Home Health Services

Provider Manual

TABLE OF CONTENTS

III. Provider-Specific Policies

TABLE OF CONTENTS

Page

CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. CONDITIONS OF PARTICIPATION

Home health agencies (HHAs) are eligible to participate in the Medicaid program providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act). Medicare-certified agencies are eligible to provide the following Medicaid services:

- Home Health Services (HHS) is the State Plan home health benefit with its services available to members of all ages. Some services are limited to a specified number of weekly visits. All services must be medically necessary as prescribed by the member's physicians in the home health agency plan of care. See HOME HEALTH SERVICES PROGRAM.
- Private-duty nursing and personal care services (PDN/PC) are covered under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) authority. These services are only for members aged 20 and under. These services are covered when they are medically necessary, appropriate, and exceed home health services policy limits. See PRIVATE-DUTY NURSING AND PERSONAL CARE SERVICES.
- Vaccines for Children (VFC). See VACCINES FOR CHILDREN.

While an agency may provide services for each of the three separate programs, the Medicaid guidelines for each program differ in a number of areas. These differences include the number of available visits or hours, billing mechanisms, and the need for prior authorization.

NOTE: Each of the programs above (HHS, PDN/PC, and VFC) is expanded in a specific section of the manual.

1. Physician Certification and Face-to-Face Encounter

Physician certification. A physician must certify that there is a clinical justification for the provision of services provided under the HHS or PDN/PC programs in a home health provider plan of care. A certification is considered to be anytime that a Start of Care (SOC) OASIS is completed to initiate care.

Physician recertification. At the end of the initial 60-day SOC period, a decision must be made whether or not to recertify the member for a subsequent 60-day period of service provided under the HHS or PDN/PC program. The plan of care must be reviewed and signed by the physician every 60 days unless one of the following occurs:

- A member transfers to another HHA, or
- A discharge and return to HHS or PDN/PC occurred during the 60-day period.

The physician is the designated professional to date and sign the certification and recertifications for HHS or PDN/PC members.

Certification and recertifications must be complete prior to when an HHA bills for Medicaid reimbursement; however, physicians should complete the certification when the plan of care is established, or as soon as possible thereafter. It is not acceptable for HHAs to wait until the end of a 60-day period to obtain a completed certification or recertification. (Medicare Benefit Policy Manual, Chapter 7, Home Health Services, Section 30.5.1, Physician Certification as amended to 05-11-15.)

Face-to-face encounter. A face-to-face encounter is a separate distinct section of, or an addendum, to the physician certification. The intent of the face-to-face physician encounter is to achieve greater physician accountability in certifying a member's eligibility for the home health benefit and establishing a member's home health plan of care. There must be a face-to-face encounter between a physician, a nurse practitioner, clinical nurse specialist, a certified nurse-midwife, or a physician assistant and the member no more than 90 days before or 30 days after the start of service. A face-to-face encounter must be completed at any time a Start of Care Outcome and Assessment Information Set (OASIS) is initiated.

The physician certification and accompanying face-to-face encounter follow Medicare directions and parameters not withstanding homebound criteria and 60 day episodes of service.

2. Plans of Care

Plan of care requirements apply to both the HHS program and the private duty nursing and personal cares program. The VFC program does not require a plan of care.

Services through the HHS program or the PDN/PC program must be prescribed by a physician in a home health plan of care. A plan of care must be completed before the start of care and reviewed by the physician, the HHA, and the member, at a minimum, of every 60 days thereafter.

Written HHA policies and procedures must specify that all clinical services are implemented only in accordance with a plan of care established by a physician's written order. HHA policies and procedures also specify if the HHA:

- Accepts physician's orders on referral communicated verbally by an institution's discharge planner, nurse practitioner, physician's assistant, or other authorized staff member followed by written, signed, and dated physician's orders, in order to begin HHA services as soon as possible.
- Accepts signed physician certification and recertification of plans of care, as well as signed orders changing the plan of care, by telecommunication systems ("fax"), which are filed in the clinical record.

The plan of care must be established and authorized in writing by the physician based on an evaluation of the member's immediate and long term needs.

3. Coordination of Care with Other Programs

The home health agency is responsible for coordination of care provided to a member. The plan of care shall reflect all services provided for the Medicaid member, regardless of whether the services are directly provided by the home health agency. All HHA personnel furnishing services maintain a liaison to ensure that their efforts are coordinated effectively and support the objective outlined in the plan of care. The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.

For example, services provided through the HHS or private duty nursing or personal cares program shall be identified as well as any services provided through other funding sources such as the:

- Home- and Community-Based Services Medicaid Waiver program,
- In-home health-related care program services,
- Local education area services,
- Maternal health programs, or
- Private insurance in a plan of care.

The home health services provided through the HHS or private duty nursing programs shall be listed in a separate section from the services provided through other funding sources. The plan shall note what service is authorized for each payer.

It is the responsibility of the home health agency to coordinate with any entity that also provides service coordination and oversight for services that are not provided or funded through the HHS or PDN/PC programs. This coordination is required to ensure:

- The optimum health for each member,
- Identify any unmet needs, and
- Eliminate the duplication of services.

4. Plan of Care Format

Medicare no longer requires home health agencies to use specific forms for the plans of care. However, it is allowable to use Medicare CMS 485, 486, or 487 forms to present the plans of care. Any plan of care must contain the information noted in the following section.

5. Plans of Care Requirements

The following section describes requirements for plans that include rehabilitation services; home health aide services; or teaching, training or counseling services.

The HHA must be acting upon a physician plan of care that meets the requirements of this section for HHA services to be covered. The plan of care must contain all pertinent diagnoses, including:

- The patient's mental status;
- The types of services, supplies, and equipment required, including services not provided by the HHA but medically necessary services provided through other programs;

- The frequency of the visits to be made;
- Prognosis;
- Rehabilitation potential;
- Functional limitations;
- Activities permitted;
- Nutritional requirements
- All medications and treatments;
- Safety measures to protect against injury;
- Instructions for timely discharge or referral; and
- Any additional items the HHA or physician chooses to include.

