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9.1 General

9.1.1 Description

Home health services are services provided to a recipient by a Medicare certified home health agency:

- At the recipient's place of residence or at a location other than a hospital, skilled nursing facility (SNF), intermediate care facility – mental retardation (ICF-MR) or intermediate care facility (ICF);

- On a physician's orders as part of a written plan of care that the physician reviews every sixty days; and

- Medical supplies, equipment and appliances suitable for use in the home are subject to the guidelines outlined in Chapter 10, Durable Medical Equipment, Prosthetic and Orthotic Devices and Medical Supplies (DMEPOS).

9.1.2 Amount, Duration and Scope

Home health services shall include:

- Nursing services provided on a part-time or intermittent basis;

- Home health aide services;

- Medical supplies, equipment and appliances suitable for use in the home, subject to prior authorization;

- Physical therapy, occupational therapy, speech therapy and audiology services subject to prior authorization (see Medicaid Guidelines for Home Health Therapy Services in Appendix 6).

9.1.2.1 Requirements for Skilled Nursing Services

a) The skilled nursing service(s) requested cannot be safely performed by the recipient or his/her caregiver (the reason why the service cannot be safely performed must be stated), and

b) One of the following conditions is met and documented in a plan of care:

- The recipient is homebound and at an ICF or SNF level of care and without specific skilled nursing service(s), the patient will require institutionalization at a higher level of care. The plan of care or Outcomes Assessment Information Set (OASIS) must document that the patient is at ICF or SNF level of care and is homebound.

- The recipient is homebound and the specific service(s) would avoid or delay hospitalization at an acute level of care for the condition being treated. The specific condition being treated must be stated.

- The recipient is not homebound, but services cannot be performed in a clinic, outpatient setting or a physician's office. The reason why services cannot be performed in these settings must be stated.

- The recipient is not homebound but has a history of recurrent hospitalization, which may be prevented by skilled nursing monitoring and timely intervention. Dates and reasons for recurrent hospitalizations must be documented.

9.1.2.2 Requirements for Home Health Aide Services

One of the two following scenarios must be met:

- All of the following requirements are met and documented in a CMS Home Health Certification and Plan of Care (Form CMS-485) and Outcome and Assessment Information Set (OASIS):

  1) The recipient is home-bound;

  2) The recipient is not able to perform the requested service(s) without assistance; OR

  3) The recipient's caregiver is not able to perform the requested services.

OR

- All of the following requirements are met and documented in a CMS Home Health Certification and Plan of Care (Form CMS-485) and Outcome and Assessment Information Set (OASIS):

  1) The recipient is not home-bound;

  2) The recipient has functional limitations in activities of daily living and/or requires skilled nursing services which would indicate that he/she is at or near an ICF or SNF level of care; and

  3) Services cannot be performed by the recipient or caregiver.

In addition, these requirements must be submitted to the Department on the CMS Home Health Certification and Plan of Care (Form CMS-485). Refer to Appendix 6 for a sample of this form or obtain a copy of the form from the CMS website: http://cms.hhs.gov/forms/cms485.pdf

9.1.3 Exclusions

Home health services shall not include medical social services and other services not specifically listed in this section.

9.1.4 Limitations

Skilled Nursing and Personal Care Home Care services reimbursement for home health services shall be limited to the following:

- Home health services shall be reimbursable on a "per visit" basis. A visit shall encompass approximately one or two hours of service;
- Only one (1) visit per day;
- Daily home visits are permitted for home health aide and nursing services and do not require a medical authorization if they are rendered:

  1) In the first two (2) weeks of care and are part of the written plan of care;
  2) During the third to the seventh week of patient care and do not exceed three (3) visits a week;
  3) During the eighth to the fifteenth week of patient care and do not exceed one (1) visit a week;
  4) From the sixteenth week of patient care and do not exceed one (1) visit every other month.

- Monthly Home Health Agency (HHA) skilled nursing visits and supplies for care of a central line (Port-A-Cath, Broviac, etc.) which is not being actively used in treatment requires documentation of medical justification as to why a line is needed when it has not been used for more than three (3) months.
- Services exceeding the parameters of this section shall be prior authorized by the department's medical consultant or it's authorized representative.

9.1.5 Authorization

a) A plan of care must be developed for all home health services even if prior authorization is not required. The plan of care must include documentation of the medical need for the specific service(s). The plan of care must be signed and dated by the physician.

b) Prior authorization is required for skilled nursing and personal care in the following situations:

Visits Per Discipline	Weeks of care
>1 visit/day	For any discipline
Daily visits	After first 2 weeks
>3 visits/week	From 3rd to 7th week
>1 visit/week	From 8th to 15th week
>1 visit/every other month	From 16th week

9.2 Home Health Agency Provided Rehabilitative Services

9.2.1 Description

Physical therapy (PT), occupational therapy (OT), speech therapy (ST), speech/language/audiology evaluations and audiology treatment is provided to homebound Medicaid recipients in the home setting by home health agencies if specific conditions apply. These services must be appropriate for the home setting.

9.2.2 Amount, Duration and Scope

Certain conditions such as those described in "Home Health Agencies" apply. Please refer to that section in this manual. The PT, OT and ST must be part of the patient's plan of care in order to be approved. Specific criteria are discussed below and referenced in Appendix 6.

9.2.3 Exclusions

Services, which do not meet the criteria, provided in this section and the Appendix will not be covered.

9.2.4 Limitations

Home health services are only payable to Medicare certified Home Health Agencies.

9.2.5 Authorization

a) Home Health Agencies (HHA's) are required to obtain prior authorization on the 1144 form for Physical therapy (PT), Occupational therapy (OT), Speech therapy (ST), Speech/Language/Audiology evaluations and Audiology treatment provided to Medicaid recipients.

