HOME HEALTH

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SECTION 1 – GENERAL INFORMATION

This chapter applies to Home Health providers.

Home health is a covered Medicaid benefit for beneficiaries whose conditions do not require continuous medical/nursing and related care, but do require health services on an intermittent basis in the home setting for the treatment of an injury, illness, or disability. Medicaid covered services may be provided in the home only if circumstances, conditions, or situations exist which prevent the beneficiary from being served in a physician's office or other outpatient setting. Except as detailed in this chapter, the beneficiary's primary need must be for nursing care and/or physical therapy, rather than personal care or physician's care.

A Home Health Agency (HHA) is an organization that provides home care services, such as skilled nursing care, physical therapy (PT), occupational therapy (OT), speech therapy (ST) and care by home health aides. The HHA must be Medicare certified to enroll as a Medicaid provider and must comply with the Medicare/Medicaid Conditions of Participation (42 CFR § 484) and the policies outlined in this manual.

Services solely to prevent an illness, injury or disability are only covered for women/newborns following delivery. For postpartum/newborn follow-up nurse visits, a nursing diagnosis can be used to establish medical necessity. Otherwise, a medical diagnosis is required to establish medical necessity. Medicaid beneficiaries are expected to be an active participant in the planning for their home health care. For beneficiaries enrolled in a Medicaid Health Plan (MHP), the HHA must contact that health plan for authorization to provide services to their members.

Medicaid home health services must be ordered, in writing, by the beneficiary's attending physician (MD, DO) as part of a written plan of care (POC) and reviewed by this physician every 60 days. The physician's order and POC must be only for functions that are within the scope of his current medical practice and Medicaid guidelines.

This chapter includes information about services covered for Medicaid and Children's Special Health Care Services (CSHCS) beneficiaries unless otherwise noted.

Private Duty Nursing (PDN) is not covered under the Home Health benefit.

1.1 FACE-TO-FACE ENCOUNTER

A physician certifying eligibility for home health services must provide documentation of a face-to-face encounter with the beneficiary within 90-days prior to or 30-days after the start of care. The face-to-face encounter may occur through telehealth in compliance with Section 1834(m) of the Social Security Act.

NOTE: The face-to-face encounter requirement pertains only to initial certification for home health services.

Only a physician may order home health services and certify a beneficiary's eligibility for the benefit. The face-to-face encounter ensures that the orders and certification for home health services are based on

current knowledge of the beneficiary's clinical condition, and will identify the primary reason for home health services.

In a situation where a physician orders home health services based on a new condition that was not evident during a visit within the 90-days prior to the start of care, the certifying physician or non-physician practitioner (NPP) must see the beneficiary within 30 days of admission to home health services.

The certifying physician must document the face-to-face encounter regardless of whether the physician or a permitted NPP performed the encounter. When the face-to-face encounter is performed by a NPP, he/she must document the clinical findings of the face-to-face encounter and communicate those findings to the physician; the physician must then sign the certification.

Permitted NPPs include:

- A nurse practitioner or clinical nurse specialist (as defined in section 1861(aa)(5) of the Social Security Act) who is working in collaboration with the physician in accordance with state law;
- A certified nurse-midwife (as defined in section 1861(gg) of the Social Security Act, as authorized by State law); or
- A physician assistant (as defined in section 1861(aa)(5) of the Social Security Act) under the supervision of the physician.

The face-to-face beneficiary encounter must be a separate and distinct section of, or an addendum to, the certification and must be clearly titled, dated and signed by the certifying physician. Use of a specific form for the certification or the plan of care is not required.

Documentation of the face-to-face encounter must reflect the certifying practitioner's assessment of the beneficiary and include:

- Date of the encounter,
- Primary reason for the encounter (medical condition),
- Clinical findings that support the need for skilled nursing or therapy services, and
- Clinical findings that support home health eligibility.

An addendum may consist of clinical documents from a hospital or post-acute facility (e.g., emergency visit record or discharge summary). It is allowable for the certifying physician to use such a document as an addendum for the face-to-face encounter if:

- The addendum contains all of the documentation requirements for face-to-face documentation;
- The addendum document, which is serving as the face-to-face documentation, is clearly titled and dated as such; and
- The certifying physician signs and dates the addendum, demonstrating that the certifying physician received that information from the allowed NPP or physician who performed the face-to-face encounter, and that the certifying physician is using that addendum document as his/her documentation of the face-to-face encounter.

While typically the same physician will certify, establish and sign the POC, it is allowable for physicians who attend to the beneficiary in the acute and post-acute settings to certify the need for home health care based on their face-to-face contact, initiate the orders (POC) for home health services, and "hand off" the beneficiary's care to the community-based physician to review and sign off on the plan of care.

SECTION 2 – HOME SETTING

Home health services are intended for beneficiaries who are unable to access services (nursing, OT, PT, speech and language pathology therapy [ST]) in an outpatient setting. However, it is not required that beneficiaries be totally restricted to their home. A determination and documentation is required by the HHA that the home is the most appropriate setting in which to provide the service(s). Home health services are **not** provided solely on the basis of convenience.

