Alaska Medicaid Provider Billing Manual

Home Health Services

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1.0 About This Manual

The Department of Health (Department) is the state agency designated to administer the Alaska Medical Assistance program, which includes the following:

- Medicaid
- Denali KidCare (DKC)

Unless otherwise specified, references to the Alaska Medical Assistance program or Alaska Medicaid mean Medicaid and DKC collectively.

This manual provides billing and coverage policies for home health services under Alaska Medicaid. Home health providers should use this manual in conjunction with:

- *Institutional Claims Management*
- *General Program Information*

This manual will be updated periodically as federal and state medical assistance regulations change. Providers will be notified of updates through remittance advice messages and announcements on the Alaska Medicaid website. Previous versions of this manual are available upon request to the Department.

Providers are responsible for using the current version of this manual.

For questions about this manual or home health coverage policies, contact Alaska Medicaid Provider Services.

2.0 Provider Enrollment

In addition to meeting all the conditions for participation identified in *General Program Information*, public and private home health agencies must meet the standards outlined in the following subsections.

2.1 Enrollment Requirements for In-State Home Health Agencies

In addition to meeting all the general conditions for participation identified in *General Program Information*, in-state home health agencies must meet the following initial enrollment requirements and ongoing participation obligations:

- Submit a completed provider enrollment form and provider information submission agreement on department-provided forms before billing for services.
- Maintain a current Alaska business license issued under AS 43.70 and 12 AAC 12.
- Be enrolled under 7 AAC 105.210 specifically as a home health agency.
- Be certified as a home health agency for the purposes of the Medicare program.

- Provide evidence of Medicare enrollment at initial enrollment and upon request; maintain concurrent Medicare and Medicaid enrollment.
- Meet all federal and state licensing and certification requirements and comply with all federal and state laws governing provision of health care services to Medicaid members, including laws related to member confidentiality, electronic transactions, and civil rights.
- Accept responsibility for all information and claims submitted to the department by the provider or the provider's billing agent.
- Submit claims in the form or format required by the department.
- Comply with barrier crimes and background check requirements under AS 47.05.300 - 47.05.390 and 7 AAC 10.900 - 7 AAC 10.990, if applicable to the provider type.
- Notify the department in writing within 30 days of any change in status affecting enrollment requirements.
- Be licensed as a home health agency under AS 47.32 and comply with all state licensing requirements in 7 AAC 12.500 - 7 AAC 12.590, including but not limited to:
  - Providing skilled nursing services and at least one additional service (physical therapy, occupational therapy, speech therapy, or home health aide services).
  - Maintaining a governing body with full legal authority and fiscal responsibility for agency operations.
  - Employing a qualified administrator.
  - Implementing and maintaining a quality improvement program.
  - Maintaining clinical records for each patient in accordance with professional standards and regulatory requirements.

NOTE: The requirements listed in the bullet immediately above are representative of key state licensing standards. Providers must review and comply with all requirements in 7 AAC 12.500 - 7 AAC 12.590.

2.2 Enrollment Requirements for Out-of-State Home Health Agencies

To enroll and maintain enrollment as an out-of-state home health agency, a provider must meet all in-state provider requirements listed above, plus the following additional requirements:

- Verify enrollment in the Medicaid program in the jurisdiction where services are provided, if Medicaid enrollment is available for home health agencies in that jurisdiction; or
- Provide documentation from that jurisdiction that Medicaid enrollment is not available for home health agencies; and
- Meet all home health agency licensing requirements in the jurisdiction where services are provided.

NOTE: Federal Medicaid program requirements prohibit Alaska Medicaid from issuing payment to any entity or financial institution outside the United States and its territories.

2.3 Electronic Visit Verification (EVV) Requirements

Under Section 12006 of the 21st Century Cures Act, home health providers must comply with EVV data submission requirements established in Alaska regulation (7 AAC 125.350). This includes using electronic means to verify, for each instance of home health service delivery, the name of the agency, the identity of the rendering provider, the identity of the member, the location of the service, the date, the start and stop times, and the type of service. Providers may use the Department's EVV vendor, Therap Services, or another Department-approved EVV system.

For additional information on how to register with Therap's EVV solution, contact Therap Alaska.

3.0 Member Eligibility

Alaska Medicaid will cover home health services provided to members who are eligible under specific eligibility categories. Eligibility categories and codes can be found in *General Program Information*.

Providers must verify member eligibility before providing any services. For questions about a member's eligibility or benefit limitations, providers should contact the Alaska Medicaid fiscal agent at (800) 770-5650 (option 1, 4) or (907) 644-6800 (option 1, 4).

