



KANSAS MEDICAL ASSISTANCE PROGRAM Fee-for-Service Provider Manual

Home Health Agency

PART II
HOME HEALTH AGENCY FEE-FOR-SERVICE PROVIDER MANUAL

Introduction

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FORMS All forms pertaining to this provider manual can be found on the [public](#) website and on the [secure](#) website under Pricing and Limitations.

DISCLAIMER: This manual and all related materials are for the traditional Medicaid fee-for-service program only. For provider resources available through the KanCare managed care organizations, reference the [KanCare](#) website. Contact the specific health plan for managed care assistance.

PART II

HOME HEALTH FEE-FOR-SERVICE AGENCY PROVIDER MANUAL

Updated 01/18

This is the provider specific section of the manual. This section (Part II) was designed to provide information and instructions specific to home health agency providers. It is divided into three subsections: Billing Instructions, Benefits and Limitations, and Appendix.

The **Billing Instructions** subsection gives information regarding the billing form applicable to home health agency services.

The **Benefits and Limitations** subsection defines specific aspects of the scope of home health agency services allowed within the Kansas Medical Assistance Program (KMAP).

The **Appendix** subsection contains information concerning codes. These appendices were developed to make finding and using codes easier for the biller.

Access to Records

Kansas Regulation K.A.R. 30-5-59 requires providers to maintain and furnish records to KMAP upon request. The provider agrees to furnish records and original radiographs and other diagnostic images which may be requested during routine reviews of services rendered and payments claimed for KMAP consumers. If the required records are retained on machine readable media, a hard copy of the records must be made available.

The provider agrees to provide the same forms of access to records to the Medicaid Fraud and Abuse Division of the Kansas Attorney General's Office upon request from such office as required by K.S.A. 21-3853 and amendments thereto.

Confidentiality & HIPAA Compliance

Providers shall follow all applicable state and federal laws and regulations related to confidentiality as part of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with section 45 of the code of regulations parts 160 and 164.

KMAP Audit Protocols

The [KMAP Audit Protocols](#) are available on the [Provider](#) page of the KMAP website under the ***Helpful Information*** heading.

BILLING INSTRUCTIONS

7000. HOME HEALTH AGENCY BILLING INSTRUCTIONS Updated 02/26

Introduction to the CMS-1500 Claim Form

Home health agency providers must use the CMS-1500 paper or equivalent electronic claim form when requesting payment for medical services and supplies provided under KMAP. Claims can be submitted on the KMAP secure website or on paper. When a paper form is required, it must be submitted on an original, red claim form and completed as indicated.

An example of the CMS-1500 Claim Form and corresponding instructions are on the KMAP [public](#) and [secure](#) websites under the Publications tab on the [Forms](#) page under the Claims (Sample Forms and Instructions) heading.

The Kansas MMIS will be using electronic imaging and optical character recognition (OCR) equipment. Therefore, information will not be recognized if not submitted in the correct fields as instructed.

Any of the following billing errors may cause a CMS-1500 Claim to deny or be sent back to the provider:

- Sending a KanCare paper claim to KMAP.
- Sending a CMS-1500 Claim Form carbon copy.
- Using a PO Box in the Service Facility Location Information field.

The fiscal agent does not furnish the CMS-1500 Claim Form to providers. Refer to **Section 1100** of the *General Introduction Fee-for-Service Provider Manual*.

Submission of Claim

Send completed claim and any necessary attachments to:
Office of the Fiscal Agent
PO Box 3571
Topeka, KS 66601-3571

7010. HOME HEALTH AGENCY SPECIFIC BILLING INFORMATION Updated 08/21

Enteral Supplies

Add modifier BO to the base code (XXXXX-BO) and place in field 24D when billing for oral supplemental nutrition.

Immunization Administration

Providers must bill the appropriate administration code in addition to the vaccine and toxoid code for each dose administered. Refer to Appendix I for a list of administration and vaccine procedure codes billable to KMAP. Reimbursement of CPT[®] codes for vaccines covered under the Vaccines for Children (VFC) program will not be allowed.

PACS software requires a charge on each line item being submitted. Providers billing electronically through the PACS system will need to indicate a charge of \$1 on the line for the vaccine/toxoid code. MMIS will deny the service even though a charge was submitted.

Home Immunization Administration for COVID-19 Vaccines

Medicaid will only reimburse code M0201 when billed with the COVID-19 vaccine administration code 90480.

HCPSC code M0201

Providers may bill this code when the COVID-19 vaccine is administered in the member's home. This code is billable in addition to the COVID-19 administration codes. It includes clinical time needed to monitor after the vaccine is administered, as well as all costs associated with administering the vaccine safely and appropriately in a member's home. KMAP only pays if the sole purpose of the visit is to administer a COVID-19 vaccine. The additional amount will not be paid if another KMAP service is provided in the same home on the same date. In these situations, reimbursement for administering the COVID-19 vaccine will be at the standard amount. If the COVID-19 vaccine is administered to more than one patient in a single home on the same day, only one additional payment will be allowed. Additional vaccines will be reimbursed at the standard rate. For further information, review KMAP [General Bulletin 21136](#).

Parenteral Supplies

Add modifier BA to the base code (XXXXX-BA) and place in Field 24D when billing for item supplies in conjunction with total parenteral nutrition.

7020. HOME HEALTH AGENCY ELECTRONIC VISIT VERIFICATION Updated 01/25

Effective February 6, 2025, AuthentiCare will become the sole approved claims entry point for services that require Electronic Visit Verification (EVV). Initial Claims for EVV covered services that are not received from AuthentiCare will be denied. Claims will be created from AuthentiCare to cover all services, excluding WORK and STEPS that require EVV.

Claims Process

- Claims will be created using the information that comes from MCO and Gainwell FFS (payer) authorizations, caregiver visits, and provider data entry.
- Negotiated rates, up to 12 diagnosis codes, and ordering provider NPI information will be on the claim for the services being provided based on data in the authorization file from payers. Providers will select the appropriate diagnosis pointers for each service line.
- Caregivers will populate the Place of Service (POS) where care takes place when submitting visit information. This will be populated into the claim.

Provider Responsibilities

Before confirming a visit in AuthentiCare to be submitted for claims processing, Provider Administrators will:

- Validate the information contained in the authorization including member, service, start and end dates, diagnosis code, ordering physician, number of approved units, and ensure that service rates are correct. If the claim billed amount is different than the calculated amount, the provider must update with their usual and customary billed amount. The provider is responsible for working with the payer to ensure a proper and accurate authorization is in the AuthentiCare system.
- Validate the visit information submitted by the caregiver.
- Address all critical exceptions found in the rules review process for visits in AuthentiCare by updating the visit information for accuracy, completeness and attesting to the accuracy of the visit information captured.
- Validate the TPL coverage information on the client record is accurate. If not, the provider will need to submit a request for an update through the KMMS provider portal.
- Validate the TPL adjudication information has been correctly entered on the claim for each TPL Payer.
- Validate and attest to the entry of all payor information related to Third Party Liability.
- Provider is responsible for the entry of TPL payments and CARC/RARCs and group codes in AuthentiCare.
- Confirm the visit for billing that will result in AuthentiCare building the claim and submitting it during its daily batch submission process.

Claims Adjustments

Providers may continue to submit claims adjustments through the provider portal. Ensure all required documentation and corrections are submitted timely.

7020. HOME HEALTH AGENCY ELECTRONIC VISIT VERIFICATION Updated 09/25

Ordering Provider Responsibilities

Managed Care Organizations (MCOs) must ensure that all authorizations for Home and Community-Based Services (HCBS) subject to EVV include the appropriate ordering provider information, regardless of provider type (05 or 55).