If the plan of care includes a course of treatment for therapy services:

- The course of therapy treatment must be established by the physician after any needed consultation with the qualified therapist;
- The plan must include measurable therapy treatment goals which pertain directly to the patient's illness or injury, and the patient's resultant impairments;
- The plan must include the expected duration of therapy services; and
- The plan must describe a course of treatment which is consistent with the qualified therapist's assessment of the patient's function.

For teaching, training, or counseling, the plan of care shall also include:

- To whom services were provided (member, family member, etc.).
- Prior teaching, training, or counseling provided.
- Date of onset of teaching, training, or counseling.
- Frequency of teaching, training, and counseling.
- Progress of individual being trained.
- Estimated length of time training will be required. Training and teaching can rarely be justified after the first certification.

6. Registered Nurse Supervisory Visits

a. RN Supervisory Visits for Home Health Aide

Payment will be made for supervisory visits two times a month when a registered nurse, acting in a supervisory capacity, provides supervisory visits of services provided by a home health aide under the HHS program or a home health aide under the Private Duty Nursing/Personal Cares program.

b. RN Supervisory Visits for Licensed Practical Nurse (LPN)

The licensed practical nurse:

- Furnishes services in accordance with HHA polices,
- Prepares clinical and progress notes,
- Assists the physician and registered nurse in performing specialized procedures,
- Prepares equipment and materials for treatment observing aseptic technique as required, and
- Assists the patient in learning appropriate self-care techniques.

These duties are performed in accordance with the HHA's professional practice standards and with guidance and supervision from RNs. Supervision is based on the professional judgment of the supervising RN in relation to the skill level of the LPN.

B. HOME HEALTH SERVICES PROGRAM

The home health services program is an appropriate alternative to unnecessary institutionalization.

- **Place of service**. The services must be provided in the member's home.
- **Qualified service providers**. The services must be provided by:
  - A registered nurse,
  - A licensed practical nurse,
  - A home health aide,
  - A speech pathologist,
  - A physical therapist, or
  - An occupational therapist.

- **Prior authorization requirements**. The HHS program does not require prior authorization as does the PDN/PC.
- **Unit of service**. A unit of service is a visit.
- **Medical necessity**. The number of visits for any of the above-noted services shall be reasonable and appropriate to meet an established medical need of the member that cannot be met by a family member, significant other, friend, or neighbor.

1. Differences from Medicare Home Health Services

Unlike the Medicare program, Medicaid members need not first require "skilled" care before they are eligible to receive home health aide services. A member who requires only home health aide services is entitled to these services under the Medicaid program without respect to the need for skilled services.

Also, unlike the Medicare program, a member does not need to be determined homebound in order to be eligible for the HHS program. However, services are covered only when provided in the member's residence.

2. Restorative and Maintenance

As in the Medicare program, payment will be made both for restorative service and for maintenance services. Essentially, "maintenance service" means service to a member whose condition is stabilized and who requires observation by a nurse for conditions defined by the physician as indicating a possible deterioration of health status. This includes members with long-term illnesses whose condition is stable rather than post-hospital.

3. Non-Payable HHS Services

The following services are not a payable benefit:

- Homemaker services
- Services provided in the home health agency office
- Transportation and escort services
- Well-child medical care and supervision

When a member is in a Medicaid Managed Care Organization (MCO), the MCO covers home health agency services.

Medical equipment rental is not reimbursable to a home health agency. Obtain and bill for dressings, durable medical equipment, and other supplies through a medical equipment dealer or pharmacy. (Special consideration may be given to unusual circumstances, such as when a pharmacy or medical equipment dealer is not available in the member's community.)

4. Services in the Home Health Services Program

The following six services are included in the HHS program:

- Skilled Nursing Care
- Home Health Aide Services
- Occupational Therapy
- Physical Therapy
- Speech-Language Pathology

a. Skilled Nursing Care

Home health agency "skilled nursing" services must be performed by a licensed registered nurse or licensed practical nurse. Services that can safely be performed by the member or by an unskilled person who has received the proper training or instruction and services provided when there is no one else to perform the services are not considered "skilled nursing services."

Skilled nursing services are evaluated based on the complexity of the service and condition of the member. Refer to ***Medicare Intermediary Manual***, Section 3118.1, and the Iowa Nurse Practice Act to determine what is considered to be a skilled nursing service.

NOTE: Private-duty nursing is a service included under the PDN/PC program for children up to age 21. It is not a service covered under the HHS program.

(1) Service Limitations

Skilled nursing is limited to five visits per week.

EXCEPTION: Wound care and insulin injections. The exception is for visits required for wound care or insulin injections. Daily skilled nursing visits or multiple daily skilled nursing visits for wound care or insulin injections are covered when ordered by a physician and included in the plan of care. The continued medical need for daily or multiple daily skilled nursing visits for wound care or insulin injections must be documented in the case notes and provided to the authorizing physician for evaluation for continued need at each certification period.

(2) Skilled Nursing for High-Risk Maternity or Child Health Care

Skilled nursing includes visits for high-risk maternity members and child health care.

These skilled nursing visits are subject to the five visit weekly limitation.

The intent of HHS to maternity patients and children is to provide services when the members are unable to receive the care outside their home and require home health care due to a high risk factor.

Routine prenatal, postpartum, or child health care for Medicaid members is a covered service in a physician's office or clinic. Therefore, Medicaid does **not** cover routine care when provided by a home health agency.

Payment is approved for care of high-risk patients when identified as such in the comment section of the billing form. In these cases, the treatment plan must indicate:

- The potential risk factors.
- The medical factor or symptom that verifies that the member is at risk.
- The reason the member is unable to obtain care outside the home.
- The medically related tasks of the home health agency.

The following list of potential high risk factors **may** indicate a need for HHS to maternity patients or children. A single risk factor is not sufficient information to allow reimbursement for home health agency services. Documentation must demonstrate:

- Evidence of the diagnosis.
- The specific services and goals.
- The medical necessity for the services to be rendered.