4.0 Covered Services

Alaska Medicaid reimburses enrolled providers for medically necessary services for eligible members when delivered, ordered, or prescribed by a provider within the scope of the provider's license or certification. Services rendered based on a prescription, order, or referral are reimbursable only if the prescribing, ordering, or referring provider is enrolled as an Alaska Medicaid provider.

Home health services must be provided to a member in their place of residence, which may include an assisted living home.

4.1 Skilled Nursing Services

Skilled nursing services are services focused on the curative, restorative, or preventive aspects of member care and that require a high level of nursing direction, observation, and skill. Skilled nursing services must be provided on a part-time or intermittent basis by or under the supervision of a registered nurse licensed under AS 08.68, in accordance with a plan of care.

Medicare-certified home health agencies enrolled with Alaska Medicaid provide skilled nursing services in accordance with 7 AAC 12.517(a).

Limited Skilled Nursing Services Through RHCs and FQHCs

Alaska Medicaid will cover limited skilled nursing services delivered through an enrolled rural health clinic (RHC) or federally qualified health center (FQHC) only when a member's place of residence is not served by any Medicare-certified home health agency. These limited services must be delivered by a registered nurse who receives written orders from a member's physician, physician assistant, or advanced practice registered nurse, and the services must be within the scope of the nurse's license (7 AAC 125.310(a)(2)).

For additional information about RHC and FQHC services, refer to the *FQHC/RHC Services Billing Manual*.

4.2 Home Health Aide Services

Home health aide services are simple procedures performed as an extension of therapy services. These include, but are not limited to:

- Providing personal care, including bathing, hair care, oral hygiene, skin care, and hand and foot care.
- Assisting a member with ambulation and exercise.
- Assisting a member with meeting nutritional needs
- Assisting a member with self-administered non-prescription and prescription medications by handing the member a medication bottle or medications prepared under the supervision of a registered nurse or a physician.
- Taking and recording vital signs.
- Reporting changes in a member's condition or needs and completing appropriate records.

Individuals employed by home health agencies to provide home health aide services must hold a current nurse aide certification from the Alaska Board of Nursing under AS 08.68 and work under the supervision of a registered nurse or appropriate therapist (7 AAC 12.519).

4.3 Physical and Occupational Therapy, Speech-Language Pathology, and Audiology Services

Physical therapy, occupational therapy, and speech-language pathology services are covered when provided by a home health agency (7 AAC 12.505(a)). These services must be provided by a qualified therapist or a qualified therapy assistant under the supervision of a therapist, in accordance with 7 AAC 12.521.

4.4 Medical Supplies

Medical supplies are items that are essential, due to their therapeutic or diagnostic characteristics, for home health agency personnel to conduct home visits or carry out the care ordered by a physician or other authorized practitioner for treatment or diagnosis of a member's illness or injury.

Supplies fall into one of two categories:

- Routine supplies: Supplies used in small quantities during most home visits. Routine supply costs are included in the home health service reimbursement rate.
- Non-routine supplies: Supplies needed to treat a member's specific illness or injury as specified in a plan of care.

Home health agencies may bill for non-routine supplies with an approved service authorization. Claims should be submitted with revenue code 0270 and the appropriate corresponding HCPCS code. For the most current list of billable non-routine supplies, refer to the *CMS Home Health Consolidated Billing Code List*, as updated annually.

4.5 Services for Dual-Eligible Members

Alaska Medicaid covers home health services for dual-eligible members when Medicare will not pay for some or all of the home health services because a member is either not confined to the home or does not need intermittent or part-time skilled nursing services.

4.6 Travel for Medical Care

Alaska Medicaid covers transportation and accommodation services when travel is required to receive non-emergent, medically necessary services. For additional information about non-emergent transportation, including how to request a service authorization, refer to *Arranging Patient Travel*.

5.0 Non-Covered Services

The following services are not covered under the Alaska Medicaid home health benefit:

- Services that are not medically necessary.
- Services provided outside the member's place of residence, except for therapy services provided in an outpatient setting.
- Services not included in an approved plan of care.
- Services provided without a valid service authorization.
- Custodial care services.
- Homemaker services, including meal preparation, shopping, and general household activities.
- 24-hour or shift nursing care.
- Services provided when the member is an inpatient in a hospital, skilled nursing facility, intermediate care facility, or other institutional setting.

6.0 Service Authorization

All home health services require a service authorization (SA) from Alaska Medicaid, except for an initial assessment.

