Home Health Care Services Skilled and Non-Skilled Payment Policy

Policy Overview

A Home Health Agency (HHA) is a public or private organization that delivers skilled nursing and other therapeutic services to a patient at home. Home Health/Home Care Services means those services provided under a home care plan authorized by a physician or non-physician practitioner (NPP). This policy outlines Neighborhood's coverage and reimbursement requirements for home health care services.

Scope

This policy applies to:

☐**Medicaid**

☐**Commercial**

☒**Dual CONNECT (Coordination only D-SNP)**

☒**INTEGRITY for Duals (Fully Integrated D-SNP)**

Prerequisites

It is the provider's responsibility to verify eligibility, coverage, and authorization criteria prior to rendering services.

For more information, please refer to:

- Neighborhood's plan specific Prior Authorization Reference page.
- Neighborhood's Home Health Care Services - Skilled & Non-Skilled Clinical Medical Policy for detailed information regarding covered services, benefit limitations, exclusions, etc.

Please contact Provider Services at 1-800-963-1001 for questions related to this policy.

Coverage Guidelines

Home Health Care services are provided under a written home care plan authorized by a health care professional[i], including full-time, part-time, or intermittent skilled and non-skilled services, delivered by a Home Health Agency.[ii]

Coverage is provided for services performed within the scope of state licensure, as defined by the Rhode Island Department of Health, within the member's home setting. A home setting is any place where the member has established his/her place of residence for the time period when home care

services are being provided. This may include his/her own dwelling, an apartment, the home of a friend or family member, a group home, a homeless shelter or other temporary place of residency or a community setting. Hospitals, skilled nursing facilities intermediate care facility for the developmentally disabled, or any other institutional facility providing medical, nursing, rehabilitative, or related care, will not be considered "home setting." A day care setting, adult day care, or adult medical care does not meet the definition of a home setting.

Covered services include:

- **Skilled Services**
- **Non-Skilled Services**
- **Private Duty Nursing (PDN) Services**

For a more detailed description outlining these services, please refer to the Home Health Care Services - Skilled & Non-Skilled Clinical Medical Policy

Skilled Services

INTEGRITY for Duals & Dual CONNECT

30-day Episodic Billing

The Medicare payment unit for home care under the Home Health Prospective Payment System (HH PPS) is a period of care, usually 30 days in length. Included in the payment are all Medicare covered home health care that is reasonable and necessary for the patient's care, including routine and nonroutine supplies used by that beneficiary during the period of care.

That means the 30-day period payment rate includes costs for the six home health disciplines and the costs for routine and non-routine medical supplies. The six home health disciplines included in the 30-day period payment rate are:

1. Skilled nursing services;
2. Home health aide services;
3. Physical therapy;
4. Speech-language pathology services;
5. Occupational therapy services; and
6. Medical social services.

Services provided under a home care plan authorized by a health care professional, including full-time, part time, or intermittent skilled nursing care, physical therapy, occupational therapy, speech–language pathology, medical social services, DME and medical supplies for use at home, and all other services must be provided by a Medicare certified home health agency[iii].

Low Utilization Payment Adjustment (LUPA)

If an HHA provides fewer than the threshold of visits specified for the period's HHRG, they will be paid a standardized per visit payment. Such payment adjustments are called Low Utilization Payment Adjustments (LUPAs).

Coding/Claim Submission Requirements

Neighborhood follows CMS HHPPS requirements as outlined in the Medicare Claims Processing Manual Chapter 10 for Home Health Agency Billing. Examples include but are not limited to:

- 837 Institutional file format (UB-04);
- Type of bill 329;
- Statement Covers;
- Admission Date/Time;
- Discharge Status;
- Condition Code(s);
- Occurrence code(s);
- Value code(s);
- Revenue code 0023 with appropriate 5-Digit Health Insurance Prospective Payment System (HIPPS) code;
- Appropriate Site of Service code (Q5001, Q5002, or Q5009);
- Appropriate Revenue/HCPC codes below;
  - 042x – Physical Therapy
    - G0151, G0157, G0159, G2168
  - 043x – Occupational Therapy
    - G0152, G0158, G0160, G2169
  - 044x – Speech Therapy Pathology
    - G0153, G0161
  - 055x – Skilled Nursing
    - G0299, G0300
  - 056x – Medical Social Services
    - G0155
  - 057x – Home Health Aid
    - G0156

Benefit Limitations and Exclusions

- Home Health services are not covered if provided in a hospital, nursing facility, intermediate care facility for the developmentally disabled, adult day center, or any other institutional facility providing medical, nursing, rehabilitative, or related care.

- Home Health services are not covered solely to allow the caregiver to work or attend school. Lack of an available caregiver does not mean that an otherwise non-skilled service becomes a skilled service.
- The cost of home health services must not exceed the cost of care in an institutional setting.
- Beneficiaries are not required to be homebound.