MCOs must include the ordering provider's first name, last name and National Provider Identifier (NPI) from CMS Form 485 (Form 485) in the authorization submitted to AuthentiCare.

If Form 485 is unavailable, the member's primary care provider or discharging physician may be used temporarily.

Diagnosis Code

MCOs must use the diagnosis code listed on Form 485. If Form 485 is unavailable, use R68.89 as the standard HCBS EVV diagnosis code.

Flexibility for Oversight

For EVV compliance, the authorization must include a provider who appropriately oversees the service plan within their professional scope. This may include a physician, primary care provider, discharging physician, or supervising therapist, depending on the service provided.

MCOs must follow these guidelines only in the context of authorization submission for EVV compliance. Any necessary clinical oversight or regulatory determinations remain the responsibility of providers in accordance with existing regulations.

The following HCBS codes require an ordering provider on the EVV authorization:

Waiver	Service	Code	EVV Code
Frail Elderly	Nursing Evaluation Visit	T1001	HCFET1001
Intellectual/Developmentally Disabled (I/DD)	Specialized Medical Care	T1000	HCDDT1000
Technology Assisted	Specialized Medical Care	T1000	TAT1000
Technology Assisted	Health Maintenance Monitoring	T1001	TAT1001
Technology Assisted	Intermittent Intensive Med.	T1002	TA1002
Technology Assisted	Agency Directed PCS	T1004	HCTAT1004
Technology Assisted	Medical Respite	T1005	TAT1005

BENEFITS AND LIMITATIONS

8100. COPAYMENT Updated 12/23

Copayments will no longer apply to Kansas Medicaid Fee-for-Service (FFS) members. The mandatory managed care authority for KanCare is transitioning from the 1115 Waiver to the Medicaid State Plan and a 1915b Waiver. Copayments are being removed from the Medicaid State Plan and will not apply to FFS members.

Managed Care members will continue to be exempt from copayments.

BENEFITS AND LIMITATIONS

8300. BENEFIT PLANS Updated 12/22

Members are assigned to one or more medical assistance benefit plans. These benefit plans entitle the member to certain services. If there are questions about service coverage for a given benefit plan, refer to **Section 2000** of the *General Benefits Fee-for-Service Provider Manual* for information on eligibility verification.

For example, home health services with limitations on durable medical equipment and supplies are covered for MediKan members when medically necessary and a physician has established a treatment plan and certified the need for the service. Refer to **Section 8400** in this manual.

Procedure codes for drugs and biologics deemed Physician Administered Drug (PAD) are not covered by MediKan.

Providers billing KMAP for home health agency services rendered to Medicare-eligible members must either bill Medicare first and obtain a denial or use the GY (statutorily excluded) modifier to bypass the Medicare-denial requirement. The GY modifier may only be used if the member has a Medicaid-covered benefit plan.

Providers can bill KMAP for services rendered to a dually eligible member if the member is not homebound per Medicare requirements. Dually eligible members have both Medicare and Medicaid coverage.

Medicaid-covered home health services may be provided in any setting in which normal life activities take place. A member is considered homebound if he or she has a condition due to an illness or injury which restricts his or her ability to leave the home without assistance. The member is dependent on the aid of supportive devices such as crutches, canes, wheelchairs and walkers, the use of special transportation, or the assistance of another person. A member is also considered homebound if his or her condition is such that leaving the home is medically contraindicated.

If a member is a qualified Medicare member (QMB) but does not meet eligibility for Medicaid coverage, **providers cannot bill KMAP for home health agency services rendered.** The member must have a Medicaid-covered benefit plan such as TXIX in addition to Medicare coverage to be eligible for fee-for-service home health visits.

Medical assistance benefits are provided through the Medicare program for QMBs. Medicaid will consider payment for Medicare coinsurance and deductible amounts only. If providers bill KMAP for home health agency services rendered to QMB-only members, the money will be recouped.

BENEFITS AND LIMITATIONS

8400. MEDICAID Updated 10/14

Advance Directives

Home health providers participating in KMAP must comply with federal legislation (OBRA 1990, Sections 4206 and 4751) concerning advance directives. An "advance directive" is otherwise known as a living will or durable power of attorney. Every home health provider must maintain written policies, procedures and materials about advance directives.

Specific Requirements

1. Each home health agency must provide written information to every adult individual receiving medical care by or through the home health agency. This information must contain:
 - a. The individual's right to make decisions concerning his or her own medical care
 - b. The individual's right to accept or refuse medical or surgical treatment
 - c. The individual's right to make advanced directives
 - d. "Description of the Law of Kansas Concerning Advance Directives" (see information below)
Note: Kansas Medicaid does not provide copies of the description to providers. It is up to providers to reproduce the description. Providers are free to supplement this description as long as they do not misstate Kansas law.
2. Additionally, each home health agency must provide written information to every adult individual about the home health agency's policy on implementing these rights.
3. A home health agency must document in every individual's medical record whether the individual has executed an advance directive.
4. A home health agency may not place any conditions on health care or otherwise discriminate against an individual based upon whether that individual has executed an advance directive.
5. Each home health agency must comply with State law about advance directives.
6. Each home health agency must provide for educating staff and the community about advance directives. This may be accomplished by brochures, newsletters, articles in the local newspapers, local news reports or commercials.

Incapacitated Individuals

An individual may be admitted to a facility in a comatose or otherwise incapacitated state and be unable to receive information or articulate whether he or she has executed an advance directive. If this is the case, families of, surrogates for, other concerned persons of the incapacitated individual must be given the information about advance directives. If the incapacitated individual is restored to capacity, the home health agency must provide the information about advance directives directly to him or her even though the family, surrogate or other concerned person received the information initially.

If an individual is incapacitated, otherwise unable to receive information or articulate whether he or she has executed an advance directive, the home health agency must note this in the medical record.

8400. MEDICAID Updated 06/12

Advance Directives continued

Mandatory Compliance with the Terms of the Advanced Directive

When a patient, relative, surrogate or other concerned/related person presents a copy of the individual's advance directive to the home health agency, the home health agency must comply with the terms of the advance directive to the extent allowed under State law. This includes recognizing powers of attorney.

DESCRIPTION OF THE LAW OF KANSAS CONCERNING ADVANCE DIRECTIVES

There are two types of "advance directives" in Kansas. One is commonly called a "living will" and the second is called a "durable power of attorney for health care decisions."

The Kansas Natural Death Act, K.S.A. 65-28,101, *et seq.*

This law provides that adult persons have the fundamental right to control decisions relating to their own medical care. This right to control medical care includes the right to withhold life-sustaining treatment in case of a terminal condition.

Any adult may make a declaration which would direct the withholding of life-sustaining treatment in case of a terminal condition. Some people call this declaration a "living will".

The declaration must be:

1. In writing
2. Signed by the adult making the declaration
3. Dated
4. Signed in front of two adult witnesses or notarized

There are specific rules set out in the law about the signature in case of an adult who can't write.

There are specific rules about the adult witnesses. Relatives by blood or marriage, heirs, or people who are responsible for paying for the medical care may *not* serve as witnesses. A declaration has no effect during pregnancy.

The declaration may be revoked in three ways:

1. By destroying the declaration
2. By signing and dating a written revocation
3. By speaking an intent to revoke in front of an adult witness

Note: The witness must sign and date a written statement that the declaration was revoked.

Before the declaration becomes effective, two physicians must examine the patient and diagnose that the patient has a terminal condition.

