare, The Joint Commission, or CHAP.

- Services must be precertified before home health care is provided to avoid a denial or benefit reductions (see page 6 for more information).

Note: FEP does not require precertification for home nursing care. Contact FEP Customer Service for benefit information to avoid a denial or benefit reduction.

- A physician must prescribe the services for a covered illness or injury.
- The patient must be homebound and require skilled care for a covered illness or injury. An MD/DO must certify the patient's confinement to the home. An individual is considered homebound if his or her physical or mental condition prohibits him or her from leaving home except to obtain medical care.
- The home environment must be appropriate for maintaining the patient in a home setting.
- A family member or other responsible person must be capable and willing to assist in the management of the patient in the home.
- Services must not constitute custodial care. "Custodial care" means
 - care to assist patient in meeting activities of daily living;
 - care that does not require continued attention and assistance from licensed medical or trained paramedical personnel.
- A physician must order medical social services because social problems exist which are or will be an impediment to the effective treatment of the patient's medical condition or the patient's rate of recovery. Wellmark limits medical social services to those services requiring the specialized knowledge and judgment of a medical social worker. Family counseling is not a covered benefit.
- Wellmark covers home health aide services to provide personal care only in conjunction with a skilled service. FEP's home nursing care benefit does not cover home health aide services; FEP benefits are available when services are provided by an RN or LPN.

- Medical supplies must be used by the home health agency during the visit.
- Physical therapy services must be medically necessary services requiring the specialized judgment and knowledge of a licensed physical therapist.
- Speech therapy services must be medically necessary services requiring the specialized judgment and knowledge of a licensed speech therapist.
- Occupational therapy services must be medically necessary services requiring the specialized judgment and knowledge of a licensed occupational therapist.

*Home health benefit
for new mothers*

A member may be covered for one postpartum home health visit to assess both the mother and the infant following an obstetrical stay, depending on the patient's coverage and the length of the hospitalization. For example, a member's Alliance Select contract benefits provide the postpartum benefit as long as the mother's hospitalization does not exceed two days for a vaginal delivery, or four days for a cesarean section. Also, the home health visit must be provided within 36 hours of discharge from the hospital to be covered.

Note: FEP does not include benefits for a postpartum home health visit.

If provided within the benefit contract's time frame, the visit does not require precertification. If the inpatient stay exceeds the maximum length allowed for the home health visit, or if the physician orders additional visits, the services must be medically necessary and precertified (see page 6). The postpartum home health visit is not typically subject to deductible, coinsurance, or copayment.

Home health agencies and staff providing the postpartum visit must:

- be able to provide services seven days a week;
- provide assessments within 36 hours of discharge;
- have obstetrical and neonatal experience;
- be able to draw blood from infants for PKU and bilirubin tests; and
- assess the mother and infant for health problems and complications.

Private duty nursing

A limited number of Wellmark member contracts provide benefits for private duty nursing services. These services by an RN or LPN are covered when provided by an approved home health agency. Services must meet medical necessity for skilled services and be billed [as a facility claim](#). Like other home health services, private duty nursing must be provided to a member who is homebound, and the care must be precertified for medical necessity skilled services to avoid denial or benefit reductions. Home health services requested for members whose contracts do not provide benefits for private duty nursing will be reviewed for medically necessary skilled nurse visits.

Home infusion therapy/specialty drug administration

The provision of home infusion therapy and specialty drug administration may require home nursing visits. For more information about home infusion therapy, please see Wellmark's *Home Infusion Therapy Guide*. These nursing services also require precertification (see page 6).

Hospice defined

Hospice

A hospice program provides care, usually in the home, for patients who are terminally ill and have a life expectancy of six months or less.