Non-Skilled Services

INTEGRITY for Duals

Medicaid home care/non-skilled services include personal care services, homemaker services, and combined personal care and homemaker services. Please refer to the Home Health Care Services - Skilled & Non-Skilled Clinical Medical Policy for coverage criteria.

Coding/Claim Submission Requirements

- Claims must be billed using the 837 Professional file format (CMS-1500).

CPT Code	Description
S5125	Attendant care services; per 15 minutes
S5125-U1	Combination of personal care and homemaking, rendered at the same time, per 15 minutes. U1 modifier must be included each time this service is billed.
S5125-U9	High Acuity Attendant care services; per 15 minutes
S5125-U1, U9	High Acuity combination of personal care and homemaking, rendered at the same time, per 15 minutes when the Minimum Data Set (MDS) reflects high acuity.
S5130	Homemaker service, NOS; per 15 minutes
T1001	Nursing assessment/evaluation

*In addition to U1 and U9, the following modifiers may apply to attendant care and combination services **(*please note**- The shift differential modifier must precede the acuity modifier when both are applicable):

Modifier	Definition
TV	Weekend/Rhode Island State Holiday Shift

Modifier	Definition
UH	Evening Shift 3PM -11PM
UJ	Night Shift 11PM-7AM

Date span billing may be used for non-skilled services, subject to the following:

- Claims should be submitted for dates of service in one calendar month;
- Date span billing is limited to one week per claim line;
    - Date span billing is prohibited when used with shift differential modifiers, unless the modifier applies to each date of service in the date span.
- Services were provided consecutively on each date within the date span;
- Any break in service within a date span (i.e., services were provided on Monday, Tuesday, and Wednesday, then on Friday and Saturday) must be indicated on a new claim line;

Time-based codes must be billed for the date of service on which they are rendered, not the date of service on which a scheduled shift begins.

Benefit Limitations and Exclusions

- Homemaking and Personal Care services are covered for up to 6hrs per week for individuals or 10hrs per week for couples who do not meet LTSS eligibility criteria.
    - Members who are identified as high risk or whose comprehensive assessment indicate a need for LTSS should be referred to EOHHS to apply for an LTSS waiver.
- Personal care, including when combined with homemaker services, may only be billed when delivered by a nursing assistant and cannot be billed when delivered by a homemaker.
- Non-skilled services do not require a physician's order.
- Non-skilled services may be delivered by a home health agency that is not Medicare certified.
- Home Care services are not covered if provided in a hospital, nursing facility, intermediate care facility for the developmentally disabled, adult day center, or any other institutional facility providing medical, nursing, rehabilitative, or related care.
- Home Care services are not covered solely to allow the caregiver to work or attend school. Lack of an available caregiver does not mean that an otherwise non-skilled service becomes a skilled service.
- The cost of home care services must not exceed the cost of care in an institutional setting.
- Beneficiaries are not required to be homebound.
- Home Care services which include procedure codes T1001, S5125, S5130, and associated modifiers should be delivered and billed as one-on-one care only. This does not preclude the same provider from delivering services to two people in the same household.[1]

[1] https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2024-12/HCBS Waiver V1.11.pdf

- Per EOHHS, staff must be assigned by the home care and/or home health provider based on staff availability and ability to serve each individual member receiving services from the provider.
    - The provider may not assign direct care staff to provide services to a member with whom the direct care staff resides.
    - The provider may not assign direct care staff to provide services to a member to whom the direct care staff has a family relationship[2].
    - The provider may not assign direct care staff to provide services to a member for whom the direct care staff:
        1. Has any type of guardianship;
        2. Has any type of power of attorney;
        3. Is the authorized representative designated on the individual member's application for Medicaid benefits.

Please refer to **210-RICR-20-05-1** for an outline of requirements and limitations pertaining to home care and home health provider agency participation in and payment by the Rhode Island Medicaid program.

Private Duty Nursing

INTEGRITY for Duals

Individual and continuous skilled care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of state law and as identified in the member's plan of care. Coverage is provided on a "per hour" or "per block hours" basis, not on basis of unique or intermittent visits. This service is intended for members who have complex medical conditions or disabilities, which are being managed at home. The member's condition requires continuous skilled care greater than two (2) hours per day that can only be conducted by an RN or LPN according to practice standards. Private duty nursing is considered supportive to the care provided to a member by their caregiver(s) in maintaining the member at home. It is not intended to replicate the services of a nursing home. The caregiver(s) must be able to safely care for the member in the absence of the home health agency.

[2] "Family relationship" means the following relationships:
a. Parent-child (including stepparent/stepchild)
b. Grandparent-grandchild (including step-grandparent/step-grandchild)
c. Sibling (including step-sibling); and
d. Spouse.

Coding/Claim Submission Requirements

- Claims must be billed using the 837 Professional file format (CMS-1500).