The desires of a patient shall at all times supersede the declaration. If a patient is incompetent, the declaration will be presumed to be valid.

The Kansas Natural Death Act imposes duties on physicians and provides penalties for violations of the laws about declarations.

8400. MEDICAID Updated 11/03

Advance Directives continued

The Kansas Durable Power of Attorney for Health Care Decisions Law, K.S.A. 58-625, *et seq.*

A "durable power of attorney for health care decisions" (Power) is a written document in which an adult gives another adult (called an "agent") the right to make health care decisions. The Power applies to health care decisions even when the adult is not in a terminal condition.

The adult may give the agent the power to:

1. Consent or to refuse consent to medical treatment
2. Make decisions about donating organs, autopsies, and disposition of the body
3. Make arrangements for hospital, nursing home, or hospice care
4. Hire or fire physicians and other health care professionals
5. Sign releases and receive any information about the adult

A Power may give the agent all those five powers or may choose only some of the powers. The Power may *not* give the agent the power to revoke the adult's declaration under the Kansas Natural Death Act ("living will"). The Power only takes effect when the adult is disabled unless the adult specifies that the Power should take effect earlier.

The adult may *not* make a health care provider treating the adult the agent except in limited circumstances.

The Power may be made by two methods:

- In writing
 - Signed by the adult making the declaration
 - Dated
 - Signed in front of two adult witnesses
- OR***
- Written and notarized

Relatives by blood or marriage, heirs, or people who are responsible for paying for the medical care may *not* serve as witnesses.

The adult, at the time the Power is written, should specify how the Power may be revoked.

The Patient Self-Determination Act, Section 1902(w) of the Social Security Act

This federal law, codified at 42 U.S.C. Sec. 1396a(w), was effective December 1, 1991. It applies to all Medicaid and Medicare hospitals, nursing facilities, home health agencies, hospices, and prepaid health care organizations. It requires these organizations to take certain actions about a patient's right to decide about health care and to make advance directives.

This law also required that each state develop a written description of the State law about advance directives. This description was written by the Health Care Policy Section of the Kansas Department of Social and Rehabilitation Services to comply with that requirement. If you have any questions about your rights to decide about health care and to make advance directives, please consult with your physician or attorney (Third Edition: January 14, 2003).

8400. MEDICAID Updated 07/25

Home Health Regulatory Revisions

1. Coverage of home health services cannot be contingent upon the member needing nursing or therapy services.
2. Home health services may be provided in any setting in which normal life activities take place, other than a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. Home health services cannot be limited to services furnished to members who are homebound.
3. Medical supplies, equipment, and appliances are suitable for use in any setting in which normal life activities take place.
4. Supplies are defined as health care-related items that are consumable or disposable or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness, or injury.
5. Equipment and appliances are defined as items that are primarily and customarily used to serve a medical purpose; generally, are not useful to an individual in the absence of a disability, illness, or injury; can withstand repeated use; and can be reusable or removable. State Medicaid coverage of equipment and appliances is not restricted to the items covered as durable medical equipment (DME) in the Medicare program.
6. States can have a list of preapproved medical equipment supplies and appliances for administrative ease, but States are prohibited from having absolute exclusions of coverage on medical equipment, supplies, or appliances. States must have processes and criteria for requesting medical equipment that is made available to members to request items not on the State's list. The procedure must use reasonable and specific criteria to assess items for coverage. When denying a request, the State must inform the member of the right to a fair hearing.
7. Additional services or service hours may, at the State's option, be authorized to account for medical needs that arise in the settings where home health services are provided.
8. Payment may not be made for the services listed below unless the physician or allowed nonphysician practitioner, with the exception of a certified nurse midwife, documents that there was a face-to-face encounter with the member that meets the requirements of 42 CFR 440.70.
 - Nursing services
 - Home health aide services
 - Medical supplies, equipment, and appliances
 - Physical therapy, occupational therapy, or speech pathology and audiology services
9. For the initiation of home health services, the face-to-face encounter must be related to the primary reason the member requires home health services and must occur within the 90 days before or within the 30 days after the start of the services.
10. For the initiation of medical equipment, the face-to-face encounter must be related to the primary reason the member requires medical equipment and must occur no more than six months prior to the start of services.
11. The face-to-face encounter may be conducted by one of the following practitioners:
 - Physician
 - Nurse practitioner or clinical nurse specialist (working in collaboration with the physician and in accordance with state law)
 - Certified nurse midwife

Home Health Regulatory Revisions continued

- Physician assistant (under the supervision of the physician)
 - Attending acute or postacute physician (for members admitted to home health immediately after an acute or postacute stay)
12. The allowed nonphysician practitioner performing the face-to-face encounter must communicate the clinical findings of the face-to-face encounter to the ordering physician. Those clinical findings must be incorporated into a written or electronic document included in the member's medical record.
13. To ensure clinical correlation between the face-to-face encounter and the associated home health services, the physician responsible for ordering the services must:
- Document that the face-to-face encounter which is related to the primary reason the patient requires home health services occurred within the required timeframes prior to the start of home health services.
 - Indicate the practitioner who conducted the encounter and the date of the encounter.
14. The documentation requirement of the face-to-face encounter will be monitored through the home health program prior authorization (PA) process. All home health services require PA. The home health provider must submit documentation of the face-to-face encounter in addition to the PA request form, Outcome and Assessment Information Set (OASIS), and CMS-485 (home health plan of care) which includes the physician's or nonphysician practitioner's orders and certification for care. A specific form for the face-to-face encounter is not required, but the documentation must contain all of the key information.
- Note:** Copies of the PA and face-to-face encounter documentation must be retained on file in the member's medical record at the home health agency.
15. The face-to-face encounter may occur through telehealth, as implemented by the State.
16. Payment may not be made for medical equipment, supplies, appliances, or DME if the face-to-face encounter is performed by a certified nurse midwife.
17. The face-to-face encounter for medical equipment, supplies, or appliances may be performed by any of the practitioners described above, with the exception of the certified nurse midwife.
18. A member's need for medical supplies, equipment, and appliances must be reviewed by a physician annually.

This policy will expand coverage of specified incontinence supplies for members 21 years of age and older. Reference the **Incontinence Supplies** portion in this manual for a list of covered incontinence supplies and a list of acceptable incontinence diagnosis codes. The coverage criteria for incontinence supplies for KAN Be Healthy - Early and Periodic Screening, Diagnostic, and Treatment (KBH-EPSDT) members (ages 5 to 20) remains the same.

Note: All home health initial start of care dates require a face-to-face visit performed by a physician or an allowed nonphysician practitioner. Supporting documentation must be included as specified above. Existing home health prior authorizations and plans of care will not require a face-to-face encounter.

8400. MEDICAID Updated 07/20

Home Health Regulatory Revisions continued

1. Orders written by a physician, nurse practitioner, clinical nurse specialist or physician assistant, working in accordance with State law, as part of a written plan of care that the ordering practitioner reviews every 60 days for services described in 42 CFR 440.70 (a) (2) and (3).
2. On the physician's orders or orders written by a licensed practitioner of the healing arts acting within the scope of practice authorized under State law, as part of a written plan of care for services described in paragraph (b) (3) the plan of care must be reviewed by the ordering practitioner as specified in regulatory guidance.
3. Non-physician practitioners may certify and recertify a member for home health services.
4. In accordance with current Kansas law non-physician (NPPs) are required to work in collaboration with a physician within their scope of practice.
5. Nursing services, as defined by and in accordance with the Kansas State Nurse Practice Act.
6. Physicians are no longer required to sign off on face-to-face encounters for the initiation of home health services performed by a nurse practitioner, clinical nurse specialist or physician assistant, working in accordance with State law. All other face-to-face requirements are still applicable.