Initial Service Authorization

To request an initial SA, a home health agency must submit a *Home Health Service Authorization Request Form* with the following documentation to the Alaska Medicaid fiscal agent:

- Documentation demonstrating a face-to-face encounter was performed by a physician, physician assistant, or advanced practice registered nurse enrolled with Alaska Medicaid.
- A plan of care/certification signed by the attending physician, physician assistant, or advanced practice registered nurse that includes:
  - Type of services needed (either ongoing or post-acute care).
  - For post-acute care, a written statement describing the expected decrease in need for home health services.
  - A written statement explaining the reason home health services are needed and why services cannot be performed in a clinic, outpatient setting, or physician's office.
- Revenue codes identifying the type(s) of home health services being requested.
- Corresponding procedure/HCPCS codes for each service requested.

Each SA remains valid for up to 60 days, unless renewed.

Service Authorization Renewals and Extensions

To request an extension or renewal of services, a home health agency must submit:

- An updated *Home Health Service Authorization Request Form* that includes:
  - The most recently approved SA number.
  - Current dates according to the plan of care/recertification.
  - Additional units being requested for the recertification period.
- An updated plan of care/recertification, signed by the attending physician, physician assistant, or advanced practice registered nurse that includes:
  - Documentation of the continuing need for home health services; or
  - For post-acute care, an estimate of the remaining duration of need for home health services.

6.1 Face-to-Face Encounter Requirement

For initiation of home health services, a member must have a face-to-face encounter with an appropriate practitioner (42 CFR 440.70(f); 42 CFR 424.22(a)(1)(v)). The face-to-face encounter must be related to the primary reason the member requires home health services and must have occurred:

- Within 90 days before the start of the home health services; or
- Within 30 days after the start of home health services.

The face-to-face encounter may be performed by a:

- Physician.
- Nurse practitioner or clinical nurse specialist.
- Physician assistant, under supervision of a physician.
- For members admitted to home health immediately after an acute or post-acute stay, the attending acute or post-acute physician.

6.2 Initial and Comprehensive Assessments

The home health agency must complete all required assessments to determine the member's needs and develop the plan of care.

Initial Assessment

A registered nurse must complete an initial assessment of a member no more than 48 hours after the referral, 48 hours after the member's return to their place of residence, or on the start-of-care date ordered by the practitioner (7 AAC 125.320(f)).

Comprehensive Assessment

Consistent with the member's needs, a registered nurse must complete a comprehensive assessment no later than five days after care starts. The assessment must include a review of all current medications to identify significant side effects, drug interactions, ineffective therapy, duplicate therapy, and member noncompliance (7 AAC 125.320(g)).

NOTE: If speech-language pathology, physical therapy, or occupational therapy is the only service ordered, the appropriate therapist (speech-language pathologist, physical therapist, or occupational therapist) may complete the initial and comprehensive assessments within the scope of their professional license, and a medication review is not required (7 AAC 125.320(h)).

6.3 Plan of Care

All home health services must be provided under a written plan of care. A physician, physician assistant, or advanced practice registered nurse must develop a plan of care in consultation with a member and the home health agency (7 AAC 12.513(a); 7 AAC 125.120(d)).

The plan of care must:

- Be signed by the physician, physician assistant, or advanced practice registered nurse.
- Be signed by the practitioner no later than 21 days after the start of care or recertification date (7 AAC 12.513(a)(2)).
- List all services to be provided, their frequency, and expected duration.
- Include all pertinent diagnoses, rehabilitation potential, functional limitations, permitted activities, nutritional requirements, medications and treatments, safety measures, measurable goals, and discharge planning (7 AAC 12.513(a)(4)).
- Be updated as needed to reflect changes in the member's condition (7 AAC 12.513(b)).

If a plan of care cannot be completed until after an evaluation visit, the physician, physician assistant, or advanced practice registered nurse must make modifications to the original plan of care as necessary to reflect the outcome of the evaluation.

6.4 Plan of Care Review

A member's physician, physician assistant, or advanced practice registered nurse and the home health agency must review the plan of care:

- At least once during an SA period *or* at least once every 60 days, whichever is the shorter period (7 AAC 125.320(i)(1); 42 CFR 440.70(a)(2)).
- More frequently if there is a significant change in a member's condition (7 AAC 12.513(a)(1); 7 AAC 125.320(i)(2)).
- If a member is discharged from care but return to the same home health agency during an SA period (7 AAC 125.320(i)(3)).

A physician, physician assistant, or advanced practice registered nurse must also review a member's need for supplies at least annually, although the Department may require more frequent reviews for particular prescribed items (7 AAC 125.320(j)).

7.0 Telehealth

Providers should refer to the Alaska Medicaid Telehealth Provider Information website for comprehensive telehealth policy, billing requirements, documentation standards, and modifier usage.

