SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.16 HOME HEALTH AGENCY

This is a subsection of Section 5: Billing and Reimbursement Guidelines of the *Professional Provider Office Manual*. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this subsection and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.BCBSLA.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.BCBSLA.com/providers.

This manual is provided for informational purposes only and is an extension of your Professional Provider Agreement. You should always directly verify member benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. The Member Contract/Certificate contains information on benefits, limitations and exclusions, and managed care benefit requirements. It also may limit the number of days, visits or dollar amounts to be reimbursed.

As stated in your agreement: This manual is intended to set forth in detail Blue Cross policies. Blue Cross retains the right to add to, delete from and otherwise modify the *Professional Provider Office Manual* as needed. This manual and other information and materials provided by Blue Cross are proprietary and confidential and may constitute trade secrets of Blue Cross.

HOME HEALTH AGENCY

Blue Cross recognizes the need to maintain consistency of billing requirements for both Blue Cross and Medicare wherever possible. Therefore, we require home health agencies to file claims using the UB-04 claim form (see instructions in the Claims Submission section of this manual) in accordance with Medicare guidelines with the following exceptions:

1. The revenues codes accepted by Blue Cross and which may be entered in Block 42 of the UB-04 claim form are limited, and revenue code descriptions for Block 43 have been modified. These modifications are necessary due to member contract/certificate variations.

   Revenue codes 551 and 559 and their respective descriptions have been changed to identify services provided by a registered nurse (RN) or a licensed practical nurse (LPN). This change is necessary because reimbursement rates are different for RNs and LPNs.

   Revenue code 261, IV therapy pump, requires a modifier in order for the correct type of service to be assigned (see the Modifier section in this manual for detailed information).

   The revenue codes with descriptions accepted by Blue Cross from participating home health agencies listed in this manual. The appropriate HCPCS or CPT code must be included in Block 44 of the UB-04 claim form when billing revenue codes with double asterisks (**), shown under the column heading "Code Reqd." This is necessary for proper pricing and payment of the service.

2. Accumulative billing of services will be accepted by utilizing a "From" and "Through" date with the total units of service for a specific revenue code or HCPCS code. However, some member contracts/certificates and/or groups require that the individual date of service be shown for each day on which services were provided. When this situation applies, you will be notified when you authorize services and also via the written confirmation of the authorization.

Authorization is required for ALL home health care. Blue Cross requires 48 hours advance notice of all home health care to be provided. The authorization will include the service and/or code to be provided and in some cases, the quantity/units of services authorized. The services that we will generally approve are included in this manual and include the range of HCPCS/CPT codes that should be billed with the revenue code.

Effective October 1, 2020, home health providers are required to request all authorizations for home health services through the BCBSLA Authorizations tool on iLinkBlue. For more on home health authorizations, refer to the Medical Management section of this manual.

Home Health Agency Revenue Codes Accepted by Blue Cross

Visit charge is defined as a consecutive period of time up to two hours during which home health care is rendered. Hourly charges exceeding two hours require additional authorization from Blue Cross.

Hourly charges for home health aides and private duty nursing (in shifts of at least eight continuous hours) must be billed using the revenue codes appropriate to the level of professional training.

Revenue Code	Description	HCPCS/ CPT Range	Code Req'd	Program Rate
258	Pharmacy - IV Solutions	J0000 thru J9999, B4150 thru B5200		Allowable Charge
261*	IV Therapy - Infusion Pump	E0781 thru E0784, E1520, A4220		Allowable Charge
264	IV Therapy - IV Therapy Supplies	A4230 thru A4232, A4221, A4222, B4034 thru B4083, B9002 thru B9999		Allowable Charge
271	Medical/Surgical Supplies & Devices, Nonsterile Supply	A4206 thru A6404		Allowable Charge
272	Medical/Surgical Supplies & Devices, Sterile Supply	A4206 thru A6404		Allowable Charge
274	Medical/Surgical Supplies & Devices, Prosthetic/Orthotic Devices	L0000 thru L4999, L5000 thru L9999		Allowable Charge
291	DME (Other than Renal), Rental	E0100 thru E1406, E1700 thru E1830		Allowable Charge
292	DME (Other than Renal), Purchase of New DME	E0100 thru E1406, E1700 thru E1830		Allowable Charge
293	DME (Other than Renal), Purchase of Used DME	E0100 thru E1406, E1700 thru E1830		Allowable Charge
294	DME (Other than Renal), Supplies/ Drugs for DME Effectiveness	E0100 thru E1406, E1700 thru E1830		Allowable Charge
300-319	Laboratory	80047 thru 89398, 36415		Allowable Charge
421	Physical Therapy - Visit Charge			Allowable Charge
424	Physical Therapy - Evaluation or Re-evaluation			Allowable Charge
431	Occupational Therapy - Visit Charge			Allowable Charge
434	Occupational Therapy - Evaluation or Re-evaluation			Allowable Charge
441	Speech-Language Pathology - Visit Charge			Allowable Charge
444	Speech-Language Pathology - Evaluation or Reevaluation			Allowable Charge
550**	Skilled Nursing-Hourly Charge (Licensed Practical Nurse)			Allowable Charge
551**	Skilled Nursing-Visit Charge (Registered Nurse)			Allowable Charge