Communication with Physicians

The Home Health Agency health care team must communicate with the physician to coordinate appropriate, adequate, effective, and efficient care for the member.

Documentation

Home Health Agency services must meet the following criteria to be considered **medically necessary**:

- **Appropriate**
 - Needed service for the member without undermining the member's independence and initiative
 - Promote safe and professionally accepted practices
- **Adequate**
 - Sufficient service to meet the needs of the member while encouraging independence
- **Effective**
 - Documented progress towards achieving individualized long- and short-term goals
- **Efficient**
 - Dollars, time and staff used in a productive manner
 - Does not duplicate other resources
 - Family and other support systems used and enhanced

Documentation in the patient's medical record must support the service(s) billed. Home health nursing documentation must provide a "total picture" of the patient and surroundings/location and identify the current reason for providing home health care and the patient's need for continuance of care **or** progress toward discharge.

Note: Documentation must specifically address the primary diagnosis for which home health services are prescribed.

Proper documentation need not appear in any specific format in the patient's record but **must** include the following:

8400. MEDICAID Updated 05/17

Documentation continued

- **Initial Assessment**
 - Date and signature of registered nurse (RN)
 - Review of systems
 - Family and other support system structure
 - Pertinent past and present medical history with approximate date of diagnoses
 - Other community resources available for care
 - Patient's environment
- **Care Plan**
 - Initiated and dated by RN
 - Individualized, follows from assessment
 - Reviewed at least every 60 days and updated as indicated
 - Documented utilization of available resources, family or other support systems
 - Discharge plan, identification of expected goals or outcomes

Providers can use the CMS-485 Home Health Certification and Plan of Care in lieu of a separate plan of care. A copy of the completed CMS-485 form must be retained in the patient's medical record.

Documentation of Visits

Home health visits must be documented in the patient's medical record. Documentation shall consist of the following:

- Length of visit, including start and stop times
- Date and signature of individual making the visit
- Care plan with notations of deviations
- Purpose of visit/documentation of location and services performed

Note: If a skilled nursing visit is performed, documentation should include:

- Patient condition and response to care
- Progress toward goals

Residence – A person's residence is wherever he or she makes his or her home. This may be his or her own dwelling, an apartment, or a relative/caretaker's home but does not include hospitals, skilled nursing facilities, or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID). However, home health services may be provided in any setting in which normal life activities take place.

The following home health services are noncovered:

- Any services determined not to be medically necessary
- Homemaker/chore services
- Medical social work services

DME Purchase/Rental

All DME services are covered for use in any setting in which normal life activities take place. DME services (purchase or rental) are noncovered in a nursing facility, swing bed facility, state institution,

8400. MEDICAID Updated 08/20

DME Purchase/Rental continued

ICF-IID, psychiatric residential treatment facility (PRTF), brain injury (BI) facility, rehabilitation facility, and hospital.

Note: If the facility receives a per diem rate for a member, the DME services are considered content of the per diem and are the responsibility of the facility.

Manually Priced Items

- KMAP requires providers to follow current policy for DME and prosthetics and orthotics (P&O).
- Current policy requires DME and P&O to be priced at the lesser of 1, 2, or 3:
 1. Set Medicaid rate
 2. Providers cost plus 35 percent
 3. Manufacturer suggested retail price (MSRP) minus 20 percent
- All DME and P&O prior authorization (PA) requests must be accompanied by an official MSRP.
- Providers actual cost and MSRP must be submitted with each PA request on all manually priced DME/P&O items and codes. This must be submitted at the same time as the PA request. All documents submitted must be free of any altering, covering up, or blacking out of information, except to maintain HIPAA requirements.
- All MSRPs must be official from the manufacturer. No handwritten MSRPs are allowed. MSRPs cannot be altered or blacked out in any way except to maintain HIPAA requirements. For example, a Medicare explanation of benefits (EOB) can have multiple Medicare members information listed on the same sheet.
- Provider's cost is the actual cost the provider paid for the item. Any discounts the provider receives must also be submitted. An official invoice from the supplier/manufacturer must be supplied. Handwritten or DME provider-manipulated invoices are not allowed. Invoices cannot be blacked out or altered in any way except to maintain HIPAA requirements.
- If an item is bought in bulk (or more than one at a time), the invoice showing the provider's actual cost and the number of units purchased must be submitted (per unit cost will be calculated).
- Costs of doing business (such as, employee's time, travel time and expenses, or office expenses) cannot be included in provider's cost.

Note: All wheelchairs, wheelchair accessories, wheelchair repairs, and covered specialty walkers are exempt from this requirement. These items will be paid at 75% of MSRP or the current Medicaid rate. Provider cost will not be required with each PA request.

8400. MEDICAID Updated 08/20

DME Purchase/Rental continued

Breast Pumps

- Codes E0602 and E0603 are covered for all female members ages 10 through 65. Breast pumps are limited to a combined total of no more than one pump every year. The prescription written by a physician must be kept in the member's file.
- The following breast pump replacement parts are limited to no more than two of each per year: A4281, A4282, A4283, A4285 and A4286.
- Noncovered breast pumps and accessories: E0604 and A4284

Dressings and Supplies

- Dressings and supplies are content of service for all nursing facilities, BI facilities, rehab facilities, clinics, offices, and hospitals. They are allowed for place of service 12 and other acceptable home health settings. Providers must render services in a manner to protect privacy and in accordance with HIPAA compliance.
- Dressings are covered when either of the following criteria is met:
 - They are required for the treatment of a wound.
 - They are required after debridement of a wound.
- Dressings are noncovered for the following:
 - Drainage from a cutaneous fistula which has not been caused by or treated by a surgical procedure
 - Stage 1 pressure ulcer
 - First degree burn
 - Wounds caused by trauma which do not require surgical closure or debridement (skin tear or abrasion)
 - Venipuncture or arterial puncture site (blood sample) other than the site of an indwelling catheter or needle
 - Silicone gel sheets used for the treatment of keloids or other scars
- Dressings include:
 - Primary dressings: therapeutic or protective coverings applied directly to wounds or lesions either on the skin or caused by an opening to the skin.
 - Secondary dressings: materials that serve a therapeutic or protective function and are needed to secure a primary dressing.
- Debridement of a wound may be any type:
 - Surgical (sharp instrument or laser)
 - Mechanical (irrigation or wet-to-dry dressings)
 - Chemical (topical application of enzymes)
 - Autolytic (application of occlusive dressings to an open wound)

Dressings and Supplies continued

- Products containing multiple materials are categorized according to the clinically predominant component (alginate, collagen, foam, gauze, hydrocolloid, hydrogel). Other multicomponent wound dressings not containing these specified components may be classified as composite or specialty absorptive dressings if the definition of these categories has been met. Multicomponent products may not be unbundled and billed as the separate components of the dressing.
- For all dressings, if a single dressing is divided into multiple portion/pieces, the code and quantity billed must represent the originally manufactured size and quantity.
- Modifiers A1, A2, A3, A4, A5, A6, A7, A8, and A9 indicate that a particular item is being used as a primary or secondary dressing on a surgical or debrided wound and also to indicate the number of wounds on which that dressing is being used. The modifier number must correspond to the number of wounds on which the dressing is being used, not the total number of wounds treated. Modifiers A1-A9 are used for informational purposes and are not required.
- Surgical dressings are covered for as long as they are medically necessary. Dressings over a percutaneous catheter or tube are covered as long as the catheter or tube remains in place and after removal until the wound heals.
- Dressing size must be based on and appropriate to the size of the wound. For wound covers, the pad size is usually about two inches greater than the dimensions of the wound. For example, a five cm. X five cm. (two in. X two in.) wound requires a four in. X four in. pad size.
- The quantity and type of dressings dispensed at any one time must take into account the current status of the wound, the likelihood of change, and the recent use of dressings.
- Dressing needs may change frequently in the early phases of wound treatment with heavily draining wounds. Suppliers are expected to have a mechanism for determining the quantity of dressing that the patient is actually using and to adjust their provision of dressings accordingly. No more than a one month's supply of dressings may be provided at one time.
- Dressings must be tailored to the specific needs of an individual patient. When dressings are provided in kits, only those components of the kit that meet the definition of a dressing, that are ordered by the physician, and that are medically necessary are covered.

