17

17 Home Health

Medicaid provides home health care services to all Medicaid-eligible persons of any age, who meet the admission criteria, based on a reasonable expectation that a patient's medical, nursing, and social needs can adequately be met in the patient's home.

To be eligible for home health care, a recipient must meet the following criteria:

- The recipient's illness, injury, or disability prevents the recipient from going to a physician's or non-physician practitioner's (NPP) office, clinic, or other outpatient setting for required treatment; as a result, he or she would, in all probability, have to be admitted to the hospital or nursing home because of complications arising from lack of treatment.
- The recipient is unable to function without the aid of supportive devices, such as crutches, a cane, wheelchair or walker; requires the use of special transportation or the assistance of another person.

The patient's attending physician or NPP must certify the need for home health services and provide written documentation to the home health provider regarding the recipient's condition which justify that the patient meets home health criteria. The physician or NPP must re-certify care every 60 days if home services continue to be necessary. The attending physician or NPP must be a licensed, active Medicaid provider.

For the initial ordering of home health services (nursing services and home health aide services), the physician or NPP who develops the recipient's written plan of care must sign and document that a face-to-face encounter is related to the primary reason the beneficiary requires home health services. The face to face encounter is conducted by a physician or NPP no more than 90 days before or 30 days after the start of services. The face-to-face encounter may be conducted by either a physician or one of the following authorized non-physician practitioners working under a collaboration agreement under Alabama law:

- Certified Nurse Practitioners or Clinical Nurse Specialists
- Certified nurse midwifes
- Physician assistants, or
- Attending acute or post-acute physicians, if recipients are admitted to home health services immediately after discharge from an acute or post-acute stay.

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The face-to-face encounters may be conducted using telehealth systems.

Refer to Chapter 14—Durable Medical Equipment (DME), Supplies, Appliances, Prosthetics, Orthotics and Pedorthics (POP), for more information on the requirements for placing the initial ordering of certain medical supplies, equipment, and appliances.

The policy provisions for home health providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 12.

17.1 Enrollment

Gainwell enrolls home health providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

To become a home health provider, a provider must be a public agency, private non-profit organization, or proprietary agency primarily engaged in providing part-time or intermittent skilled nursing and home health aide services to patients in their homes. Only in-state home health agencies are eligible for participation in Medicaid.

Electronic Visit Verification (EVV)

Electronic visit verification is required for Home Health providers. These services are electronically verified when the following information is electronically captured by the EVV solution:

- (i) the type of service performed,
- (ii) the individual receiving the service,
- (iii) the date of the service,
- (iv) the location of service delivery,
- (v) the individual providing the service, and
- (vi) the time the service begins and ends

All Home Health provider must secure their own EVV system prior to provider enrollment. The EVV Attestation Form must be completed by the Home Health provider prior to enrolling. Failure to complete the form will result in denial of application. This form can be found on the Medicaid Agency website at:

9.4.16_EVV_Attestation_Form_PDN_HH_TA_Waiver_Providers_5-2-24.pdf (alabama.gov)

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a home health provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for home health-related claims.

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NOTE:

The 10-digit NPI is required when filing a claim.

Home health providers are assigned a provider type of 5 (Home Health). The valid specialty for home health providers is 050 (Home Health).

Enrollment Policy for Home Health Providers

To participate in Medicaid, home health providers must meet the following requirements:

- Be certified to participate as a Medicare provider
- Be certified by the Division of Licensure and Certification of the Alabama Department of Public Health as meeting specific statutory requirements and the Conditions of Participation

Federal requirements mandate providers re-validate periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-validate. Failure to re-validate and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-validate, providers will have to submit a new application for enrollment.

Change of Ownership (CHOW) and Closures

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. Refer to Chapter 19, Hospital for additional information on Change of Ownership.

17.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

17.2.1 Covered Services

Registered Nurse Services (RN)

If ordered by the patient's attending physician or NPP, a registered nurse employed by a certified home health agency can provide part-time or intermittent nursing services to a patient.

- The RN is responsible for a nursing care plan, which is made in accordance with the physician's or NPP written plan of care.
- Restorative, preventive, custodial and maintenance, and supportive services are covered.