Authorization is not required for the following:

- Prior or medical authorization is not required for initial Physical therapy (PT) or Occupational therapy (OT) evaluations, if they are part of a plan of care and if they are performed for the purposes of assessing therapy need and or establishing a plan of care.

- Speech evaluations for dysphagia and speech therapy for dysphagia found on the speech evaluation do not require prior authorization. (HHA's must clearly state that the speech evaluation was for dysphagia and the date of the evaluation must appear in the "Justification" section. The request for evaluation must be consistent with the diagnosis(es) entered by the physician. A plan of care including the therapy for dysphagia must be attached to the 1144 form.) A medical authorization, however, is required.

b) All enteral and parenteral therapy and supplies require prior authorization on the 1144 form.

c) For medically necessary PT/OT in the home setting, Medicaid will approve a maximum of three (3) PT/OT visits per week for the first two (2) weeks of therapy under the following circumstances:

1) The patient is homebound and the therapy is being provided in his/her home.

2) A plan of care, signed by a physician, clearly indicates the three (3) PT/OT visits are medically necessary. The plan of care is attached to a properly completed 1144 form. (If the plan of care indicated that less than three (3) PT/OT visits are medically necessary, only the number specified on the plan of care will be approved.)

3) After the initial two weeks of therapy, Medicaid will evaluate the plan of care based on medical necessity and cost-effectiveness. Submit requests for authorizations for PT/OT services in the first two weeks of therapy as soon as a plan of care indicates that PT/OT is needed.

d) The Medical Guidelines for Home Health Therapy Services will be used in determining reasonable and medically necessary PT, OT and ST services. If the PT, OT and/or ST services do not meet the criteria in the guidelines, services will be denied. These guidelines can be found in Appendix 6.

9.3 Billing

a) Effective October 1, 2000, Medicare began reimbursing services provided by Medicare certified home health agencies using the Home Health Prospective Payment System (HHPPS). **Hawaii Medicaid has not and is not currently planning to implement the HHPPS**.

b) All UB92 submittals will be processed as claims for actual services rendered. "Requests for Anticipated Payment (RAPs)" will not be accepted.

c) There is no requirement that billing must be for a 60 day episode of care.

d) The table, which follows cover, the data elements required in the initial submission of claims. It does not cover UB-92 coding for adjustments, replacements, and cancellations.

e) The table lists only the specific form locator (FL) blocks which Medicare requires completed by HHAs in HHPPS, the name of the field, and the information which should be entered in the field when billing Medicaid when Medicaid is the patient's primary insurer or when the services provided are not a benefit of the primary insurer. Please consult the most current edition of the Hawaii State UB92 Provider Manual Hawaii for completion of other FL blocks.

Form Locator (FL)	Description	Data Elements to Enter
4	Type of Bill	Enter 32X; X= 1 (admit through discharge); 2 (1st interim claim); 3 (interim continuing claim); 4 (interim last claim).
6	Statement Covers Period "From" and "Through" Dates	Enter the beginning and ending service dates of the period included on the bill.
17	Admission Date	Enter the date of the first billable visit/the date the patient was admitted/the start of care.
20	Source of Admission	Enter applicable source codes; if applicable, use the following new codes B = transfer from another HHA; and C = discharged and readmitted to your HHA within a 60 day episode.
22	Patient Status	Enter applicable patient status; enter 06 if patient was discharged from HHA care prior to the end of a 60-day episode.

Form Locator (FL)	Description	Data Elements to Enter
42	Revenue Code	Enter the revenue code 0023 before or after all revenue codes for supplies and services provided for the statement period have been listed. 0023 revenue code may be entered more than once if additional Health Insurance Prospective Payment System (HIPPS) code(s) is/are applicable during the period being billed. All other revenue codes should be entered before or after revenue code 0023 and the HIPPS code(s).**
43	Description	Enter the description "Home Health (HH) Services" to the line(s) corresponding to revenue code of 0023. Enter descriptions which correspond to other revenue codes on lines corresponding to the revenue codes
44	HCPCS/Rates	Enter the HIPPS Code generated from the grouper software which corresponds to the revenue code "0023" and the FL 43 description "HH Services." Enter the HCPCS code which match(es) other revenue code(s) and description(s).
45	Service Date	Enter the first billable service date for each revenue code 0023. For other revenue codes (except supplies), enter the service date which matches the revenue code, description, and HCPCS of the specific HH service billed.
46	Service Units	Leave this blank for revenue code 0023. Enter the number of units provided for the day for the HCPCS code(s) listed. For skilled nursing, home health aide, physical therapy, occupational therapy, and speech therapy, 15 minutes equal 1 unit.
47	Total Charges	Leave this blank for revenue code 0023. Enter the total charges for each line number for all other revenue codes.
50	Payer Identification	Enter all health insurance the patient has.

** Revenue code 0023 (with HIPPS codes) does not have to be entered for home health agency services provided to children and pregnant women since an OASIS is not required for home health agency services furnished to children and pregnant women.

f) The HCPCS Codes and associated revenue codes to be used for billing are:

Revenue Code	HCPCS Code	Description of Services for In-Home Health Setting, for each 15-minutes
550	G0154	Skilled Nurse
551	G0154	Skilled Nurse
570	G0156	Home Health Aide
571	G0156	Home Health Aide
420	G0151	Physical Therapist
421	G0151	Physical Therapist
430	G0152	Occupational Therapist
431	G0152	Occupational Therapist
440	G0153	Speech and Language Pathologist
441	G0153	Speech and Language Pathologist