All covered home health services must be rendered in a beneficiary's home, except for those services listed below. Home may be the beneficiary's owned/rented home, an apartment, Assisted Living Facility, Adult Foster Care (AFC) facility, or home of another family member (secondary residence of the beneficiary, i.e., joint custody situation for a minor child).

- Home Health aide services are not a covered benefit for beneficiaries who reside in a Home for the Aged (HFA) or Adult Foster Care (AFC) facility as this would be duplication of personal care services already provided by staff of these facilities.
- Michigan Department of Health and Human Services (MDHHS) does not cover any Home Health services rendered to a beneficiary in a hospital, nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), Intermediate Care Facility for the Mentally Ill (ICF/MI), school or adult day care.

To determine if services in the home, rather than in an outpatient setting, are most appropriate, consider the following:

- Is in-home care necessary for the adaptation, training or teaching of nursing or treatment procedures, plans, equipment, appliances or prosthetics in the home setting?
- Is in-home care necessary to prevent undue exposure to infection and/or stress for the beneficiary as identified and documented by a health care professional?
- Is leaving the home medically contraindicated, as identified and documented by a health care professional?
- Is in-home care necessary to prevent a documented problem with access to services, continuity of care or provider, or coordination of services, as documented by a health care professional?
- Is in-home care the most cost-effective method to provide care?

Services must be appropriate and necessary for the treatment of an identified illness, injury or disability. The services provided must be consistent with the nature and severity of the beneficiary's illness, injury or disability, his particular medical needs and accepted standards of medical practice. Beneficiaries with established frail conditions may need assessments by skilled nurses to prevent further decline of the frail condition.

SECTION 3 – PLAN OF CARE

The plan of care (POC) must include the following:

- Date of most recent hospitalization.
- All pertinent medical diagnoses, prognosis, functional limitations and rehabilitation potential.
- Detailed documentation of mental status.
- Detailed documentation of nutritional requirements, medications, and treatments.
- Activities permitted and special circumstances, conditions, or situations that require services to be provided in the home and not in a physician's office or outpatient clinic.
- Date of the HHA's first visit for this admission.
- The start of care date for which the HHA began providing home care and certification period. (This date remains the same on subsequent POCs until the beneficiary is discharged from home health care services.)
- Detailed description of each service, supplies, and equipment required, including frequency of visits and duration of services.
- Documentation of orders for therapy services, which include the specific procedures and modalities to be used, the amount, frequency, and duration.
- Detailed description of current goals as related to the services provided and the goal for referral or discharge planning.
- A full description of the reason(s) that initial and/or continued home care is needed (e.g., pertinent laboratory values, medications, wounds, abnormal vital signs).
- Safety measures to protect against injury (e.g., fall safety measures, medication management, infection control).
- Identification of other resources used by the beneficiary (e.g., Area Agency on Aging, Protective Services, Home Help Services).

If the physician orders Home Health aide services and the beneficiary is also receiving personal care through another entity (Home Help Program, MI Choice Waiver), there must be a coordination between the two entities and documentation in the POC to verify there is no duplication of services. (Refer to the Personal Care Section of this chapter for additional information.)

- Date of physician's last contact.
- Role of family or support person.

If Home Health aide services are ordered, an assessment of the family's ability and willingness to perform the services must be made and included in the POC. If the family is unable to perform the services, the reason must be stated on the POC.

- HHA's name, address and provider NPI number, and beneficiary's name, date of birth, and Medicaid ID number.
- The attending physician's signature and date he signed the POC. The POC must be signed and dated by the beneficiary's attending physician before the HHA submits a claim to MDHHS for payment.
- Any additional items the home health agency or physician chooses to include.

If the attending physician signs the POC after the service(s) is rendered, there must be a pre-existing written or verbal order for the service(s) to be covered by Medicaid. If the service(s) is rendered prior to the date the physician dated the POC and there is no pre-existing written or verbal order, Medicaid does not cover the service(s) provided. The verbal order obtained from the ordering physician must contain the signature of the HHA staff person who obtained the verbal order and the date the verbal order was received. All verbal orders must be countersigned and dated by the ordering physician before the claim is submitted to MDHHS for payment.

Ordering physicians must determine that medical/health services are medically necessary and/or appropriate. Any increase in the frequency of services, addition of new services, or modifications of treatment during a certification period must be authorized by the attending physician and documented in the beneficiary's medical record by way of a verbal order or written order prior to the provision of the increased, additional, or modified treatment.

The POC signed by the attending physician, along with any written or verbal orders as needed, and progress notes must be retained in the beneficiary's medical record.

SECTION 4 – OUTCOME AND ASSESSMENT INFORMATION SET

The Centers for Medicare & Medicaid Services (CMS) requires Medicare certified HHAs to use a standard assessment data set, referred to as the Outcome and Assessment Information Set (OASIS). The requirement to collect and submit OASIS clinical data applies to all beneficiaries receiving Medicare and/or Medicaid home health services. This means beneficiaries under Medicaid traditional fee-for service (FFS), MHP, Children's Waiver, Home and Community Based Services Waiver for the Elderly and Disabled (MI Choice Waiver), Habilitation Supports Waiver, Healthy Michigan Plan, and CSHCS who receive home health services are to have OASIS information collected by the HHA. Assessments for all beneficiaries are to be conducted in compliance with Medicare certification requirements.