It may not be appropriate to use some combinations of a hydrating dressing on the same wound at the same time as an absorptive dressing. Because composite dressings, foam wound covers, hydrocolloid wound covers, and transparent film, when used as a secondary dressing, are meant to be changed at frequencies less than daily, appropriate clinical judgment should be used to avoid their use with primary dressings which require more frequent dressing changes. While a highly exudative wound might require such a combination initially, with continued proper management, the wound usually progresses to a point where the appropriate selection of these products results in the less frequent dressing changes which they are designed to allow. An example of an inappropriate combination is the use of a specialty absorptive dressing on top of nonimpregnated gauze being used as a primary dressing.

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Dressings and Supplies continued

Alginate Dressings

- Codes A6196, A6197, A6198, and A6199 are covered for:
 - Moderately to highly exudative full thickness wounds (stage III or IV ulcers)
 - Alginate or other fiber gelling dressing fillers for moderately to highly exudative full thickness wound cavities (stage III or IV ulcers)
- Alginate or other fiber gelling dressing covers are not medically necessary on dry wounds or wounds covered with eschar. Usual dressing change is up to once per day. One wound cover sheet of the approximate size of the wound or up to two units of wound filler (one unit equals six inches of alginate or other fiber gelling dressing rope) is usually used at each dressing change. It is usually inappropriate to use alginates or other fiber gelling dressings in combination with hydrogels. The medical necessity for more frequent change of dressing must be documented.

Composite Dressings

- Composite dressings are products combining physically distinct components into a single dressing that provides multiple functions. These functions must include, but are not limited to:
 - A bacterial barrier
 - An absorptive layer other than an alginate or other fiber gelling dressing, foam, hydrocolloid, or hydrogel
 - A semi-adherent or nonadherent property over the wound site
- Codes A6203, A6204, and A6205
Usual composite dressing change is up to three times per week, one wound cover per dressing change. The medical necessity for more frequent change of dressing must be documented.

Compression Bandages

- All bandages are noncovered when used for strains, sprains, edema, or situations other than as a dressing for a wound.
- Light compression bandages, self-adherent bandages, and conforming bandages are covered when they are used to hold wound cover dressings in place over any wound type.
- Moderate or high compression bandages, conforming bandages, self-adherent bandages, and padding bandages are covered when they are part of a multilayer compression bandage system used in the treatment of a venous stasis ulcer.
- Elastic bandages are those that contain fibers of rubber (latex, neoprene), spandex, or elastane. Roll bandages that do not contain these fibers are considered nonelastic bandages even though many of them (such as gauze bandages) are stretchable.

8400. MEDICAID Updated 05/10

Dressings and Supplies continued

- Codes A6442, A6443, A6444, A6445, A6446, and A6447 describe roll gauze-type bandages made either of cotton or of synthetic materials such as nylon, viscose, polyester, rayon, or polyamide. These bandages are stretchable, but do not contain elastic fibers. These codes include short-stretch bandages.
- Codes A6448, A6449, and A6450 describe ACE-type elastic bandages.
- Codes A6451 and A6452 describe elastic bandages that produce moderate or high compression that is sustained typically for one week. They are commonly included in multilayer compression bandage systems.
- Suppliers billing these codes must be able to provide documentation from the manufacturer verifying that the performance characteristics specified in the code narratives have been met.
- When multilayer compression bandage systems are used for the treatment of a venous stasis ulcer, each component is billed using a specific code for the component: A6451, A6452, A6443, A6444, A6454, A6441, or A6456.
- Most compression bandages are reusable. Usual frequency of replacement would be no more than one per week unless they are part of a multilayer compression bandage system. The medical necessity for more frequent change of dressing must be documented.
- Conforming bandage dressing change is determined by the frequency of change of the selected underlying dressing.

Contact Layer Dressings

- Contact layers are thin, non-adherent sheets placed directly on an open wound bed to protect the wound tissue from direct contact with other agents or dressings applied to the wound. They are porous to allow wound fluid to pass through for absorption by an overlying dressing.
- Contact layer dressings are used to line the entire wound. They are not intended to be changed with each dressing change. Usual dressing change is up to once per week. The medical necessity for contact layer dressings must be documented and submitted with each PA request. Further medical justification must be submitted for more frequent dressing changes.

Foam Dressings

- Codes A6209, A6210, A6211, A6212, A6213, A6214, and A6215
- Foam dressings are covered when used on full thickness wounds (stage III or IV ulcers) with moderate to heavy exudates.
- Usual dressing change for a foam wound cover used as a primary dressing is up to three times per week. When a foam wound cover is used as a secondary dressing for a wound with very heavy exudates, dressing change may be up to three times per week.
- Usual dressing change for foam wound fillers is up to once per day. The medical necessity for more frequent change of dressing must be documented.

8400. MEDICAID Updated 05/10

Dressings and Supplies continued

Gauze Dressings

- Impregnated gauze dressings are woven or nonwoven materials into which substances such as iodinated agents, petrolatum, zinc paste, crystalline sodium chloride, chlorhexadine gluconate, bismuth tribromophenate, water, aqueous saline, hydrogel, or other agents have been incorporated into the dressing material by the manufacturer.
- Codes A6216, A6217, A6218, A6219, A6220, A6221, A6402, A6403, A6404, and A6407
Usual nonimpregnated gauze dressing change is up to three times per day for a dressing without a border and once per day for a dressing with a border. It is usually not necessary to stack more than two gauze pads on top of each other in any one area. The medical necessity for more frequent change of dressing must be documented.
- Codes A6222, A6223, A6224, and A6266
Usual dressing change for gauze dressings impregnated with other than water, normal saline, or hydrogel is up to once per day. The medical necessity for more frequent change of dressing must be documented.
- Codes A6228, A6229, and A6230
Usual dressing change for gauze dressings impregnated with water or normal saline is up to once per day. The medical necessity for more frequent change of dressing must be documented.
- Gauze or gauze-like products are typically manufactured as a single piece of material folded into a multi-ply gauze pad. Coding must be based on the functional size of the pad as it is commonly used in clinical practice.

Gloves Non-Sterile

- Code A4927: PA required.
- Nonsterile gloves are covered for patient or family use if the patient is currently infected with MRSA or VRE. A culture (C&S) performed within 30 days of the request must be submitted with each PA request. Upon each renewal, a new culture (C&S) performed within 30 days of the request must be submitted. This new culture must document current MRSA or VRE infection. Once the member no longer shows current MRSA or VRE infection, nonsterile gloves are noncovered.
- Nonsterile gloves for use by home health staff, HCBS staff, or staff from any other paid company are considered content of service and will not be paid separately. Nonsterile gloves allowed for patient or family use may not be used by paid staff.
- Nonsterile gloves are limited to no more than one box (100 gloves) every three months.