(3) Prenatal Patients

Potential high risk factors for pregnant women include:

- Age 16 or under.
- First pregnancy for a woman aged 35 or over.
- Previous history of prenatal complications (fetal death, eclampsia, Cesarean section delivery, psychosis, diabetes).
- Current prenatal problems, such as hypertensive disorders of pregnancy, diabetes, cardiac disease, sickle cell anemia, low hemoglobin, mental illness, or drug or alcohol misuse.
- Sociocultural or ethnic problems, such as language barriers, lack of family support, insufficient dietary practices, history of victimization (child abuse or neglect), or single mothers.
- Pre-existing disabilities, such as sensory deficits or mental or physical disabilities.
- History of infant problems, such as premature birth, congenital anomalies, or sudden infant death.
- Second pregnancy in 12 months.
- Death of a close family member or significant other within the previous year.

(4) Postpartum Maternity Patients

Potential high risk factors for postpartum women include:

- Age 16 or under.
- First pregnancy for a woman aged 35 or over.
- Major postpartum complications, such as severe hemorrhage, eclampsia, or Cesarean section delivery.

- Pre-existing mental or physical disabilities, such as deafness, blindness, hemiplegia, activity-limiting disease, sickle cell anemia, uncontrolled hypertension, uncontrolled diabetes, mental illness, or intellectual disability.
- Drug or alcohol abuse.
- Symptoms of postpartum psychosis.
- Special sociocultural or ethnic problems, such as lack of job, family problems, single mother, lack of support system, history of child abuse or neglect.
- Demonstrated disturbance in maternal and infant bonding.
- Discharge or release from hospital against medical advice before 30 hours postpartum.
- Insufficient antepartum care by history.
- Multiple births.
- Non-hospital delivery.

(5) Newborns

Potential high risk factors for newborns include:

- Birth weight 5 pounds or under or over 10 pounds.
- History of severe respiratory distress.
- Major congenital anomalies as neonatal complications that necessitate planning for long-term follow-up, such as post-surgical care, poor prognosis, home stimulation activities, or periodic development evaluation.
- Disabling birth injuries.
- Extended hospitalization and separation from other family members.
- Genetic disorders such as Down's syndrome and phenylketonuria, or other metabolic conditions that may lead to intellectual disability.
- Noted parental rejection or indifference toward the baby, such as never visiting or calling about the baby's condition during the baby's extended stay.

- Family sociocultural or ethnic problems, such as low education level or lack of knowledge of child care.
- Discharge or release against medical advice before 36 hours of age.
- Nutrition or feeding problems.

(6) Preschool or School-Aged Children

Potential high risk factors for preschool or school-aged children include:

- Child or sibling victim of child abuse or neglect (services are necessary to assist the child to remain in or return to the family home, if possible).
- Intellectual or physical disabilities necessitating long-term follow-up or major readjustments in family life style.
- Failure to complete basic series of immunizations by 18 months, or boosters by 6 years.
- Chronic illness, such as asthma, cardiac, respiratory or renal diseases, diabetes, cystic fibrosis, or muscular dystrophy.
- Malignancies, such as leukemia or carcinoma.
- Severe injuries necessitating treatment or rehabilitation.
- Disruption in family or peer relationships.
- Suspected developmental delay.
- Nutritional deficiencies.

b. Home Health Aide Services

Home health aide services are unskilled services that are covered if the following conditions are met:

- The service, the frequency, and the duration are stated in a written plan of treatment established by a physician. The service provider is encouraged to collaborate with the member or, in the case of a child, with the member's caregiver in the development and implementation of the plan of treatment.
- The member requires personal care services as determined by a physician, registered nurse or a designated therapist.

- The services are given under the supervision of a registered nurse or a physical or occupational therapist or a speech-language pathologist who assigns the aide who will provide the care and makes supervisory visits. See RN Supervisory Visits for Home Health Aide.
- Services are provided on an intermittent basis. "Intermittent basis" is defined as services that are usually two to three times a week for two to three hours at a time.
- Service provided four to seven days per week, not to exceed 28 hours per week, are allowed as intermittent services when ordered by a physician and included in a plan of care. Increased services may also be allowed as intermittent services on a short-term basis of two to three weeks when medically necessary and provided due to unusual circumstances. Document the need for the excessive time required.

Home health aide daily care may be provided for members who are employed or attending school and whose disabling conditions (e.g., quadriplegia) require them to be assisted with morning and evening activities of daily living in order to support their independent living.

"Personal care services" include the activities of daily living, e.g., helping the member to bathe, get in and out of bed, care for hair and teeth, exercise, and take medications specifically ordered by the physician, but ordinarily self-administered, and retraining the member in necessary self-help skills.

When the primary need of the member for home health aide services is for personal care, the aide may perform certain household services to prevent or postpone the member's institutionalization. Examples of household services are:

- Changing the member's bed.
- Light meal preparation.
- Light cleaning.
- Laundering essential to the member's comfort and cleanliness.
- Rearrangements to ensure that the member has and can safely reach necessary supplies or medications.

If household services are incidental and do not substantially increase the time spent by the aide in the home, the entire visit is considered a covered service.

Domestic or housekeeping services that are not related to member care are not a covered service if personal care is not rendered during the visit.

c. Occupational Therapy

The following sections explain general requirements and covered services for occupational therapy.

(1) General Requirements

The coverage decision for occupational therapy services is based on the need for the skills of a therapist and not only on the diagnosis. To be covered under home health rehabilitation services, occupational therapy services must:

- Be provided in the member's home.
- Improve or restore functions that have been impaired by illness or injury or enhance the member's ability to perform those tasks required for independent functioning.
- Be reasonable and necessary for the treatment of the member's illness or injury.
- Be performed by a qualified occupational therapist or a qualified licensed occupational therapist assistant under the general supervision of a qualified, licensed occupational therapist, as allowed by Iowa licensure.
- Follow an active written treatment plan established by the physician that is reviewed and updated every 30 days. A current plan of treatment must be submitted with the claim for each month. The plan of treatment must include:
  - The member's functional limitations.
  - Date of onset of conditions being treated.
  - Restorative potential.
  - Modalities of treatment.
  - Goals.
  - Progress notes.
  - Documentation of progress toward the goals.

(2) Covered Services

Restorative therapy is a covered occupational therapy service when an expectation exists that the therapy will result in a significant practical improvement in the member's condition.