The OASIS requirements do not apply if the HHA is providing only housekeeping/ chore services, prepartum and postpartum services, or if the beneficiary is under 18 years of age.

HHAs are also required to electronically transmit the OASIS data to the designated state agency responsible for collecting OASIS data in accordance with CMS specifications. MDHHS contracts with a vendor to provide OASIS transmission assistance. HHAs needing assistance with transmitting data to the state repository should contact the MDHHS contractor. (Refer to the Directory Appendix for contact information.)

The CMS rules for OASIS are published in the Federal Registers that are available online at the OASIS website. (Refer to the Directory Appendix for website information.)

SECTION 5 – POST-PAYMENT REVIEW

Ordering physicians must determine that medical/health services are medically necessary and/or appropriate. All home health services ordered are subject to review for conformity with accepted medical practice and Medicaid coverage and limitations. Post-payment reviews of paid claims may be conducted to assure that the services provided, as well as the type of provider and setting, were appropriate, necessary, and compliant with Medicaid policy. Post-payment review also includes verification that appropriate procedure codes were used to bill the services provided.

Post-payment review includes verification that all third-party resources were utilized to their fullest extent prior to billing MDHHS. If post-payment review reveals that MDHHS was billed prior to utilizing these resources and the HHA knew the beneficiary had other insurance coverage for the service rendered, it may be considered fraud.

The General Information for Providers Chapter of this manual contains additional information regarding post-payment review and fraud.

SECTION 6 – NURSING SERVICES

Nursing services are covered on an intermittent (separated intervals of time) basis when provided by, or under the direct supervision of, a registered nurse (RN). Nursing care provided by a licensed practical nurse (LPN) must be under the supervision of an RN, and the RN must co-sign the LPN's documentation.

A nursing visit may include, but is not limited to, one or more of the following nursing services:

- Administering prescribed medications that cannot be self-administered.
- Changing an indwelling catheter.
- Applying dressings that require prescribed medications and aseptic techniques.
- Teaching the beneficiary, available family member, willing friend or neighbor, or caregiver (paid or unpaid) to carry out all or some of the services, as detailed below.
- Observation and evaluation, as detailed below.

Intermittent (separated intervals of time) nurse visits are intended for beneficiaries who generally require nursing services on a short-term basis (typically 60 days or less) for the treatment of an acute illness, injury, or disability and who cannot receive these services in an outpatient setting. Intermittent nursing visits may last from 15 minutes to one or two hours and are reimbursed at a flat rate (i.e., Medicaid fee screen for a visit) regardless of the length of the visit.

Intensive care (for cases that require five or more visits per week or beyond 60 days) may be reviewed by MDHHS during post-payment audit to determine if home care was medically appropriate and a cost effective alternative to institutional care.

Intermittent nurse visits are not covered for a beneficiary receiving Private Duty Nursing Services.

6.1 COVERED NURSING SERVICES

The following nursing services are covered home health care services. Limitations, conditions and special considerations are noted when applicable. (Refer to the Billing & Reimbursement for Institutional Providers Chapter of this manual for billing information.)

6.1.A. BLADDER TRAINING

When use of a catheter is temporary, visits made by the nurse to change the catheter must also include instruction to the beneficiary in bladder training methods. The actual bladder training (e.g., forcing fluids or other measures) does not require the skills of a nurse. After the catheter is removed, a limited number of visits (maximum two visits per month) are allowed to observe and evaluate the effectiveness with which the bladder training has been accomplished (e.g., the degree to which the bladder is emptying).

6.1.B. ENEMAS

Giving enemas usually does not require the skills of a nurse, and Medicaid does not cover such visits unless the physician has ordered that a nurse give the enema because of clinical indications.

6.1.C. Eye Drops and Topical Ointments

Two nurse visits are allowed to teach the administration of eye drops and topical ointments. Nurse visits solely to perform these services are not covered.

6.1.D. Intravenous Infusions

If the beneficiary is in need of intravenous infusion and an infusion clinic or ancillary Medicaid provider (who has no nurse) does not cover the service, or family member/care giver will not accept this task, the HHA may perform this service and bill accordingly. Medicaid will reimburse claims for professional services (e.g., nursing services) associated with the administration of Medicare Part D drug(s) to dually eligible Medicaid/Medicare beneficiaries.

6.1.E. Neonatal Jaundice

Nurse visits related to neonatal jaundice require supporting documentation in the beneficiary's medical record that the nurse visits are required for a specific medical condition. Supporting documentation should include pertinent laboratory values.

6.1.F. Observation/Evaluation

If the attending physician determines that the beneficiary's condition is unstable and that significant changes may occur, Medicaid covers nurse visits for observation/evaluation. Once the beneficiary's condition has stabilized and there has been no significant change (e.g., no change in medication or vital signs, no recent exacerbation in the beneficiary's condition) for a period of three weeks, and no other necessary nursing services are being furnished, nursing visits solely for observation/evaluation are no longer covered.