8400. MEDICAID Updated 05/10

Dressings and Supplies continued

Hydrocolloid Dressings

- Codes A6234, A6235, A6236, A6237, A6238, A6239, A6240, and A6241
- Hydrocolloid dressings are covered for use on wounds with light to moderate exudates.
- Usual dressing change for hydrocolloid wound covers or hydrocolloid wound fillers is up to three times per week. The medical necessity for more frequent change of dressing must be documented.

Hydrogel Dressings

- Codes A6231, A6232, A6233, A6242, A6243, A6244, A6245, A6246, A6247, and A6248
- Hydrogel dressings are covered when used on full thickness wounds with minimal or no exudates (stage III or IV ulcers).
- Hydrogel dressings are not usually medically necessary for stage II ulcers. Documentation must substantiate the medical necessity for use of hydrogel dressings for stage II ulcers (location of ulcer is sacro-coccygeal area).
- Usual dressing change for hydrogel wound covers without adhesive border or hydrogel wound fillers is up to once per day. Usual dressing change for hydrogel wound covers with adhesive border is up to three times per week. The medical necessity for more frequent change of dressing must be documented.
- The quantity of hydrogel filler used for each wound must not exceed the amount needed to line the surface of the wound. Additional amounts used to fill a cavity are not medically necessary.
- Documentation must substantiate the medical necessity for code A6248 billed in excess of three units (fluid ounces) per wound in 30 days.
- Use of more than one type of hydrogel dressing (filler, cover, or impregnated gauze) on the same wound at the same time is not medically necessary.

Specialty Absorptive Dressings

Specialty absorptive dressings are unitized multilayer dressings which provide:

- A semi-adherent quality or nonadherent layer
- Highly absorptive layers of fibers such as absorbent cellulose, cotton, or rayon
- These may or may not have an adhesive border.
- Codes A6251, A6252, A6253, A6254, A6255, A6256, A6460, and A6461:
Specialty absorptive dressings are covered when used for moderately or highly exudative wounds (stage III or IV ulcers). Usual specialty absorptive dressing change is up to once per day for a dressing without an adhesive border and up to every other day for a dressing with a border. The medical necessity for more frequent change of dressing must be documented.

Dressings and Supplies continued

Tape

- Codes A4450 and A4452
- Tape is covered when needed to hold on a wound cover, elastic roll gauze, or nonelastic roll gauze. Additional tape is usually not required when a wound cover with an adhesive border is used. The medical necessity for tape in these situations must be documented.
- Tape change is determined by the frequency of change of the wound cover. Quantities of tape submitted must reasonably reflect the size of the wound cover being secured.
- Usual use for wound covers measuring 16 square inches or less is up to two units per dressing change; for wound covers measuring 16 to 48 square inches, up to three units per dressing change; for wound covers measuring greater than 48 square inches, up to four units per dressing change.

Transparent Dressings

- Codes A6257, A6258, A6259
- Transparent film dressings are covered when used for an open, partial thickness wound with minimal exudates or closed wounds.
- Usual dressing change is up to three times per week. The medical necessity for more frequent change of dressing must be documented.

Tubular Dressings

Code K0620 may be used to bill for either an elastic or nonelastic tubular dressing.

Wound Covers

- Wound covers are flat dressing pads. A wound cover with adhesive border is one which has an integrated cover and distinct adhesive border designed to adhere tightly to the skin.
- Some wound covers are available both without and with an adhesive border. For wound covers with an adhesive border, the code to be used is determined by the pad size, not by the outside adhesive border dimensions.
- When a wound cover with an adhesive border is being used, no other dressing is needed on top of it and additional tape is usually not required. Reasons for use of additional tape must be well documented. An adhesive border is usually more binding than that obtained with separate taping and is therefore indicated for use with wounds requiring less frequent dressing changes.

Wound Fillers

- Wound fillers are dressing materials which are placed into open wounds to eliminate dead space, absorb exudates, or maintain a moist wound surface.
- Wound fillers come in hydrated forms (pastes, gels), dry forms (powder, granules, beads), or other forms such as rope, spiral, and pillows. Wound fillers not falling into any of these categories are noncovered.

8400. Updated 05/17

Dressings and Supplies continued

- The units of service for wound fillers are one gram, one fluid ounce, six-inch length, or one yard depending on the product. If the individual product is packaged as a fraction of a unit, determine the units billed by multiplying the number of dispensed items by the individual product size and rounding to the nearest whole number.
- For some wound fillers, the units on the package do not correspond to the units of the code. For example, some pastes or gels are labeled as grams (instead of fluid ounces); some wound fillers are labeled as cc or ml (instead of fluid ounces or grams); some are described by linear dimensions (instead of grams). In these situations, the supplier must contact the manufacturer to determine the appropriate conversion factor or unit of service which corresponds to the code.
- Use of more than one type of wound filler or more than one type of wound cover in a single wound is rarely medically necessary, and the reasons must be well documented.

Wound Pouch

- Code A6154:
Limited to 12 units per 30 days. A wound pouch is a waterproof, collection device with a drainable port that adheres to the skin around a wound.

Enteral Nutrition

Modifiers

Modifier BO is required when applicable for oral supplemental nutrition.

General Requirements

All enteral nutrition, pumps, and miscellaneous supplies must be prescribed. Providers must maintain a copy of the prescription in the member's file. Nutrients and supply items are to be billed for quantities expected to supply the member for no more than one month.

Enteral Nutritional Products

PA must be obtained for all enteral nutritional products provided to non-KBH-EPSDT members.

Any new or existing enteral nutritional product that has been reviewed by CMS and assigned a HCPC code may be covered when the member meets criteria. The provider must identify the CMS-assigned procedure code when requesting a PA. Enteral nutritional products that have not been reviewed by CMS and assigned a procedure code are considered noncovered.

KBH-EPSDT-eligible members must determine WIC eligibility before obtaining enteral nutrition from KMAP. If the member is eligible for WIC, enteral nutrition must be obtained from WIC services before obtaining from KMAP. Enteral nutrition products provided to KBH-EPSDT-eligible members do not require PA.

Enteral Nutrition continued

Food Thickener

Food thickener requires PA for all members.

Oral Supplementation

- Oral supplemental nutrition is covered for KBH-EPSDT-eligible members who require supplemental nutrition over and above normal daily nutrition due to medical conditions. Normal daily nutrition is not considered supplemental and is noncovered.
- Oral supplemental nutrition is noncovered for non-KBH-EPSDT members. Extreme medical cases in which a member is in immediate life-threatening jeopardy may be reviewed for coverage.

Enteral Supplies

- Enteral supplies that have an assigned HCPC code must be requested under the appropriate code. Enteral supplies that do not have an assigned HCPC code may be covered under B9998 with PA. B9998 requires PA for all ages.

Note: PA must be obtained for all enteral supplies provided to non-KBH-EPSDT members with the exception of B4087 and B4088.

- Button G-Tubes are covered under B4087 and B4088 up to a combined total of six per year without PA.
- Extension sets are covered with PA under B9998 up to a maximum of four per month.
- Enteral feeding supply kits are limited to one per day. Providers may dispense one month supply at a time. An individual 60cc syringe is not considered a feeding supply kit and may not be billed as such. If supplying an individual 60cc syringe, PA must be requested under B9998.
- Nasogastric tubing, with or without stylet or a combination of the two, are limited to a combined total of three tubes per 90 days, regardless of provider.
- Stomach and gastrostomy tubing are limited to a combined total of six per year, regardless of provider.
- Haberman Feeders for cleft lip/palate are covered for KBH-EPSDT members. They are limited to two per six months and require PA at all times.
- Individual 60 cc syringes may be covered under B9998 with PA up to a maximum of four per month.