Where there is a valid expectation of improvement at the time the occupational therapy program is instituted, but the expectation (goal) is not realized, services are covered only up to the time one can reasonably conclude the member will not improve.

The teaching of activities of daily living and energy conservation to improve the level of independence of a member is covered when it requires the skill of a licensed therapist and meets the definition of restorative therapy.

Maintenance therapy, or any activity or exercise program required to maintain a function at the present level, is **not** a covered service. However, **design** of a maintenance program and infrequent but periodic evaluation of its effectiveness by the therapist is covered.

Planning and implementing therapeutic tasks are covered, such as:

- Activities to restore sensory-integrative functions.
- Selection and teaching of tasks designed to restore physical function.
- Providing motor and tactile activities to increase input and improve responses for a stroke patient.

The designing, fabricating, and fitting of orthotic and self-help devices are considered covered services if they relate to the member's condition and required occupational therapy. A maximum of 13 visits is reimbursable.

Vocational and prevocational assessment and training are not payable by Medicaid. These include services that are related **solely** to specific employment opportunities, work skills, or work settings.

Occupational therapy frequently necessitates the use of various supplies, e.g., ceramic tiles, leather, etc. The cost of such supplies may be included in the occupational therapy cost center.

d. Physical Therapy

The coverage decision for physical therapy services is based on the need for the skills of a therapist and not only on the diagnosis. The following sections explain general requirements and covered services for physical therapy.

(1) General Requirements

To be covered under home health rehabilitation services, physical therapy services must:

- Be reasonable and necessary to the treatment of the member's illness, injury, or disabling conditions.
- Be specific and effective treatment for the member's medical or disabling conditions.
- Be provided in the member's home.
- Relate directly and specifically to an active written treatment plan established by the physician after any needed consultation with the qualified physical therapist. The plan must be reviewed and updated every 30 days. A current plan of treatment must be submitted with the claim for each month. The plan must include:
  - The member's functional limitations.
  - Date of onset of conditions being treated.
  - Restorative potential.
  - Modalities of treatment.
  - Goals.
  - Progress notes.
  - Documentation of progress toward the goals.
- Be of such a level of complexity and sophistication, or the condition of the member must be such, that the services required can be safely and effectively performed only by a qualified physical therapist or under the supervision of the therapist.

The initial physical therapy evaluation must be provided by a licensed physical therapist. This evaluation may have been performed by other than the home health agency staff.

A qualified physical therapist assistant may provide any restorative services performed by a licensed physical therapist under supervision of a therapist as allowed by Iowa licensure.

The provider must demonstrate that there is a need to establish a safe and effective maintenance program related to a specific illness, injury, or disabling condition. The selection and teaching of tasks to restore physical functions are covered.

- Meet the guidelines defined for restorative, maintenance, or trial therapy.

  There must be an expectation that there will be a significant, practical improvement in the member's condition in a reasonable amount of time, based on the member's restorative potential assessed by the physician. The amount, frequency, and duration of the services must be reasonable.

(2) Covered Services

When a member is under a restorative physical therapy program, the physical therapist regularly reevaluates the member's condition and adjusts the program. It is expected then, that the physical therapist has designed a maintenance program before discharge.

Consequently, maintenance programs that are not established until after the restorative program has been completed are not considered reasonable and necessary to the treatment of the member's condition and are excluded from coverage.

Hot packs, hydrocollator, infrared treatments, paraffin baths, and whirlpool baths do not ordinarily require skills of a qualified physical therapist. These are covered when the condition is complicated by other conditions, such as circulatory deficiency or open wounds, or if the service is an integral part of a skilled physical therapy procedure.

Gait training and gait evaluation and training constitute a covered service if the member's ability to walk has been impaired by a neurological, muscular, or skeletal condition or illness. The gait training must be expected to significantly improve the member's ability to walk.

Repetitious exercise to increase endurance of weak or unstable members can be safely provided by supportive personnel, e.g., aides or nursing personnel. Therefore, it is not a covered physical therapy service.

Ultrasound, short wave, and microwave diathermy treatments are considered covered services.

Use of isokinetic or isotonic equipment in physical therapy is covered when normal range of motion of a joint is affected due to bone, joint, ligament, or tendon injury or postsurgical trauma. Billing can be made only for the time the therapist actually spends instructing the member and assessing the member's progress.

Therapeutic exercises may constitute a physical therapy service due either to the type of exercise employed or the condition of the member.

Range-of-motion tests must be performed by a qualified physical therapist. Range-of-motion exercises require the skills of a qualified physical therapist **only** when they are part of the active treatment of a specific disease or disabling condition that has resulted in a loss or restriction of mobility. Documentation must reflect:

- The degree of motion lost,
- The normal range of motion, and
- The degree to be restored.

Range-of-motion to unaffected joints only does not constitute a covered physical therapy service.

Reconditioning programs after surgery or prolonged hospitalization are **not** covered as physical therapy (work-hardening programs, for example). However, initial instruction for such programs is a covered service.

e. Speech-Language Pathology

For speech-language pathology services, the treatment plan shall additionally reflect the goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

(1) General Requirements

To be covered by the HHS program as a habilitative service, speech-language pathology services shall:

- Be provided in the member's home;
- Be related directly to an active written treatment plan that is reviewed and updated every 30 days. A current plan of treatment must be submitted with the claim for each month, include the functional limitations and document progress toward the goals;
- Follow a treatment plan established by a licensed skilled therapist after consultation with a physician;
- Be reasonable and necessary to the treatment of the member's illness or injury;
- Relate to a specific medical diagnosis or disabling condition which will significantly improve a member's practical functional level in a reasonable and predictable period of time;
- Require the skilled services of a speech therapist. Services provided by a speech aide are not reimbursable; and
- Meet the guidelines defined for restorative, maintenance, diagnostic, or trial therapy.

(2) Covered Services

Speech pathology activities that are considered covered services include restorative therapy services to:

- Restore functions affected by illness, injury, or disabling condition resulting in a communication impairment, or
- Develop functions where deficiencies currently exist.