Visits for observation/evaluation to ensure stability of a beneficiary who has an established disability or frail condition are covered by Medicaid if circumstances, conditions, or situations exist that prevent the beneficiary from obtaining services from a physician's office or outpatient clinic as described in the Home Setting Section of this chapter. Such visits are limited to two visits per month.

Nurse visits for observation/evaluation to insure stability of a beneficiary's condition cannot be billed within a 30-day period of an initial/subsequent postpartum/newborn follow-up nurse visit, suspected abuse nurse visit or aide visit.

If the beneficiary is enrolled in the MI Choice Waiver, a nurse visit for observation and evaluation to insure stability is not a home health covered service but a responsibility of the waiver staff. (Refer to the Directory Appendix for the website containing the regional map and addresses of the MI Choice Waiver agents.)

6.1.G. Oral Medications

Administration of oral medications does not usually require the skills of a nurse in the home setting. Visits are covered only if the complexity of the beneficiary's condition and/or the number of drugs prescribed require the skill or judgment of a nurse to detect and evaluate side effects (adverse reactions) and/or provide necessary teaching and instruction.

Placing medication in envelopes/cups, giving reminders, etc., to assist the beneficiary in remembering to take them does not constitute a nursing service.

6.1.H. Postpartum / Newborn Follow-up Nurse Visit

Home visits for assessment, evaluation and teaching are covered for women and newborns following delivery when a physician has determined the mother or newborn may be at risk. The goals of these services include:

- Fostering a positive outcome for the mother and newborn by detecting medical complications manifested during the postpartum/newborn period;
- Instructing the mother in newborn care; and
- Identifying situations that may require intervention with medical and community resources.

The HHA must assess and document, in writing, that the beneficiary is receiving services by a Maternal Infant Health Program (MIHP) provider. If the HHA is also an enrolled MIHP provider, services for the mother and newborn cannot be billed as home health care but must be billed as MIHP services. If the beneficiary is receiving MIHP services from another provider and the HHA is also providing services, the POC must clearly identify why home health services are needed in addition to MIHP and that the two providers do not duplicate services.

Medicaid allows one initial postpartum visit, one initial newborn visit, and one subsequent visit to mother and newborn for a total of three visits per pregnancy.

- The initial postpartum visit must be billed using the mother's Medicaid ID number.
- The initial newborn visit must be billed using the newborn's Medicaid ID number.
- The subsequent visit may be billed under either the mother's ID number or newborn's ID number, based on the most time spent with each beneficiary.

6.1.I. Prenatal Nurse Visit

Medicaid covers home visits for a specific pregnancy related medical condition provided by a HHA.

Home visits provided for preventive health services which address psychosocial issues, provide education, provide transportation, etc. and that do not provide treatment for an illness or injury are a covered service of the MIHP, not Home Health.

6.1.J. Routine Prophylactic and Palliative Skin Care

The recognized stages of decubitus ulcers are classified as:

- Stage I - Inflammation or redness of the skin;
- Stage II - Superficial skin break with erythema of surrounding area;
- Stage III - Skin break with deep tissue involvement; and
- Stage IV - Skin break with deep tissue involvement with necrotic tissue present.

The existence of Stage III or IV decubiti or other widespread skin disorders may necessitate the skills of a nurse. The physician's orders for treating the skin determine the need for this service.

The presence of Stage I or II decubiti, rash, or other relatively minor skin irritations do not indicate a need for nursing care unless ordered by a physician. Bathing the skin, applying creams, etc. are not covered nursing services.

6.1.K. Suspected Abuse / Neglect

If there is reasonable cause to suspect that a beneficiary may be in danger of abuse, neglect, exploitation, cruelty, or other hazards, the HHA must report the suspected abuse to the Adult or Child Protective Services Unit of the local MDHHS office. (Refer to the General Information for Providers Chapter of this manual for additional information.)

Once suspected abuse is reported, the local MDHHS office can request supplemental home health visits to complement the protective services from MDHHS. Medicaid covers up to two home health visits for this purpose. The HHA must document in the beneficiary's medical record the county and the name of the individual MDHHS staff member who approved the request.

Approved visits must be ordered by the attending physician and documented in the beneficiary's medical record.

A nursing visit for suspected abuse cannot be billed within 30 days of an aide visit, an observation/evaluation, or an established disability or frail condition visit.

6.1.L. Teaching and Training Activities

HHA services are not covered if the beneficiary has a willing, available, and competent designated caregiver (e.g., family member, friend, neighbor, Home Help provider) that can demonstrate the ability for the beneficiary and/or designated caregiver to provide appropriate care. Medicaid does cover HHA teaching and training activities to enable the beneficiary to become independent of skilled care. The teaching of a procedure or service is covered if it is reasonable and necessary for the treatment of a specific illness, injury or disability.

If a beneficiary or available family member is mentally/physically able to be taught and utilize a particular procedure, and the nurse has completed the teaching but the beneficiary or available family member is subsequently noncompliant, a maximum of three additional teaching visits are allowed for reinforcement teaching. (Medicaid defines noncompliance as the failure or refusal to follow instructions related to improving or stabilizing a condition.)

Teaching visits are not covered if a beneficiary, family member, friend, or neighbor is not mentally or physically able to be taught and utilize a procedure or service as documented in the POC. In these cases, as well as when a caregiver could be taught but is not available or willing to be taught, aide visits (not nurse visits) may be covered to perform these services as long as other Medicaid coverage criteria are met.