Home Blood Glucose Monitors and Supplies

Home blood glucose monitors and supplies are covered for insulin-treated diabetes (Type I) and noninsulin-treated diabetes (Type II). PA is required on voice-synthesized monitors and reusable pens. For regular monitors and other supplies, PA is not required unless the request exceeds the covered limits. For requests over the limits covered by KMAP, a PA must be obtained. All types of home blood glucose monitors are limited to one device every two years per member (no matter what kind).

Home Blood Glucose Monitors and Supplies continued

- Modifier KX must be used if the member is insulin treated (insulin-dependent diabetic). Modifier KS must be used if the member is not insulin treated (noninsulin-dependent diabetic). Modifiers KX and KS cannot be billed together on each detail line. If no modifier is included, the claim will deny.
- Code E2100 requires PA and is allowed only for members with a severe visual impairment defined as a best corrected visual acuity of 20/200 or worse.
- Insulin delivery devices (reusable pens) are covered with a limit of 1.5 ml or 3 ml size per year. The member must have impaired visual acuity of 20/200 or worse and/or severely impaired manual dexterity. Medical necessity must show why the member cannot use a multidose vial, and the member must not have home health visits for the purpose of filling insulin syringes.
- The following devices are noncovered by KMAP:
 - Replacement battery, any type, for use with medically necessary home blood glucose monitor owned by member
 - Replacement lens shield cartridge for use with laser skin piercing device
 - Blood glucose monitor with integrated lancing/blood sample
 - Skin piercing device for collection of capillary blood, laser
- For home blood glucose supplies, providers must not dispense a quantity of supplies exceeding a member's expected usage. Regardless of usage, a supplier must not dispense more than a three-month quantity of glucose testing supplies at a time. Suppliers should stay attuned to atypical usage patterns on behalf of their clients and verify with the ordering physicians that the atypical usage is, in fact, warranted. Suppliers must not automatically dispense a quantity of supplies on a predetermined regular basis, even if the member has authorized this in advance.
- The ordering physician does not have to approve the order refill; however, the member or the member's caregiver must specifically request refills of glucose monitor supplies before they are dispensed.
- **Testing strips are to be billed 1 UNIT equals 1 BOTTLE (50 strips).** Billing of testing strips will be reviewed at least yearly. Any inappropriate billing will be recouped.
- Providers must keep the order for home blood glucose monitoring supplies and monitors on file. The order must include all the following elements:
 - Item to be dispensed
 - Quantity of item(s) to be dispensed
 - Specific frequency of testing
 - Whether the member has insulin-treated or noninsulin-treated diabetes
 - Treating physician's signature
 - Date of the treating physician's signature
 - Start date of the order (only required if start date is different than signature date)

Home Blood Glucose Monitors and Supplies continued

- Orders that state “as needed” are not acceptable and will result in those items being denied as not medically necessary.
- The supplier is required to have a renewal order from the treating physician every 12 months. This renewal order must also contain the required information specified above.
- For members to be eligible for home blood glucose monitors and supplies, they must meet all of the following basic criteria:
 - Member has diabetes (ICD-10 codes E08-E013) which is being treated by a physician.
 - Glucose monitors and related accessories and supplies were ordered by a physician who is treating the member’s diabetes, and the treating physician maintains records reflecting the care provided including, but not limited to, evidence of medical necessity for the prescribed frequency of testing.
 - Member (or member’s caregiver) successfully completed training or is scheduled to begin training in the use of the monitor, test strips, and lancing devices.
 - Member (or member’s caregiver) is capable of using the test results to ensure appropriate glycemic control of the member’s diabetes.
 - Device is designed for home use.
- For members to be eligible for more than the limits listed above, a PA is required, and the member must meet the following criteria:
 - Coverage criteria listed above for glucose monitoring supplies are met.
 - Supplier of test strips and lancets or lens shield cartridge maintains in its records the order from the treating physician.
 - Member has nearly exhausted the supply of test strips and lancets or useful life of one lens shield cartridge previously dispensed.
 - Treating physician has ordered a frequency of testing that exceeds the usage guidelines and has documented in the member’s medical record the specific reason for the additional materials for that particular member.
 - Treating physician has seen the member and has evaluated his or her diabetes control within six months prior to ordering quantities of strips and lancets or lens shield cartridges that exceed the usage guidelines.
- If a refill of supply quantities is dispensed that exceeds the usage guidelines, there must be documentation in the physician’s records (such as a specific narrative statement that adequately documents the frequency at which the member is actually testing or a copy of the member’s log) or in the supplier’s records (such as a copy of the member’s log) that the member is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed. If the member is regularly using supply quantities that exceed the usage guidelines, new documentation must be present at least every six months.

Home Blood Glucose Monitors and Supplies continued

- Home blood glucose monitor and supplies limits for insulin-treated diabetes (Type I) are:
 - One monitor is allowed every two years, regardless of the type.
 - Test strips (1 unit equals 1 bottle) are allowed at six units (300 strips or 6 bottles) every 30 days.
 - Platforms (1 unit equals 1 box) are allowed at one unit (1 box) every 30 days.
 - Calibration solution/chips are allowed at four units per year.
 - Spring-powered device for lancet is allowed at one unit every six months.
 - Lancets (1 unit equals 1 box) are allowed at three units (3 boxes).
 - One reusable pen insulin delivery device (either size) is allowed every year.
- Home blood glucose monitor and supplies limits for noninsulin-treated diabetes (Type II) are:
 - One monitor is allowed every two years, regardless of the type.
 - Test strips (1 unit equals 1 bottle) are allowed at two units (100 strips or 2 bottles) every 30 days.
 - Platforms (1 unit equals 1 box) are allowed at one unit (1 box) every 90 days.
 - Calibration solution/chips are allowed at two units per year.
 - Spring-powered device for lancet is allowed at one unit every six months.
 - Lancets (1 unit equals 1 box) are allowed at one unit (1 box) every 30 days.

Oral Supplemental Nutrition

- Oral supplemental nutrition is covered for KBH-EPSDT members only. To bill, use the appropriate HCPCS code.
- Supplemental nutrition is not covered for adults and non-KBH-EPSDT members.

Modifiers

Modifier BA is required when applicable, to be used for items supplied in conjunction with total parenteral nutrition (TPN).

General Requirements

All parenteral nutrition, pumps, and miscellaneous supplies must be prescribed by a physician or allowed nonphysician practitioner. Providers must maintain a copy of the prescription in the member's file. DME services provided for parenteral administration of total nutritional replacements and intravenous (IV) medications require the participation of services from a local Home Health Agency, physician, advanced registered nurse practitioner or pharmacist.

Parenteral Nutrition

TPN in conjunction with enteral or oral feedings is covered for a KBH-EPSDT-eligible member when enteral/oral nutrition constitutes a small portion of the member's dietary intake and/or the member is being weaned from TPN feedings. Nutrients and supply items are to be billed for quantities expected to supply the member for no more than one month.