Reimbursement

Except for continuous care, Wellmark reimburses for hospice care with per diem payments. A per diem payment is a payment for each day that a patient is provided actual hospice care. Hospice services cover respite care and the following home health services, which are included in the per diem reimbursement:

- nurse visits
- home health aide visits
- medical social worker visits
- physical therapy
- homemaker visits
- volunteer services
- bereavement counseling¹
- speech/language pathology
- occupational therapy
- medical supplies
- home medical equipment
- dietician services
- chaplain services
- drugs related to terminal disease

Wellmark covers the following types of services when the hospice provides or arranges, and bills the services:

- Routine home care—Covered for each day the patient is at home and not receiving continuous care.
- Continuous home care—Covered during periods of crisis and only as necessary to maintain the terminally ill patient at home. A period of crisis is a period of time when the patient or family requires continuous care to achieve palliative care or management of acute medical symptoms. Nursing care is the primary care used during continuous home care. To qualify as continuous nursing care, the patient must receive a minimum of eight hours of care in a 24-hour period. The 24-hour day begins and ends at midnight. Wellmark will reimburse the 15-minute rate for the patient receiving continuous care. [For details, see "Billing for Home Health and Hospice" in this guide.](#)

Nursing care requirement

A registered nurse or a licensed practical nurse must provide more than half of the nursing care given in a 24-hour period. The care does not have to be continuous (e.g., the nurse may provide four hours of care in the morning and four hours of care in the evening of the same day). If a home health aide supplements the nursing care, Wellmark benefits cover the care; however, FEP does not cover home health aide services.

¹Bereavement counseling and chaplain services cannot be billed separately, but may be included in the per diem payment.

*Respite care defined,
benefit maximums*

- Respite care—short-term inpatient or home care provided to the patient when necessary to provide rest and relief help to the family members or other persons caring for the patient. Inpatient respite care is not required to meet the normal medical necessity criteria that ordinarily apply to inpatient admissions. Benefits vary based on terms of member's benefit contract.

Typically, Wellmark benefit contracts do not provide benefits for more than five consecutive days of respite care at a time. Inpatient respite care is limited to a total of 15 days during the episode of hospice care. Some benefit contracts may also include outpatient respite care, which is usually limited to 15 days. Any portion of a day in which a patient receives respite care counts as one day.

- General inpatient care—includes hospitalization for pain control or acute/chronic symptom management that the patient cannot receive in other settings. Be sure to precertify inpatient care within the time frames identified on the patient's health insurance card.

Exclusions

Total Parenteral Nutrition (TPN), palliative chemotherapy and radiation are not included in our payment and should be billed separately. Services not listed as being included in the reimbursement (page 4) can be billed by the providers of service using the appropriate revenue codes.

*Additional hospice
coverage guidelines*

Additional guidelines for coverage of hospice services include the following:

- Medicare must certify and/or Wellmark must pre-approve the hospice agency furnishing services.
- Services must be precertified with Wellmark prior to the start of care (see page 6), whether providing inpatient or home care. The agency must have a written plan of treatment signed by a physician. FEP does not require precertification. Instead, FEP *requires a **prior approval*** before providing home hospice care (see page 6).
- Wellmark requires notification when the level of care changes to continuous home care or respite care. FEP does not.
- Wellmark benefits are available only for terminally ill patients with a life expectancy of six months or less.

III Precertification Process

The precertification provision requires the facility to notify Wellmark before a patient's scheduled admission to home health or hospice services. This allows Care Coordination staff to verify that the patient will receive services in the most medically appropriate setting.

FEP members Precertification is **not** required for FEP members for home nursing care. However, prior approval is *required* before hospice care begins. This process ensures the best possible care for the member's medical condition. To receive prior approval for FEP hospice services, call **800-532-1537**.

Wellmark members To precertify care for all other Wellmark members, call **800-552-3993**.

Payment reduction for failure to precertify When required, failure to obtain precertification will result in a denial or the following payment/benefit reductions:

When service provider is responsible When a participating facility is responsible for obtaining the precertification and fails to do so, the facility will receive a payment reduction of the lesser of 50 percent of the maximum allowable fee (MAF) or \$5000. The service provider cannot bill the member for this payment reduction.

When member is responsible When a member is responsible for obtaining precertification and fails to do so, the member will receive a benefit reduction of the lesser of 50 percent of the maximum allowable fee (MAF) or the dollar amount specified in his or her benefit contract.

