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For Human Services use only:

General Letter No. 8-AP-449

Employees' Manual, Title 8
Medicaid Appendix

July 1, 2016

HOME HEALTH SERVICES MANUAL TRANSMITTAL NO. 16-1

ISSUED BY: Iowa Medicaid Enterprise

SUBJECT: **HOME HEALTH SERVICES MANUAL**, Chapter III, *Provider-Specific Policies*, Contents (page 1), revised; and pages 1 through 6, revised.

Summary

The **HOME HEALTH SERVICES MANUAL** is revised to align with current IA Health Link policies, procedures, and terminology.

Effective Date

January 1, 2016

Material Superseded

This material replaces the following pages from the **HOME HEALTH SERVICES MANUAL**:

<u>Page</u>	<u>Date</u>
Chapter III	
Contents (page 1)	June 1, 2014
1-6	March 1, 2015

Additional Information

The updated provider manual containing the revised pages can be found at:
<http://dhs.iowa.gov/sites/default/files/Hhserv.pdf>

If any portion of this manual is not clear, please contact the Iowa Medicaid Enterprise Provider Services Unit at 800-338-7909 or locally (in Des Moines) at 515-256-4609, or email at imeproviderservices@dhs.state.ia.us.



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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 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 physician 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. A physician 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 62 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 HCFA 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.