Teaching and training activities covered by Medicaid include, but are not limited to:

- Giving an injection
- Prefilling insulin syringes
- Inserting/irrigating a catheter
- Administering eyedrops/topical ointments
- Caring for a colostomy or ileostomy
- Administering oxygen
- Preparing and following of a therapeutic diet
- Applying dressings to wounds that require prescription medications and aseptic techniques
- Bladder training
- Bowel training (e.g., bowel incontinency, constipation due to beneficiary's immobility)
- Performing activities of daily living (e.g., dressing, eating, personal hygiene) for the beneficiary through use of special techniques and adaptive devices where the beneficiary has suffered a loss of function
- Aligning and positioning a bed-bound beneficiary
- Performing transfer activities (e.g., from bed to chair or wheelchair, wheelchair to bathtub)
- Ambulating by means of crutches, walker, cane, etc.

Medicaid reimbursement for teaching visits is based on whether the teaching provided in the home is a reinforcement of previous teaching or is initial instruction. If teaching constitutes reinforcement of training previously received, fewer visits should normally be required than for initial training.

Visits made solely to remind or emphasize to the beneficiary, family member, friend, or neighbor the need to follow the instructions are not covered services. However, visits to supervise and evaluate the practical application of training require the skills of a nurse and are considered reasonable and necessary where the complexity of the service being taught indicates such visits are warranted (e.g., insulin injections or preparation of formula feedings for gastrectomy beneficiaries).

Whether the teaching is reinforcement or initial, the nurse must establish the goal(s) or intended outcome(s) for the beneficiary and a reasonable period of time to attain them and document these in the POC. The beneficiary must be encouraged to become independent of skilled services in his home whenever feasible.

Visits for teaching and training activities solely to ensure stability or solely to prevent an illness, injury, or disability are only covered for beneficiaries who have an established or frail condition or for women/newborns following delivery, as detailed in previous sections.

Except as detailed above, visits solely for teaching designed to prevent an illness, injury, or disability are not covered. Visits for teaching must be necessary for the treatment of a specific illness. For example, instruction in the importance of good nutritional habits, exercise regimens, and good hygiene are not covered services in the absence of a specific supporting diagnosis of illness, injury, or disability.

6.2 Noncovered Nursing Services

The following services are not covered as home health nursing services. As noted, they may be covered under another service.

6.2.A. Bathing

Bathing does not require the skills of a nurse and is not covered by the Medicaid home health benefit.

6.2.B. Prefilling Insulin Syringes

If the sole purpose of a nurse visit is to prefill insulin syringes, this service is not covered as a nursing visit.

This service is covered as an aide visit with a maximum of two visits per month. The Remarks section of the claim must state that the visit was for prefilling insulin syringes.

6.2.C. Psychiatric Nursing Visit

Nursing visits for the primary purpose of providing a psychiatric nursing service are not a Home Health benefit covered by Medicaid, but may be covered under another Medicaid

program. Examples of noncovered nurse visits include psychiatric evaluation, psychotherapy, administration of psychotropic drugs, assessment of beneficiary's adjustment to a psychotropic drug, venipuncture to obtain specimen for psychiatric medication review, and nurse visit to prefill medication cups/boxes, giving reminders, etc., to assist the beneficiary in remembering to take psychiatric medication.

6.2.D. Routine Foot Care

Medicaid does not cover nursing visits solely to provide routine foot care (e.g., removal of corns, calluses, trimming of nails). Nursing visits for the debridement of mycotic nails are not covered by the Medicaid home health benefit.

SECTION 7 – THERAPIES (OCCUPATIONAL, PHYSICAL AND SPEECH)

7.1 OCCUPATIONAL THERAPY

For all beneficiaries, Occupational Therapy (OT) must be medically necessary, reasonable, and required to:

- Help the beneficiary return to the functional level prior to illness or disability;
- Help the beneficiary return to a functional level that is appropriate to a stable medical status; or
- Prevent a reduction in the beneficiary's medical or functional status that would occur had the therapy not been provided.

If Medicare determines that the service is not medically necessary, Medicaid also considers the service not medically necessary.

Medicaid covers OT services when provided by:

- A licensed occupational therapist (OT).
- A licensed occupational therapy assistant (OTA) under the supervision of an OT (i.e., the OTA's services must follow the evaluation and treatment plan developed by the OT, and the OT must supervise and monitor the OTA's performance, with continuous assessment of the beneficiary's progress). All documentation must be reviewed and co-signed by the supervising OT. Evidence of supervision must be documented in the beneficiary's medical record by the licensed OT.
- A student completing his clinical affiliation under the direct supervision of (i.e., in the presence of) an OT. All documentation must be reviewed and co-signed by the supervising OT. Evidence of supervision must be documented in the beneficiary's medical record by the licensed OT.

OT may be provided without prior authorization (PA) by a HHA in the home setting for beneficiaries of all ages for up to 60 consecutive calendar days, with a maximum of 24 visits within those 60 days. If continued therapy is required beyond the initial 60 days, the OT must request PA by completing a Occupational Therapy - Physical Therapy – Speech Therapy Prior Approval Request/Authorization form (MSA-115) and mailing or faxing it to the Program Review Division. (Refer to the Directory Appendix for contact information.)