Home health required information We need the following information before we can approve **home health services**:

- 1) The specific services ordered by the physician including frequency of visits
- 2) Functional limitations of the patient to support homebound status (how often does the patient leave home and for what reason?)
- 3) Clinical information to support the medical necessity of the services

Hospice required information Wellmark requires the following information to precertify **hospice care**:

- 1) Certification by the physician that the patient has a life expectancy of six months or less
- 2) Clinical information indicating that the patient is receiving palliative care only

Plan of Treatment/Patient Status Report

*Documentation for
HHA precertification*

HHAs are required to have a Plan of Treatment/Patient Status Report (POT/PSR) on file. Wellmark may request an audit of a Member's POT/PSR at any time.

*Changes in current
plan of treatment (ex-
tension of services)*

When the need arises to extend or change a patient's home care, the facility must notify the case manager with the updated request. Use the chart below to decide when to take action.

Note: If we grant a new approval, the facility must obtain a Plan of Treatment that reflects any changes.

If:	Then:
service needs to extend beyond current precertified period	contact a nurse reviewer
change in current plan of treatment or level of care occurs	request extension of services

III Billing for Home Health and Hospice

Effective July 1, 2010, precertification for home health and hospice services will be based on 15-minute units. The units of service should reflect only face-to-face time with the patient. Wellmark will monitor units of service and may require documentation to support the number of units. Visits are to be reported by rounding the time to the nearest 15-minute increment, and cannot be split into multiple lines.

Calculate units using the following table:

15-minute units of service

Units of Service	Time Increments
1 unit	1 minute to < 23 minutes
2 units	23 minutes to < 38 minutes
3 units	38 minutes to < 53 minutes
4 units	53 minutes to < 68 minutes
5 units	68 minutes to < 83 minutes
Continue adding 15-minute increments as needed	

Fees are based on 15-minute increments and are inclusive of all costs, including travel and documentation time.

One date of service on each claim line

When billing home health or hospice services facility claims, please submit detailed claim lines using a single date of service. If a claim line is billed with a date span, only one date of service will be paid.

Home Health

*Home health
revenue codes*

Use the following *home health* revenue codes to bill home health services. List revenue codes [in loop 2400 SV201 on electronic claims](#) or in form locator (FL) 42 on the UB-04. A description, [when required, may be added in loop 2400 SV202-7 when filing electronically, or in FL43 on the UB-04.](#) Home health services should have a Type of Bill 33X in [loop 2300 CLM05 or in form locator 4 on the UB-04.](#) HCPCS codes must be submitted [in loop 2400 SV202-2 on electronic claims or in FL44 on the UB-04 when indicated below.](#)

Categories of Care	Revenue Code	HCPCS Code	Unit
Skilled Nursing	0550	Yes	15 minutes
Physical Therapy	0420	Yes	15 minutes
Occupational Therapy	0430	Yes	15 minutes
Speech Therapy	0440	Yes	15 minutes
Medical Social Worker	0560	Yes	15 minutes
Home Health Aide	0570	Yes	15 minutes
Home Health—Other Visits (To be used for Extended Nursing Care)	0580	N/A	Hour
Home Health—Other Visits (To be used for Private Duty Nursing—RN)	0582	N/A	Hour
Home Health—Other Visits (To be used for Private Duty Nursing—LPN)	0589	N/A	Hour
Durable Medical Equipment	0290, 0291, 0292, 0293, 0294, 0299	As appropriate	As appropriate
Medical Supplies	0270-0279	As appropriate	As appropriate
Drugs	0631-0637	As appropriate	As appropriate

Payment for Home Health services will be made at the lesser of charge or Wellmark's fee schedule, less applicable deductible, copayment, and/or coinsurance amounts.

Hospice

Use the following revenue codes to bill *hospice* services. List revenue codes in loop 2400 SV201 on electronic claims or in form locator (FL) 42 on the UB-04. A description, when required, may be added in loop 2400 SV202-7 when filing electronically, or in FL43 on the UB-04.

Use Type of Bill 81X or 82X as appropriate in loop 2300 CLM05 or in FL4.

81X = Non-hospital based hospice

82X = Hospital based hospice

HCPCS codes must be submitted in loop 2400 SV202-2 on electronic claims or in FL44 on the UB-04 when indicated below.