"Communication impairments" fall into the general categories of disorders of:

- Voice
- Fluency
- Articulation
- Language
- Swallowing disorders resulting from any condition other than mental impairment

Treatment of these conditions is payable if restorative criteria are met.

Aural rehabilitation, the instruction given by a qualified speech pathologist in speech reading or lip reading to members who have suffered a hearing loss (input impairment), constitutes a covered service if reasonable and necessary to the member's illness, or disabling condition. Group speech therapy is not covered. Audiological services related to the use of a hearing aid are not reimbursable.

Teaching a member to use sign language or to use an augmentative communication device is reimbursable. The member must show significant progress outside the therapy sessions for these services to be reimbursable.

Where a maintenance program is appropriate, the initial evaluation, the instruction of the member and caregivers to carry out the program, and supervisory visits to monitor progress are covered services. Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable.

However, designing a maintenance program, in accordance with the requirements of maintenance therapy and monitoring the progress, are covered. Click here for coverage of design and monitoring of a maintenance program.

C. PRIVATE-DUTY NURSING AND PERSONAL CARE SERVICES

Private-duty nursing and personal care services for children with special needs are covered for Medicaid members aged 20 or under when:

- The services are medically necessary.
- The services exceed the intermittent criteria listed earlier in this manual.
- The service planning process has taken place.
- Prior authorization is approved.

These services are intended to:

- Promote alternatives to prolonged hospitalizations or institutionalization by providing for medically necessary and effective home care.
- Provide ongoing nursing support to a technology-dependent child or a child with multiple medical needs related to an acute or chronic medical condition in the home environment.

The objectives of services to children with special needs are:

- To provide direct patient care, supervision of family caregivers, and teaching of the necessary skills to care for a medically compromised child at home,
- To promote quality care and a safe home environment for the child,
- To provide for comprehensive and coordinated care in a cost-effective manner, and
- To reduce the number of hours funded and provided by the program to the minimum level necessary to meet the medical needs of the child safely while ensuring that quality care is maintained in the child's home environment.

Payment for private-duty nursing or personal care services for members aged 20 or under will be approved if determined to be medically necessary. "Medical necessity" means:

- The service is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and
- No other equally effective course of treatment is available or suitable for the member requesting the service.

The role of the parents is central to the management of home care and must permeate all planning. Use family-centered concepts when working with the family to develop a treatment plan. Also involve the child in the planning of treatment services, based on the child's age and understanding of the condition.

The services are considered supportive to the care provided to the child by family, foster parents, or delegated caregivers. Whenever possible, teach the nursing regimen to the child, the family, or the foster parents, or delegate the regimen to an unlicensed caregiver to achieve the goals and objectives.

Maintenance of the nursing regimen plan of care is the responsibility of the child, family, foster parents, or delegated caregivers, with a registered nurse providing any necessary supervision and follow-up. Decrease care as the family, foster parents, or caregivers become able to meet the member's needs.

Home health services are directed to support the extra burdens on the parents due to the child's medical needs. They are not available to meet a family's normal needs for child care and supervision, such as while a parent works.

1. Personal Care Services

"Personal care services" are services provided by a home health aide or certified nurse's aide that are delegated and supervised by a registered nurse under the direction of the child's physician. Services may be provided to a child in the child's place of residence or outside the child's residence when normal life activities take the child outside the place of residence. Some of the care must be provided in the child's home.

Personal care services do **not** include:

- Respite care (a temporary intermission or period of rest for the caregiver to relieve the caregiver of the duties of providing continuous support and care to the child).
- Services provided to other members of the child's household.
- Services that require prior authorization that are provided without regard to the prior authorization process.
- Assessment and monitoring.
- Cueing for behavior management.
- Other services listed in Non-Payable Services.

2. Private-Duty Nursing

"Private-duty nursing services" are services provided to a child by a registered nurse or a licensed practical nurse under the direction of the child's physician. Services may be provided in the child's place of residence or outside the child's residence, when normal life activities take the child outside the place of residence.

Private-duty nursing services do **not** include:

- Respite care (a temporary intermission or period of rest for the caregiver to relieve the caregiver of the duties of providing continuous support and care to the child).
- Nurse supervision services, such as chart review, case discussion, or scheduling by a registered nurse.
- Services provided to other members of the child's household.
- Services that require prior authorization that are provided without regard to the prior authorization process.
- Other services listed in Non-Payable Services.

3. Service Planning for Special-Needs Children

The child's assigned case manager or service worker is responsible for completing the service planning process. If there is not an assigned service worker or case manager, a Child Health Specialty Clinic nurse will be assigned to this role.

This planning process must be completed for each child before requesting a prior authorization for private-duty nursing or personal care services. (A time-limited authorization may be approved for children who need services before the planning process can be completed. See Special Circumstances.)

The planning process must be repeated for each prior authorization request. The service worker, case manager or Child Health Specialty Clinic staff are responsible for tracking when the existing prior authorization will expire.

This planning will result in a new prior authorization request and supporting documentation being prepared and submitted at least four weeks before the expiration of the current prior authorization. The planning process is needed to ensure that funding for services is not jeopardized by the failure to complete and timely submit a prior authorization.

If the child will turn 21 within the next twelve months, the child's service worker or case manager should begin planning for services when the child is no longer eligible for prior-authorized services. This step is important in order to transition the child to adult services and to make sure the member's needs are met through other available services.

a. Planning Process

The service worker, case manager or Child Health Specialty Clinic staff will involve in the planning process. Others who may be included in the planning process are:

- The family
- Providers
- Area education agency staff (for children in school)

Others who may be involved when applicable include:

- Child Health Specialty Clinic staff
- Insurance case managers
- HMO representatives
- Iowa Plan contractor staff
- Special program resources
- Physicians
- Family support people and advocates
- Department of Human Services service help desk staff
- Home- and community-based services specialists
- Medicaid policy staff

At a minimum, the planning should address:

- What was covered by any prior authorization that will be expiring.
- Any changes which have occurred.
- If there were services that could not be covered when the current prior authorization was approved.