NOTE: This manual's telehealth guidance applies only to Alaska Medicaid. Federal Medicare telehealth standards are separate, distinct, and often more restrictive. Providers must understand and follow the requirements of the appropriate payer for each service, especially when billing for dual-eligible members.

8.0 Coordination of Services

Alaska Medicaid requires that delivery of and payment for home health services be coordinated with other providers and payers to ensure comprehensive care without duplication of services or payment. This includes:

- Medicare (Dual-Eligible Members): For members enrolled in both Medicare and Alaska Medicaid, providers must understand Medicare's coverage rules and bill Medicare as the primary payer when services are covered by both programs. Alaska Medicaid may cover services not covered by Medicare or pay cost-sharing for Medicare-covered services.
- Third-Party Insurance: When a member has other insurance, providers must bill that insurance first. Alaska Medicaid is the payer of last resort.
- Other Medicaid Services: Providers must coordinate with providers of other Alaska Medicaid-covered services to prevent duplication of care.

For complete coordination of benefits policies and billing procedures, refer to *General Program Information*.

9.0 Claim Submission

9.1 Billing for Home Health Services

Home health agencies must bill for services on the UB-04 Claim Form using revenue codes and HCPCS codes identified in this manual. Services billed without both a revenue code and a HCPCS code will be denied.

Refer to *Institutional Claims Management* for claim submission instructions and to the *UB-04 Claim Form Instructions* for claim form completion instructions specific to Alaska Medicaid.

9.2 Revenue Codes

Home health services are identified by specific revenue codes published by the National Uniform Billing Committee (NUBC). To review all published revenue codes, refer to *the UB-04 Data Specifications Manual* available from the American Hospital Association.

Alaska Medicaid covers the following revenue codes (subject to the provider's scope of certification, license, or accreditation):

Revenue Code	HCPCS Code	Description
0270	Various*	Non-routine supplies
0421	S9131	Physical therapy visit
0431	S9129	Occupational therapy visit
0441	S9128	Speech therapy visit
0551	T1030	Skilled nursing visit, by registered nurse
0551	T1031	Skilled nursing visit, by LPN
0571	T1021	Home health aide (per visit)
0572	S9122	Home health aide (per hour)

*For the most current list of billable non-routine supplies, refer to *the CMS Home Health Consolidated Billing Code List*.

9.3 Electronic Visit Verification

Claims for services requiring EVV will be validated against the Department's EVV system. Providers must comply with EVV data submission requirements described in Section 2.3.

EVV Denial and Exception Codes

Claims for services requiring EVV are validated against the Department's EVV system. If claim and EVV data do not match, the claim will be denied. Specific denial/exception codes are used to identify mismatches:

Exception Code	Description
5501	Member ID not confirmed
5502	Billing provider ID not confirmed
5511	Date of service not confirmed
5513	Rendering provider not confirmed
5514	Procedure code not confirmed
5516	Submitted units not confirmed

For general EVV questions, contact Therap Alaska. For questions about EVV-related denials, contact the Department’s EVV project team:

- Secure email/DSM (PHI): hss.dsds.evv@hss.soa.directak.net
- General email (no PHI): hss.dsds.evv@alaska.gov

10.0 Pricing Methodology

Under 7 AAC 145.510, Alaska Medicaid reimburses home health agencies at 80% of the agency's usual and customary charges billed in accordance with 7 AAC 145.020. The reimbursement amount is calculated as 80% of the charge the home health agency bills for the service—the same charge the agency would bill to other payers for the same service. Agencies should bill their standard charges; Alaska Medicaid will automatically apply the 80% payment rate.

Example: If an agency's standard charge for a skilled nursing visit is $100, Alaska Medicaid will reimburse $80 (80% of $100).

Providers must bill their actual charges and may not inflate charges specifically for Medicaid billing purposes. All billing must comply with the requirements of 7 AAC 145.020.

11.0 Legal Authority

11.1 Federal

42 CFR 424, 42 CFR 431, 42 CFR 440, 42 CFR 441, 42 CFR 455, 42 CFR 456, 42 CFR 484,

42 USC 1396, Section 12006 of the 21st Century Cures Act

11.2 State

7 AAC 12, 7 AAC 105, 7 AAC 110, 7 AAC 115, 7 AAC 120, 7 AAC 125, 7 AAC 145, 7 AAC 150,

7 AAC 160, 12 AAC 12, AS 08.68, AS 47.05, AS 47.07, AS 47.32

12.0 Revision History

Revision Date	Revision Summary
11/18/2025	Updated layout, language, and hyperlinks; added statutory and regulatory citations
3/1/2024	Department of Health rebrand, updated hyperlinks; added EVV information; added medical supplies information; added billing information; updated service authorization information; completed misc. updates for consistency

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