Hospice revenue codes

Categories of Care	Revenue Code	HCPCS Code	Unit
Routine Home Care	0651	No	1
Inpatient Respite Care	0655	No	1
Continuous Care	0652	No	15 minutes
General Inpatient Care	0656	No	1
Drugs	0631-0637	Yes	As Appropriate

Keep in mind that patients may have deductible, coinsurance, and lifetime maximum amounts for home health or hospice services. Day limits and dollar maximums may limit the scope of the patient's benefits. When a patient's benefit contract has day limitations, we calculate days on a 3:1 ratio (home health/hospice to inpatient days).

If you have questions about home health or hospice benefits, please call:

Wellmark Blue Cross and Blue Shield of Iowa
and

Wellmark Health Plan of Iowa

800-362-2218 or **515-376-4688**

Wellmark Blue Cross and Blue Shield of South Dakota

800-774-3892 or **605-373-7292**

Federal Employee Plan

800-532-1537 or **515-376-4784**

Secure online tools

You may also verify eligibility and benefits using the secure Web tools available at Wellmark.com. To gain first-time access to our secure online tools, apply by selecting the [Register for Wellmark.com](#) link on our website's Provider page.

Once you have access to our secure online tools, simply log in to [Wellmark.com](#) and click on the Provider tab. Under *Provider Tools*, select *View Eligibility & Benefits*.

Iowa Service Contacts

Wellmark Blue Cross and Blue Shield of Iowa
Wellmark Health Plan of Iowa, Inc.
Des Moines, IA 50306-9232

Wellmark Blue Cross and Blue Shield of Iowa*

Wellmark Health Plan of Iowa, Inc.*
..... 800-362-2218 or 515-376-4688

Federal Employee Program*
..... 800-532-1537 or 515-376-4784

Tyson Foods
..... 800-526-5710

Iowa Bankers *for benefit questions only*
..... 800-258-1415 (call 800-362-2218 for claims issues)

UI Care, UI GradCare, and UI Select
..... 800-355-2031

Ford Retirees
Physicians ... 800-344-8525; Facilities ... 800-249-5103

Admission Notification, Precertification, and Case Management
..... 800-552-3993

Network Relations
..... 515-376-5167

Contact to discuss contracting opportunities in your area

Pregnancy Program*
..... 866-460-9742

Disease Management Program*
..... 866-816-5264

Network Administration*
.... 800-708-1342 or 515-376-5100

Providing information about:
network participation provider number
address change application status
credentialing/recredentialing status
taxpayer identification number change

BlueCard® Program*
Out-of-state members' claim status or payment information
..... 800-362-2218 or 515-376-4688

Out-of-state members' eligibility information
.... 800-676-2583

EC (Electronic Commerce) Solutions*
..... 800-407-0267
Providing: Electronic claims and reports information

Pharmacy Department
..... 800-600-8065

South Dakota Service Contacts

Wellmark Blue Cross and Blue Shield of South Dakota
Sioux Falls, SD 57104

Wellmark Blue Cross and Blue Shield of South Dakota*
Provider/Customer Service Center
..... 800-774-3892 or 605-373-7292

Federal Employee Program*
..... 800-532-1537

Tyson Foods
..... 800-526-5710

Admission Notification, Precertification, and Case Management
800-642-9273

Network Relations
.... 800-700-9137 or 605-373-7460

Fax Numbers
..... 888-517-9419 or 515-376-9039

Contact to discuss contracting opportunities in your area

Pregnancy Program*
..... 866-460-9742

Disease Management Program*
..... 866-816-5264

Network Administration*
.... 800-708-1342

Providing information about
network participation provider number
address change application status
taxpayer identification number change

BlueCard® Program
Out-of-state members' claim status or payment information
..... 800-774-3892

EC (Electronic Commerce) Solutions*
..... 800-407-0267
Providing: Electronic claims and reports information

Pharmacy Department
..... 800-600-8065



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*You will find e-mail links to these areas from our website at
Wellmark.com > *Contact Us (top right of page)*. Select
For Providers and on the next screen, choose your state.