- Definitions of terms, including:
  - Home health services
  - Private-duty nursing
  - Personal care
  - Medical necessity
  - Scope of practice
  - Home- and community-based (HCBS) waiver services
  - In-home health-related care
- Hierarchy for the use of:
  - Insurance,
  - Home health services,
  - Prior authorized services,
  - HCBS waiver services,
  - Medical transportation,
  - State funded services, and
  - Other funding such as county, school and civic organization funding.
- How different plans for the child interact, such as:
  - Schedules,
  - Uses of services,
  - Level of detail, and
  - How families, providers, and others involved in the planning are notified of service approvals.
- How HCBS waiver-funded nursing and HHS can be used.
- Use of HCBS waiver services such as:
  - Supported community living,
  - Homemaker,
  - Consumer-directed attendant care,
  - Respite, and
  - The requirements for use of gatekeeper services.
- Enrolled and available HCBS waiver providers in the area.
- Documentation requirements for home health agencies.
- When and how multiple provider agencies are used.
- Planning for non-school days.
- Process for conference calls to be used if problems occur in finalizing the plan.

If services will meet the Home Health Services program guidelines, a prior authorization will not be needed. The service worker, case manager or Child Health Specialty Clinic staff will notify IME of the resolution.

If it becomes evident during the planning that not all the issues can be resolved, or one or more of the core members of the team does not agree with the plan, a conference call must be scheduled. (See Conference Call.)

If the interdisciplinary team (IDT) determines that the child's medical needs cannot be met within the benefits available through **all** funding sources available to the child, including family or informal support systems, an exception to policy (ETP) may be requested.

The directions for submitting an ETP are located at the following: http://dhs.iowa.gov/appeals/exceptions_policy

Review all sections of this online resource. It is important to bear in mind that it is the requestor's responsibility, in collaboration with the IDT members, to provide the written information and documentation that supports the extreme medical need for the services being requested through an ETP.

b. Service Authorization

When the planning results in the need for submission of a new prior authorization request, the service worker, case manager, or Child Health Specialty Clinic staff will request the home health agency to provide a copy of the prior authorization request. (See Prior Authorization for instructions on preparing form 470-0829, *Prior Authorization Request*.) This will be sent to the IME Medical Services Unit.

The service worker, case manager or Child Health Specialty Clinic staff will advise the family that:

- The home health agency has not submitted the new prior authorization request, and
- Funding for services may be jeopardized or consideration may need to be given to securing a different provider.

The Medical Services team will complete the Medical Needs Acuity Scoring Tool (MNAST) or the Functional Needs Acuity Scoring Tool (FNAST) or the Social Needs Acuity Scoring Tool (SNAST) to determine the services to be authorized based on the treatment plan and additional information submitted for review.

If the prior authorization can be approved as submitted, the Medical Services Unit will notify the service worker, case manager, or Child Health Specialty Clinic staff, who will confirm that the family's need for service has not changed. If the needs remain the same, the Medical Services Unit will approve the prior authorization as requested and return it to the provider with a copy of the scoring tool completed for the individualized review.

Other activities needed to implement the decision may include revision of plans, submission of HCBS waiver forms, and completion of notices of decision by case managers and service workers. The home health provider may be asked to provide this information to the Prior Authorization Unit for review. Click here to view detailed information regarding the use of these tools and provider instructions.

If the prior authorization cannot be approved as submitted, the Medical Services Unit will notify the service worker, case manager, or Child Health Specialty Clinic staff, who will determine if other services discussed during the planning can be used to meet the need or if a conference call is needed.

c. Conference Call

If the issues cannot be resolved through the planning process, the service worker, case manager, or Child Health Specialty Clinic staff will:

- Schedule a conference call by contacting the scheduler at IME.
- Provide the names and telephone numbers of those who will participate.

At a minimum, those participating in the call will include:

- The service worker or case manager
- The family
- Providers
- IME medical review staff

Others participating, when applicable include:

- Area education agency staff (for children in school)
- Child Health Specialty Clinic staff
- Insurance case managers
- HMO representatives
- Iowa Plan contractor staff
- Special Program Resources
- County central point of coordination for children aged 16 through 20
- Physicians
- Family support people and advocates
- Department of Human Services service help desk staff
- Home- and community-based services specialists
- Medicaid policy staff

Calls will be scheduled at a mutually agreed upon time before the expiration date of the current prior authorization. They should be scheduled as soon as possible to allow adequate time for decisions to be made before the expiration of the prior authorization.

The IME Medical Services Unit will convene conference calls as scheduled. At the end of the conference call, the facilitator will provide a verbal summary of the outcome of the discussion.

The Medical Services Unit will complete a written summary of the conference call and keep it in the member's file at IME. The information on the summary will include, at a minimum:

- The child's name and state identification number.
- The date the planning conference call was held.
- The participants in the planning conference call.
- A brief description of the outcome, including amount and type of services to be provided.

d. Special Circumstances

The service worker, case manager or Child Health Specialty Clinic staff will ensure that a planning discussion occurs in the following situations:

- A child is discharged from the hospital
- A child is determined to be terminally ill
- A child's service needs change
- Changes in eligibility occur
- Responsibility for services transfers from one agency to another
- An initial prior authorization request with a proposed plan of care is submitted and no supporting documentation is available
- A current prior authorization needs to be modified

A prior authorization request based on a proposed plan may be approved for a limited period of time, usually not more than four to eight weeks, to allow the regular planning process for services to occur.

When the IME Medical Services Unit receives a request to modify a current prior authorization, the service worker, case manager or Child Health Specialty Clinic staff will be notified. A mutual decision will be made to initiate planning, using some or all of the planning process, or approve a time-limited modification. Policy staff will be included in this discussion as needed.

e. Hospital Discharge Planning

For a child being discharged from a hospital, an initial prior authorization or modification of an existing prior authorization may be approved for a limited period. See Special Circumstances.

Encourage the family to have support systems in place by working with the hospital discharge planner and community support system. "Support systems" are services, resources, information, training, and emotional support that enable a family to assume responsibility and provide care for a technology-dependent child or a child with a chronic disability in addition to meeting the goals and accomplishing tasks of family life.