Licensed Practical Nurse Services (LPN)

If ordered by a patient's attending physician or NPP, a licensed practical nurse, supervised by an RN employed by a participating home health agency, can provide intermittent or part-time nursing services to the patient when assigned by the RN.

LPN services are provided in accordance with existing laws governing the State Board of Nursing.

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Home Health Aide or Orderly Services

A home health aide or orderly can provide personal care and services as specified in the attending physician's or NPP plan of care.

Supervisory visits by the registered nurse must be performed at least every 60 days when services are provided by the LPN, home health aide, or orderly. These services may be provided on a part-time basis only and must be ordered by the attending physician or NPP. The RN who is responsible for the care of the patient must supervise the service.

17.2.2 Noncovered Services

There is no coverage under the Medicaid Home Health Care plan for visits by paramedical personnel, physical therapists, speech therapists, occupational therapists, and inhalation therapists.

Medicaid also does not cover sitter service, medical social workers, or dietitians.

Supervisory visits made by an RN to evaluate appropriateness of services being rendered to a patient by an LPN, aide, or orderly are considered administrative costs and may not be billed as skilled nursing services. The registered nurse will provide and document in the case record on-site supervision of the LPN, home health aide, or orderly at least every 60 days. The registered nurse will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performances by the worker.

17.2.3 Visits

A visit is a personal contact in the place of residence of a patient by a health worker employed by a certified Medicaid home health agency for the purpose of providing a covered service.

Home health care visits to Medicaid recipients must be medically necessary and provided in accordance with a Medicaid Home Health Certification form signed by a licensed physician or NPP. Home Health records are subject to on-site audits and desk reviews by the professional staff of Medicaid.

If a Medicaid recipient receiving home health visits is institutionalized and is referred to home health upon discharge from the institution, a new Medicaid Home Health Certification form must be completed and retained by the home health agency.

NOTE:

Home health care visits, including nurse aide visits, are limited to 104 per calendar year. Nurse aide visits are restricted to two visits per week.

17.2.4 Medicare/Medicaid Eligible Recipients

Persons eligible for Medicare and Medicaid are entitled to all services available under both programs, but a claim must be filed with Medicare if Medicare covers the services. A patient may not receive home visits under both programs simultaneously. If Medicare terminates coverage, Medicaid may provide visits.

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17.3 Prior Authorization and Referral Requests

Additional skilled nursing visits and home health aide visits are limited to EPSDT and must be prior authorized once the recipient has exceeded 104 home health visits in a calendar year. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the Alabama Coordinated Health Network (ACHN) Program, refer to Chapter40 ACHN Billing Manual to determine whether your services require a referral from the Primary Care Physician (PCP).

17.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by home health providers.

17.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers are encouraged to bill Medicaid claims electronically.

Home health providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a UB-04 claim form is required. Medicare-related claims must be filed using the Institutional Medicaid/Medicare Related Claim Form.

NOTE:

Claims must contain the detail date of service. Span-billing dates of service on the detail line IS NOT Allowed. The provider must submit each date of service on a separate line on the claim.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

17.5.1 Time Limit for Filing Claims

Medicaid requires all claims for home health to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

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17.5.2 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the
American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

NOTE:

ICD-9 or ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

17.5.3 Procedure Codes and Modifiers

The following procedure codes apply when filing claims for home health services. Medicaid requires all claims for home health providers to be filed within one year of the date of service. Refer to Chapter 5, for general claims filing information and instructions.

Home Health Services

Revenue Code	*Procedure Code*	*Description*
551	S9124	Nursing care in the home by LPN; per hour
551	S9123	Nursing care in the home by RN; per hour
571	S9122	Home Health aide or CNA providing care in the home; per hour

Billing for Supplies

Home health providers must enroll as a DME provider to bill for supplies. Supplies may not be billed on a UB-04 claim form.

17.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-04claim form.

17.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to Claims with Third Party Denials.

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Refer to Section 5.7, Required Attachments, for more information on attachments.

NOTE:
When an attachment is required, a hard copy UB-04 claim form must be submitted.

17.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
UB-04 Claim Filing Instructions	Section 5.3
Institutional Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.2
Medical Necessity/Medically Necessary Care	Chapter 7
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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