Requests for PA to continue active OT must also include:

- A treatment summary of previous periods of OT, including measurable progress on each short-term and long-term goal. This should include the treating OT's analysis of the therapy provided during the previous month, the rate of progress, and justification for any change in the treatment plan. (Daily treatment notes are not required.)
- A progress summary related to the identified treatment goals reporting progress toward those goals, as well as revised goals for the requested period of therapy.
- Documentation must cover a period no more than 30 days before the time period for which PA of continued therapy is being requested.

- A statement of the beneficiary's response to treatment, including factors that have affected progress.
- A statement detailing coordination of services with other therapies, if appropriate.
- A copy of the prescription signed by the physician and dated within 30 days prior to the initiation of the request for continued OT services.
- A discharge plan.

7.2 Physical Therapy

For all beneficiaries, physical therapy (PT) must be medically necessary, reasonable, and necessary to help the beneficiary return to the functional level prior to illness or disability or to a functional level that is appropriate to a stable medical status within a reasonable amount of time. Therapy provided to make changes in components of function that do not impact the beneficiary's ability to perform age-appropriate tasks is not covered. If Medicare determines that the service is not medically necessary, Medicaid also considers the service not medically necessary.

For beneficiaries over age 21, PT is covered if it can be reasonably expected that therapy will result in an increase in the beneficiary's ability to perform day-to-day activities.

For CSHCS beneficiaries, PT must be directly related to the CSHCS eligible diagnosis(es) and prescribed by the specialty physician who is overseeing the care of the beneficiary. Functional progress must be demonstrated and documented.

Medicaid covers PT, when medically necessary, for beneficiaries under age 21 who are not enrolled in CSHCS.

PT services must be provided by a licensed Physical Therapist (PT) or an appropriately supervised licensed Physical Therapy Assistant (PTA) (i.e., the PT supervises and monitors the PTA's performance with continuous assessment of the beneficiary's progress). All documentation must be reviewed and co-signed by the supervising PT. Evidence of supervision must be documented in the beneficiary's medical record by the licensed PT. The Code of Ethics, Standards of Practice, and Practice Guidelines provided by the American Physical Therapy Association (APTA) should serve as the basis of appropriate standards of practice.

PT services may be covered for one or more of the following criteria:

- Therapy can be expected to result in the restoration or amelioration of the anatomical or physical basis for the restriction in performing age-appropriate functional mobility skills.
- The service is diagnostic.
- Therapy is for a condition that is temporary in nature and creates decreased mobility.
- Skilled services are designed to set up, train, monitor, and modify a maintenance or prevention program to be carried out by family or caregivers. (The performance of maintenance/preventive therapies is not a covered service.)

PT may include:

- Training in functional mobility skills (e.g., ambulation, transfers, and wheelchair mobility)

- Stretching for improved flexibility
- Instruction of family or other caregivers
- Treatment modalities to facilitate gains in function, strength, or mobility
- Training in the use of orthotic/prosthetic devices

7.2.A. Active Therapy

PT may be provided up to a maximum of 24 times within the first 60 consecutive calendar days in the home setting without PA. There must be a written order for PT signed by the physician/licensed physician's assistant and kept in the beneficiary's medical record. If therapy is not initiated within 30 days of the prescription date, a new prescription is required.

To request approval to continue therapy beyond the initial 60 days, the PT must complete an Occupational Therapy - Physical Therapy – Speech Therapy Prior Approval Request/Authorization form (MSA-115) and mail or fax it to the Program Review Division. (Refer to the Directory Appendix for contact information.) The PT may request up to 60 consecutive calendar days of additional therapy in the home setting.

7.2.B. Maintenance/Monitoring Services

In some cases, a beneficiary may not need active treatment, but the skills of a PT are required for training or monitoring of maintenance programs that are being carried out by the family or caregiver. Training or monitoring may be provided up to four times per 60 consecutive calendar day period in the home setting without PA.

PA requests are required for additional maintenance/monitoring services and may be for up to 60 consecutive calendar days in the home setting. The PT must complete an MSA-115 and include:

- A service summary, including a description of the skilled services being provided. This should include the PT's analysis of the rate of progress, and justification for any change in the treatment plan. Documentation must cover the period immediately before the time for which PA is being requested.
- A comprehensive description or copy of the maintenance/activity plan.
- A statement of the beneficiary's response to treatment, including factors affecting progress.
- A statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate.
- A discharge plan.

Mail or fax requests for continued maintenance/monitoring services to the Program Review Division. (Refer to the Directory Appendix for contact information.)

7.3 SPEECH-LANGUAGE THERAPY

Medicaid does not cover Speech-Language Therapy (ST) in the home. Under exceptional circumstances ST is covered in the home for children enrolled in CSHCS. Medicaid beneficiaries not enrolled in CSHCS may obtain ST from an outpatient hospital or hearing center.