CPT Code	Modifier	Description
T1000		RN services, up to 15 minutes
T1000	TE	LPN/LVN services, up to 15 minutes
T1001		Nursing assessment/evaluation

The modifiers below can be used with T1000 when appropriate.

Modifier	Definition
TV	Weekend/Rhode Island State Holiday Shift
UH	Evening Shift 3PM -11PM
UJ	Night Shift 11PM-7AM

Benefit Limitations and Exclusions

- An approved LTSS-HCBS waiver is required for adult members to receive PDN services.
- It is considered duplication or overlap of services for a member to receive:
  1. Private duty nursing services and home health aide services, and/or *
  2. Private duty nursing services and home infusion nursing oversight services *

  *When there is duplication or overlap of services, the lowest level of care needed to safely meet the member's needs may be covered.
- Home care services should be delivered and billed as one-on-one care only. This does not preclude the same provider from delivering services to two people in the same household.[3]
- Private Duty Nursing services may be delivered by a home health agency that is not Medicare certified.

Member Responsibility

For Neighborhood **CONNECT** (Coordination only D-SNP plan), providers must submit claims to Neighborhood and any remaining copays/coinsurance amounts and Medicaid covered benefits to EOHHS for reimbursement.

INTEGRITY for Duals members may have a monthly patient share provision, as determined by the Rhode Island Executive Office of Health and Human Services (RI EOHHS).

Patient share will be applied and is deducted from the benefit allowed amount at the time of payment adjudication. Providers should submit the claim with total billed charges, including patient share.

[3] https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2024-12/HCBS Waiver V1.11.pdf

Claim Submission

Billable services are subject to contractual agreements, when applicable. Providers are required to submit complete claims for payment within contractually determined timely filing guidelines.

Coding must meet standards defined by the American Medical Association's Current Procedural Terminology Editorial Panel's (CPT®) codebook, the International Statistical Classification of Diseases and Related Health Problems, 10th revision, Clinical Modification (ICD-10-CM), and the Healthcare Common Procedure Coding System (HCPCS) Level II.

Documentation Requirements

Neighborhood reserves the right to request medical records for any service billed. Documentation in the medical record must support the service(s) billed as well as the medical necessity of the service(s). Neighborhood follows CMS standards for proper documentation requirements.

To qualify for reimbursement, all records must be kept in accordance with Rhode Island state and federal regulations.

A medical record must be created for each member receiving Home Health/Home Care Services, and contain **no less** than the following:

- Patient identification (name, address, birth date, gender, date of admission or readmission);
- Source of Patient Referral;
- Name of Physician (including address and telephone number);
- Plan of Care
- Personal Care objectives;
- Homemaker objectives (where applicable);
- Medical diagnosis and nursing assessment, therapeutic goals, prognosis and all conditions relevant to the plan of care, including any known allergies and reactions, surgical procedures, surgical complications, infections, prior diagnoses, presence of pressure ulcers, incontinence, disabilities;
- Drug, dietary, treatment, and activity orders;
- Signed and dated clinical and progress notes;
- Signed and dated record of service refusal;
- Copies of summary reports sent to the attending physician;
- Changes in and reviews of the patient's plan of care, signed by responsible professional;
- Documentation of an advance directive (if any) and a copy of the advance directive, if provided to the facility by the patient; and
- Discharge Summaries.

Disclaimer

This payment policy is informational only and is not intended to address every situation related to reimbursement for healthcare services; therefore, it is not a guarantee of reimbursement.

Claim payments are subject to the following, which include but are not limited to: Neighborhood Health Plan of Rhode Island benefit coverage, member eligibility, claims payment edit rules, coding and documentation guidelines, authorization policies, provider contract agreements, and state and federal regulations. References to CPT or other sources are for definitional purposes only.

Neighborhood processes Dual CONNECT and INTEGRITY for Duals in accordance with CMS Medicare guidelines. Refer to CMS Medicare guidance for complete rules and claims processing policies.

This policy may not be implemented exactly the same way on the different electronic claims processing systems used by Neighborhood due to programming or other constraints; however, Neighborhood strives to minimize these variations.

The information in this policy is accurate and current as of the date of publication; however, medical practices, technology, and knowledge are constantly changing. Neighborhood reserves the right to update this payment policy at any time. All services billed to Neighborhood for reimbursement are subject to audit.

Document History

Date	Action
11/01/2026	Updated non-skilled Coding/Claim Submission.
08/01/2026	Updated Coding Grid to reflect coding changes for Private Duty Nursing codes.
01/01/2026	Policy effective date.

[i] *Contract between CMS, RI EOHHS, and NHPRI*, "Health Care Professional": A physician or other provider of health care services under this Demonstration, including but not limited to: a podiatrist, optometrist, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy assistant.

[ii] RIGL 17-23-4; 42 CFR, Part 484 - Conditions of Participation: Home Health Agencies

[iii] *Contract between CMS, RI EOHHS, and NHPRI*: Home Health Services defined.