The discharging hospital has a responsibility to assist the family to identify potential providers of the home health agency services and to teach the necessary skills to the caregivers within the hospital setting. This teaching can be continued the first several weeks to reinforce skills with the caregivers.

Facility discharge planning includes extensive teaching of the main family caregivers within the facility setting, before discharge of the member. Teaching must include:

- An understanding of the child's diagnosis and prognosis.
- Ability to provide direct patient care.
- Demonstrated knowledge of the use and care of needed equipment.
- Emergency measures in the care of the member, including emergency preparedness for utility failure.

The family should be centrally involved in the selection process of the home care agency. Ideally, the family should select the home health agency at least two weeks before discharge and notify the agency of the referral.

The home health agency should be involved in the development of the home care plan before discharge. Coordination between the discharging hospital and the home health agency should be reflected on the plan of treatment. The care plan must address short-term goals as well as the long term nature of the care required.

Training family members in the care of the child should begin as early as possible in the hospital, but at least within the two weeks before discharge. The training of the family must include:

- Detailed documentation (written instruction) of the child's care needs.
- A systematic process for teaching the care of the child to parents and siblings (when appropriate).

Rooming in while the child is still an inpatient is recommended. Parents should be taught alternative ways of doing things, so they will become comfortable with problem solving regarding the care needs. Proper education of the caregivers regarding actions to take in the case of emergencies is essential before discharge home.

The discharging hospital should assist the family in locating a community-based pediatrician or other physician who is willing to be the child's medical home and accept primary care coordination for the member. The lines of communication must be open between the physician, the family caregivers, and the home health agency.

The parents are central to the management of home care. During all stages of adjusting to home care, it is very important to remember that the parents (or primary caregivers) remain the only "constant" factor in the home care experience over time. They have the accumulated knowledge and experience of their needs, as well as the needs of their child, which a health care provider may not have.

Coordination between the discharge planner or hospital social worker and the home health agency or the person responsible for ensuring psychosocial support must be initiated on an outpatient basis immediately at the time of discharge. Stressors imposed on the family due to the various factors involved in service delivery systems must be recognized.

The goal of all service providers should be to ensure alternative ways of decreasing stress and increasing the effectiveness of the services provided in the most cost-effective manner while enhancing family functioning.

Home care is a lot of work. Families will do better knowing the benefits and limitations up front, rather than getting discouraged because care for their child at home is not what they expected.

Giving the parents honest and factual information helps to better prepare them to the realities of home care. Parents need to know and understand that they have a responsibility in maintaining a business relationship with service providers.

Often, the depersonalization of home care is difficult for families to cope with but, nonetheless, reality. Presenting this reality before its occurrence helps to prepare the families for the idea that they need to rely on themselves to ensure that the service contracted for is, in fact, provided.

4. Prior Authorization

Private-duty nursing or personal care services require prior authorization. Medical personnel will individually review each prior authorization request. Prior authorization requests may be approved, modified, or denied.

The skill level approved for private-duty nursing or personal care services is based on the medical needs of the child and the Iowa Board of Nursing scope of practice guidelines, not the staffing preference of the provider or family.

Private-duty nursing or personal care services must be ordered in writing by a physician, as evidenced by the physician's signature on the plan of care.

A prior authorization request can be reviewed without the physician's completed order, but any changes in the order must be communicated to the IME Medical Services Unit. (The plan of care must be signed prior to submitting the claim for payment.)

The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization. Request prior authorization based on the planning process outlined under Service Planning for Special-Needs Children.

Submit initial requests and requests for renewal on form 470-0829, *Request for Prior Authorization*. See Chapter IV. *Billing Iowa Medicaid*, for full instructions.)

Prior authorizations are member-specific, not provider-specific. Agencies that accept members who have a current approved prior authorization from the member's previous home health agency should notify the IME Medical Prior Authorization Unit by letter to receive a copy of the current prior authorization.

To request a transfer of the prior authorization to a new home health agency, notify the IME Medical Services Unit in writing. The written request must address the reasons for the agency change, the effective day of the change, and any changes in the services to be provided.

Questions related to prior authorization may be directed to the IME Medical Prior Authorization Unit at (888) 424-2070, or locally in Des Moines at (515) 256-4624.

5. Place of Service

Private-duty nursing and personal care services are provided to a member in the member's place of residence, or outside the member's residence when normal life activities take the member outside the place of residence.

Additional hours of services will not be authorized outside the member's residence beyond what would normally be authorized in the residence. The need for care to participate in activities outside the home is not a basis for authorizing additional hours of service.

Services provided in nursing facilities, skilled nursing facilities, intermediate care facilities for the intellectually disabled (ICF/ID), or hospitals are not payable. Services that are provided in the home health agency office are not payable.

6. Non-Payable Services

The following services are not payable as private-duty nursing or personal care:

- Homemaker services
- Homework assistance
- Medical transportation

- Nurse supervision services, such as chart review, case discussion, or scheduling by a registered nurse
- Respite care (temporary intermission or period of rest for the caregiver that relieves the caregiver of the duties of providing continuous support and care to the member)
- Service requested for nonmedical reasons
- Services provided to other members of the member's household
- Services that require prior authorization that are provided without regard to the prior authorization process
- Services to members aged 21 and over
- Two Medicaid services provided simultaneously
- Well-child medical care and supervision

Assessment and monitoring that require the skills of a licensed nurse are covered under private-duty nursing, but are not covered under personal care.

Medical equipment rental is not reimbursable to a home health agency. Supplies incidental to a member's care may be billed monthly (i.e., syringes for Prolixin injections).

Obtain and bill for dressings, durable medical equipment, and other supplies through a medical equipment dealer or pharmacy. (Special consideration may be given to unusual circumstances; e.g., a pharmacy or medical equipment dealer is not available in the member's community.)

Home health agency services for a member in a Medicaid MCO are covered by the MCO.

D. VACCINES FOR CHILDREN

Only administration of a vaccine covered through the Vaccines for Children (VFC) program will be reimbursed unless the VFC program vaccine stock is depleted. If depleted, reimbursement shall be made for both the administration of the vaccine and the vaccine itself. In these situations the Medicaid program will provide notice of the lack of availability of the specific vaccine and the date that vaccine costs will be reimbursed. Use the appropriate revenue code for vaccine administration for VFC vaccine administrations. If the agency is providing a home health service as a visit under the Home Health Services program, the administration of a vaccine is considered covered in the encounter and no separate payment will be made.