552**	Skilled Nursing-Hourly Charge (Registered Nurse)			Allowable Charge
559**	Skilled Nursing-Visit Charge (Licensed Practical Nurse)			Allowable Charge
561	Medical Social Services - Visit Charge			Allowable Charge
571**	Home Health Aide - Visit Charge			Allowable Charge
600	Oxygen (Home Health)	E0424 thru E0480, E0442-E0444, E0600, E0601, E0550 thru E0585, E1353 thru E1406		Allowable Charge
999	Other Patient Convenience Items			Allowable Charge

Please Note: Allowable charges for revenue codes that are not specifically listed above will be established periodically.

* *More on IV Therapy - Infusion pump (Revenue code 261) on the next page*

** *More on skilled nursing revenue codes below*

More on Revenue Codes for Skilled Nursing

Revenue Code	Description
550	Skilled Nursing – Hourly Charge – Licensed Practical Nurse (Private Duty Nursing)
552	Skilled Nursing – Hourly Charge – Registered Nurse (Private Duty Nursing)
572	Home Health Aide – Hourly Charge
The Allowable Charge for revenue codes 550, 552 and 572 for private duty nursing or home health aide services will be considered for approval during the private duty nursing or home health aide services authorization process. Services and procedures (CPT/HCPCS) not listed on the above schedule will be reimbursed at the lesser of the billed charge or an amount established by Blue Cross. The presence of a revenue code or allowable charge on this listing is not to be interpreted as meaning that the patient has coverage or benefits for that service.	

The allowable charge for revenue codes 551 and 559 for skilled nursing includes, but is not limited to:

1. Pre- and post-hospital assessment
2. IV infusion
3. Administration of medication: PO, IM, SQ
4. Training and educating patient, family and caregiver
5. Wound care management
6. Patient monitoring

7. Laboratory blood drawing
8. Physician case conference
9. Discharge assessment
10. All medical equipment and supplies associated with one through nine above whether reusable or non-reusable including, but not limited to:

Alcohol prep sponge	Non-sterile gauze	Tape
Band-Aids	Non-sterile specimen	Thermometer cover
Gloves	Over the counter – for skin tears	Vacutainers with needles
Incontinent cleaners	Personal care items	
Lotion	Sharps disposable containers	

The allowable charge for revenue codes 551 and 559 for skilled nursing includes, but is not limited to, the following HCPCS/CPT codes:

99070	A4330	A4490	A4640	A5071-A5073
A4206-A4210	A4335	A4495	A4649	A5081
A4212	A4364	A4500	A4663	A5082
A4215	A4398	A4510	A4670	A5093
A4233-A4236	A4402	A4550	A4770	A5120
A4244-A4246	A4421	A4554	A4913	A6216-A6221
A4250	A4450	A4627	A4927	A6260
A4259	A4452	A4630	A5051-A5055	E2360
A4328	A4455-A4456	A4635-A4637	A5061-A5063	

Modifiers that must be included with IV Therapy - Infusion Pump (revenue code 261):

BP The beneficiary has been informed of the purchase and rental options and has elected to purchase the item

BU The beneficiary has been informed of the purchase and rental options and after 30 days has not informed the supplier of his/her decision

BR The beneficiary has been informed of the purchase and rental option and has elected to rent the item

LL Lease/Rental (use Modifier LL when DME equipment rental is to be applied against the purchase price)

NU New Equipment

Q0 Investigational clinical service provided in a clinical research study that is in an approved clinical research study

RR Rental (use Modifier RR when DME is to be used)

UE Used durable medical equipment

NR New when rented (use Modifier NR when DME that was new at the time of rental is subsequently purchased)