There must be a written order for ST by the physician documented in the beneficiary's medical record. Coverage is limited to services for:

- Articulation
- Language
- Rhythm
- Swallowing
- Training in the use of speech generating devices

The school system provides educational speech; therefore, educational speech is not a covered Medicaid or CSHCS benefit. Examples of educational speech are enhancing vocabulary, improving sentence structure, improving reading, increasing attention span, and identifying colors and numbers.

MDHHS reimburses services for ST when provided by:

- A licensed speech-language pathologist (SLP).
- An appropriately supervised SLP candidate (i.e., in their clinical fellowship year [CFY] or having completed all requirements but has not obtained a license). All documentation must be reviewed and co-signed by the appropriately credentialed supervising SLP. Evidence of supervision by the appropriately credentialed supervising SLP must be documented in the beneficiary's medical record.
- A student completing his clinical affiliation under direct supervision of (i.e., in the presence of) a licensed SLP. All documentation must be reviewed and co-signed by the appropriately credentialed supervising SLP. Evidence of supervision by the appropriately credentialed supervising SLP must be documented in the beneficiary's medical record.

The SLP must complete an Occupational Therapy - Physical Therapy - Speech Therapy Prior Approval Request/Authorization form (MSA-115) for all services requested through the HHA for a CSHCS beneficiary. Mail or fax the form to the Program Review Division. (Refer to the Directory Appendix for contact information.) Therapy may be requested for up to 60 consecutive calendar days in the home setting.

If continued ST services are required, the SLP may request up to an additional 60 consecutive calendar days for the CSHCS beneficiary. A MSA-115 form must be completed and submitted with the following information:

- A treatment summary of the previous period of ST, including measurable progress on each short-term and long-term goal. This should include the treating SLP's analysis of the therapy provided during the previous month, the rate of progress, and justification for any change in the treatment plan. (Daily treatment notes are not required.)

- A progress summary related to the identified treatment goals reporting progress toward those goals, as well as revised goals for the requested period of therapy.
- Documentation must cover the period no more than 30 days before the time period for which prior approval of continued therapy is being requested.
- A statement of the beneficiary's response to treatment, including factors that have affected progress during this interim.
- A statement detailing coordination of services with other therapies, if appropriate.
- A copy of the prescription hand signed by the physician and dated within 30 days prior to the initiation of continued ST services.
- The anticipated frequency and duration of continued treatment.
- A discharge plan.

7.4 Resuming Therapies

If OT, PT, or ST services must be resumed within a 12-month period for the same diagnosis, prior approval is required. The provider must submit an MSA-115 form, along with a copy of the discharge summary of the previous therapy, or an explanation of the changes in functional or medical status since therapy ended. These requests may be submitted by mail or fax to the Program Review Division. (Refer to the Directory Appendix for contact information.)

SECTION 8 – HOME HEALTH AIDES

Home health aide services are covered only when ordered by the attending physician and performed in conjunction with direct, ongoing skilled nursing care and/or PT.

For example, if a beneficiary with a diagnosis of quadriplegia requires a monthly urinary catheter change, and this is not in conjunction with other skilled nursing needs, home health aide services would not be covered. Another example would be that of an elderly and frail beneficiary with a diagnosis of osteoarthrosis requiring a monthly observation/evaluation visit. If their need is assistance with personal care needs (such as eating/feeding, bathing, toileting, dressing, transferring, laundry, housework, shopping/errands) at specified intervals (e.g., daily, weekly) not in conjunction with direct, ongoing nursing and/or PT services, Medicaid would not cover the aide services.

If the beneficiary's attending physician orders home health aide services to be performed in conjunction with the nursing and/or PT services, the HHA must assess the ability of the family or another entity (e.g., Home Help Program or MI Choice Waiver) to perform the services. If the family or other entity is unable to perform the service, the reason must be fully documented in the POC. (Refer to the Personal Care Section in this chapter for additional information.)

8.1 SUPERVISORY VISIT

HHA registered nurses (RNs) must assign a Home Health aide to a particular beneficiary, prepare written instructions for the beneficiary's care, and supervise home health aide visits. It is the responsibility of the supervising RN to co-sign all documentation completed by the Home Health aide. Also, RNs must make a supervisory visit to the beneficiary's home at least once every two weeks and document the supervisory visit in the beneficiary's medical record.

SECTION 9 – PERSONAL CARE

If the physician orders home health aide services and the beneficiary is also receiving personal care services through another entity (e.g., Home Help Program, MI Choice Waiver), there must be coordination between the two providers and documentation in the POC to verify that there is no duplication of personal care services.

9.1 HOME HELP PROGRAM [CHANGE MADE 4/1/18]

The Home Help Program provides unskilled personal care services (i.e., assistance with ADLs, IADLs) and other services allowed by the Home Help Program to assist eligible beneficiaries who are blind, disabled, or otherwise functionally limited. The beneficiary's adult services worker at the local MDHHS office arranges for these services with the personal care provider. The Home Health **(revised 4/1/18)** POC must clearly identify why the HHA services are required along with Home Help. Medicaid covers occasional follow-up HHA visits made to observe, evaluate and document the beneficiary's progress if ordered by the attending physician.