E. BASIS OF PAYMENT

1. Home Health Services Program

Services included under the HHS program are reimbursed on the low utilization payment amount (LUPA) methodology, with state geographic adjustments.

A unit is a visit.

These LUPA visit rates are adjusted every two years beginning July 1, 2015, to reflect the most recent Medicare LUPA rates.

The services subject to this methodology are:

- Skilled nursing,
- Home health aide,
- Occupational therapy,
- Physical therapy,
- Speech pathology, and
- Medical social services.

Click here to view the Iowa HHA LUPA Wage Indexes and Rates, designated by a metropolitan or rural county.

Cost Report

The HHS program does not require the submission of an annual cost report. The LUPA rate methodology is a rate schedule.

2. Private Duty Nursing and Personal Cares Program

Payment to a home health agency for private-duty nursing or personal care services is on an hourly fee-for-service basis. As a general rule, billing is per calendar month. Only the amount of care approved on the prior authorization can be billed.

Reimbursement is made for an hourly unit of service based on a fee schedule.

Report

Private-duty nursing and personal care services are reimbursed at an interim rate with cost settlement after the cost report is filed.

Reimbursement for private-duty nursing and personal care services shall be made based on a unit rate that is calculated retrospectively for each provider considering reasonable and proper costs of operation.

The basis of pay is the provider's actual, reasonable cost for rendering the service, as reflected in the provider's submitted and approved cost report. The purpose of the cost report is:

- To establish unit rates of payment for Medicaid-payable private-duty nursing and personal care services according to published unit definitions; and
- To determine a final reconciliation to actual costs once a fiscal period is completed.

The agency shall identify and allocate costs directly attributable to each of the defined services that the agency provides.

Costs that cannot be directly attributed to any of the defined services but can be related to the private-duty nursing and personal care services in general may be allocated as indirect costs.

Cost Principles

Current OMB Circular #A-87 guidelines require capitalization of fixed assets when they have a useful life of more than one year and an acquisition cost which equals the lesser of:

- $5,000.00, or
- The capitalization level established by the county or other entity for financial reporting purposes.

For purposes of Medicaid-payable services, OMB guidelines for depreciation and amortization reimbursement apply. It is the Iowa Department of Human Services' policy to allow a three-year write-off of computer equipment and software programs.

OMB Circular #A-87 reflects financing costs (including interest) paid or incurred on or after September 1, 1995, associated with building acquisition, construction, fabrication, reconstruction, or remodeling completed on or after October 1, 1980, as allowable. Financing costs (including interest) paid or incurred on and after September 1, 1995, for operating purposes are also allowable.

Allowable costs are limited to those costs that are considered reasonable, necessary, and related to the service provided to the member.

"Reasonable cost" for purposes of Medicaid-payable services is defined as that amount of cost or expense that would ordinarily be incurred by similar providers in similar markets. It is that level of cost which a prudent and cost conscious buyer of goods and services is ordinarily willing to incur in providing these kinds of services.

Submission of Cost Reports

Click here to access cost report templates listed on the IME Provider Services website.

Submitting the cost reports via email to costaudit@dhs.state.ia.us allows the Provider Audits and Rate Setting Unit to begin processing the desk review of the cost report sooner. The provider shall also submit a printed, signed copy of the certification page. Send the signed certification page of the cost report to:

Iowa Medicaid Enterprise
Attn: Provider Audits and Rate Setting Unit
PO Box 36450
Des Moines, IA 50315

Submit actual, final costs report no later than the last day of the third month following the close of the fiscal period.

Provide supporting documentation for the allocation method used in determining indirect costs and in apportioning direct costs. In general, ensure that supporting documentation is maintained for all costs reported and numbers of staff devoted to private-duty nursing and personal care services. This documentation must be kept available in a format that can be easily audited at any time.

Instructions for Completing the Cost Report

Click here for the instructions for completing the cost report. For questions, contact the Provider Cost Audit and Rate Setting Unit at (866) 863-8610, locally in Des Moines at (515) 256-4610, or by email at costaudit@dhs.state.ia.us.

F. PROCEDURE CODES AND NOMENCLATURE

1. Home Health Services Program

Specific revenue codes have been established for billing per service discipline visit. Only the following 3 digit codes ending in "1," as listed below are reimbursable. Other revenue codes will deny.

Revenue Code	Description
551	Skilled nursing care
421	Physical therapy
441	Speech therapy
431	Occupational therapy
571	Home health aide
561	Medical social worker

A unit of service is one visit. Prepare one claim that includes all home health services provided during a calendar month.

Claims submitted without a revenue code and an applicable diagnosis code will be denied.

2. Private Duty Nursing and Personal Cares Program

HCPCs codes have been established for billing. One unit equals one hour. Claims submitted without a procedure code and an ICD-10-CM diagnosis code will be denied.

Code	Description
S9122	Home health aide or certified nurse assistant providing care in the home; per hour

3. Vaccines for Children Program

Use current CPT codes for immunizations. The immunization procedure includes the supply of related materials.

Providers must provide immunizations under the VFC Vaccines. A list of available vaccines through the VFC program are found at Iowa Department of Public Health website or at (800) 831-6293.

When a child receives a vaccine outside of the VFC schedule, Medicaid will provide reimbursement.

Bill the appropriate CPT code for vaccine administration in addition to the CPT code for the vaccine. For VFC vaccine, the charges in field 47 should be "0."

G. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

Claims for Home Health Services are billed on federal form UB-04, *Health Insurance Claim Form*.

Click here to view a sample of the UB-04.

Click here to view billing instructions for the UB-04.

Refer to Chapter IV. *Billing Iowa Medicaid* for claim form instructions, all billing procedures, and a guide to reading the Iowa Medicaid Remittance Advice statement.

The Billing Manual can be located online at:
http://dhs.iowa.gov/sites/default/files/All-IV.pdf