9.2 HOME AND COMMUNITY BASED SERVICES WAIVER FOR THE ELDERLY AND DISABLED [CHANGE MADE 7/1/18]

Medicaid's Home and Community Based Services Waiver for the Elderly and Disabled (MI Choice Waiver) covers those services to aged and disabled individuals (age 18 and over) who, without the provision of waiver services, would require nursing facility care. Examples of services are chore, respite, and emergency response systems.

MI Choice beneficiaries are identified in the eligibility response with the Benefit Plan ID of MI Choice-MC. **(revised per bulletin MSA 17-46)** (Refer to the Beneficiary Eligibility chapter for additional information.) When the physician orders home health services, and the beneficiary is enrolled in the waiver program, the HHA should contact the waiver agent in order to assure coordination and verify there is no duplication of care provided.

SECTION 10 – DURABLE MEDICAL EQUIPMENT (DME) / SUPPLIES

Durable Medical Equipment (DME), certain medical supplies, orthotic and prosthetic appliances, shoe supplies, and oxygen (gas and equipment) are covered services for HHA beneficiaries. These items must be supplied and billed by a Medicaid enrolled medical supplier, orthotist, prosthetist, shoe supplier, or oxygen supplier, except as noted below. The beneficiary's attending physician (MD, DO, DPM) must order these items in writing. These providers may have to obtain PA for certain services, and the services provided must be in accordance with Medicaid policies.

MDHHS encourages the HHA to submit the beneficiary's POC to the medical supplier to help support the need for the item.

Routine medical supply items are included in the reimbursement for the HHA's nurse or aide visit. No separate reimbursement for such supplies is allowed. These supplies include, but are not limited to:

- Band-aids
- Enema kits (e.g., Fleet)
- Gloves (sterile, nonsterile), up to four pair
- Simple dressing (including 10 4x4's and one roll of tape)
- Skin cleansers - swabs or wipes (e.g., iodine, alcohol, Betadine)
- Sterile solutions (up to 30 ml.)
- Syringes and needles
- Thermometers
- Cotton swabs, balls
- Specimen cups
- Suture removal kits
- Gowns

If the treatment regimen requires quantities beyond those listed above for gloves, simple dressings, or sterile solutions, the HHA or the medical supplier may bill separately for the additional quantities. The need for additional supplies must be documented in the medical record.

The MDHHS Home Health Database, available on the MDHHS website, contains a list of medical supply items that may be billed separately from the nurse or aide visit. If the quantity needed is beyond what is listed on the Home Health Database, the supplies must be billed by a DME/Medical Supplier. (Refer to the Directory Appendix for website information.) These are items that may be left in the beneficiary's home between visits where repeated applications are required, and the applications will be performed by the beneficiary, family member, nurse, etc. Supplies billed to Medicaid must be dispensed to a specific beneficiary and must be ordered by the attending physician as part of a written POC.

SECTION 11 – NONCOVERED SERVICES

The services listed below are **not** covered under the home health program.

11.1 HOME UTERINE ACTIVITY MONITOR

Home health services related to the use of a home uterine activity monitor (HUAM) are not separately reimbursable. Reimbursement is made on a per diem rate to a medical supplier approved by MDHHS to provide this service. All equipment, perinatal nursing services, technical services, and supplies necessary for the provision of the HUAM are included in the rate.

11.2 DRUGS AND BIOLOGICALS

The cost of drugs and biologicals are not HHA benefits but may be covered by Medicaid. For information on PA for certain prescribed drugs, contact the MDHHS Pharmacy Benefits Manager (PBM). (Refer to the Directory Appendix for contact information.)

11.3 EVALUATION VISITS

Nursing or PT evaluation visits to assess the acceptance of the beneficiary by the HHA are not covered (e.g., adequacy of the environment for providing nursing care or PT in the home, ability and willingness of family members to meet the beneficiary's medical needs in the home setting, if the beneficiary meets Medicaid home health policy criteria). When the agency makes such an initial evaluation visit, the cost of the visit is considered an administrative cost of the agency and is not covered as a visit because the beneficiary has not been accepted for care by the HHA.

If, however, during the course of this initial evaluation visit the beneficiary is accepted by the HHA for care, and is also furnished the first service as ordered under the physician's POC, the visit becomes the first billable visit.

11.4 HOSPICE

MDHHS does not separately reimburse HHAs for services related to the beneficiary's terminal illness when the beneficiary is enrolled in a hospice program. All HHA services related to the beneficiary's terminal illness are either arranged for (contractual agreement), or provided by, the hospice program.

11.5 MEDICAL SOCIAL SERVICES

Medical social services are not a Medicaid covered HHA service.

11.6 MISSED VISITS

Missed visits are not covered. If a beneficiary is not home when HHA staff arrives to provide a service, MDHHS does not reimburse the agency for the missed visit. The HHA may not charge the beneficiary for a missed visit unless it is the HHA's normal practice to charge everyone for missed visits. (The HHA must notify the beneficiary, in advance, that the beneficiary is required to pay for missed visits.)

11.7 Oxygen

The administration of oxygen is included in the cost of the nurse or aide visit and is not separately reimbursable.

Oxygen gas and equipment are Medicaid benefits when supplied and billed by an enrolled pharmacy, oxygen supplier, or medical supplier in accordance with Medicaid policy.