Oral Supplemental continued

Parenteral Supplies

- Parenteral supplies that have an assigned HCPC code must be requested under the appropriate code. Parenteral supplies that do not have an assigned HCPC code may be covered (with PA) under B9999 if the member meets criteria.
- Parenteral kits and their components are generally considered all-inclusive items necessary to administer therapy. Payment will not be made to suppliers or members for additional components billed separately. Usual items in the different kits include but are not limited to these items:

A4221 – SUPPLY KIT PRE-MIX

Gloves	Gauze Sponges
Alcohol Wipes	Micropore Tape
Iso. Alcohol	Plastic Tape
Acetone	Injection Caps
Providone Iodine Scrub	Syringes
Providone Iodine Ointment	Needles
Providone Swabs	Ketodiasitix
Providone Sticks	Destructrip

B4222 – SUPPLY KIT HOME MIX

Containers	Gauze Sponges
Gloves	Injection Caps
Alcohol Wipes	Micropore Tape
Iso. Alcohol	Plastic Tape
Acetone	Needles
Providone Iodine Scrub	Syringes
Providone Iodine Ointment	Ketodiasitix
Providone Sticks	Destructrip

A4222, A4223 – ADMIN KIT

Admin Sets/Luer	Lock & Clamps
Micron Filter	Extension Sets
Pump Cassettes	2- or 3-Way connectors

Family Planning

- Family planning is any medically approved treatment, counseling, drugs, supplies or devices which are prescribed or furnished by a provider to individuals of child-bearing age for purposes of enabling such individuals to freely determine the number and spacing of their children.
- When a service provided in conjunction with a KBH-EPSDT screen relates to family planning, complete the family planning block (24H) on the claim form to ensure that federal funding is used appropriately.

8400. Updated 02/24

Immunizations/Vaccines

Reimbursement for covered immunizations for children is limited to the administration of the vaccine only. Vaccines are supplied at no cost to the provider through Vaccines for Children, a federal program administered by KDHE.

Home Health Aide

- Home health services must be performed by a home health aide under the general supervision of an RN. A home-health aide care plan outlining specific duties of the aide is required. Home health aide services need not be related to skilled nursing visits. A supervisory visit of a home health aide is required at least every two weeks when the patient is under a skilled service plan of care.
- Home health aide services must be prior authorized for all members. Members not on an HCBS waiver can receive home health aide services and skilled nursing services on the same day with PA.
- Use code G0156 for home health aide services, up to four 15-minute units. Up to one hour of home health aide services can be prior authorized but cannot exceed four 15-minute units per day of G0156. G0156 cannot be billed on the same day as T1021.
- A supervisory visit of a home health aide is required to be performed by an RN every two weeks unless:
 - The patient is receiving only skilled therapy services and home health aide services. A skilled therapist may make the supervisory visit at least every two weeks in lieu of an RN.
 - The Home Health Agency is providing care for patients other than those requiring an active medical care program (such as patients who require supportive home health aide care). Only such supervision as the Home Health Agency feels necessary is required in such cases.
- If the sole purpose of a home health aide visit in excess of twice weekly is to provide personal hygiene, medical necessity of the visit(s) must be documented. (Refer to **Section 4100** of the *General Special Requirements Fee-for-Service Provider Manual*.)
- Home health aide duties include but are not limited to the following:
 - Personal hygiene (such as shampoo, routine nail care)
 - Linen change
 - Maintenance exercises
 - Medication
 - Assistance with routine oral medications in accordance with 42 CFR (Code of Federal Regulation) 484.80
 - May check compliance and report to RN
 - May apply over-the-counter topical medications
 - Vital signs: Must be addressed in the care plan and reported to the RN

Home Health Aide continued

- Bowel/bladder procedures
 - May obtain urine specimens
 - May perform enemas or impaction removal if:
 - Ordered by a physician or allowed nonphysician practitioner
 - No contraindications exist
 - Bowel condition is chronic
 - May empty ostomy/urine bags
- Simple, nonsterile dressing changes
- Other procedures for which specific and adequate training has been provided
- Home health aide duties **do not** include the following:
 - Set-up of medications
 - Ordering or having medications refilled
 - Performing blood sugars
 - Whirlpool treatments for vascular or wound conditions
 - Warm moist packs
 - Physical assessments beyond vital signs
 - Sterile, wet-to-dry, or complex dressing changes
 - Packing or debridement of wounds
 - Health-related teaching

Medical Supplies

- Medical supplies are allowed when all of following apply:
 - Are necessary and reasonable for treatment of the patient's illness or injury
 - Are used in any setting in which normal activities of life take place
 - Are properly prescribed by a physician or allowed nonphysician practitioner
 - Are a covered service
- Prescriptions for medical supplies are **only** accepted from the following professionals:
 - Doctors of Medicine (M.D.)
 - Doctors of Osteopathy (D.O.)
 - Doctors of Podiatric Medicine (D.P.M.)
 - Chiropractors (may prescribe cervical collars and "soft type" spinal supports only)
 - Allowed nonphysician practitioners

Ostomy Adhesives

Ostomy adhesives are limited to one type every 30 days. Liquid adhesive is limited to four units every 30 days and disk or foam pad is limited to 20 units every 30 days.

Ostomy Belts

Purchase of ostomy belts (all kinds) is limited to one unit every 30 days.

Ostomy Deodorants

Ostomy deodorants are limited to one type every 30 days. Liquid deodorant is limited to eight units every 30 days and solid is limited to 100 units every 30 days.

Medical Supplies continued

Ostomy Skin Barriers

- Only one selection of the following skin barriers is allowed within a 30-day time frame with the following limits, regardless of provider:
 - Ostomy skin barrier, liquid is limited to two units every 30 days.
 - Ostomy skin barrier, powder is limited to 10 units every 30 days.
 - Ostomy skin barrier, nonpectin-based, paste is limited to four units every 30 days.
 - Ostomy skin barrier, pectin-based, paste is limited to four units every 30 days.
 - Skin barrier, wipes or swabs is limited to 150 units every 30 days.
(1 unit equals 1 wipe/swab.)
- The following items (or combinations of these items) are limited to a combined total of 20 units every 30 days, regardless of provider:
 - Ostomy skin barrier, solid 4x4 or equivalent
 - Ostomy skin barrier, with flange
 - Skin barrier, solid, 6x6 or equivalent
 - Skin barrier, solid, 8x8 or equivalent

Ostomy Pouches

- Drainable and urinary ostomy pouches are limited to a combined total of 20 units every 30 days.
- Closed ostomy pouches are limited to a combined total of 60 units every 30 days.

Miscellaneous Ostomy Supplies

- Stoma caps and continent device stoma plugs are limited to a combined total of 31 units every 30 days.
- The following individual items are limited to the amount stated below every 30 days:
 - Percutaneous catheter/tube anchoring device, adhesive skin attachment - 10 units
 - Appliance cleaner, incontinence and ostomy appliances – 1 unit
 - Ostomy accessory, convex insert – 10 units
 - Continent device, catheter for continent stoma – 1 unit
 - Ostomy absorbent material (sheet/pad/crystal packet) – 60 units
 - Ostomy ring – 10 units
 - Ostomy lubricant – 4 units
 - Ostomy irrigation supply, bag – 2 units
 - Ostomy irrigation set – 2 units
 - Ostomy irrigation supply, cone/catheter – 2 units
 - Ostomy irrigation supply, sleeve – 4 units
 - Ostomy faceplate equivalent, silicone ring – 3 units
 - Adhesive remover wipes – 150 units
 - Ostomy filters (any type) – 50 units
 - Ostomy faceplate – 3 units
 - Ostomy clamps – 10 units

8400. Updated 02/24

Medical Supplies continued

Other Medical Supplies

- Ostomy vents are limited to two units every 180 days.
- Code A4421 is noncovered.
- Humidifying filters are limited to 36 filters per calendar month.
- Code A4554 is limited to three units per month. (One unit equals 50 pads.)
- Code A4553 is limited to 20 units per 12 months (1 unit equals 1 pad).

Passive Motion Exercise

Rental of a passive motion exercise device is covered for outpatient use for a maximum period of 14 consecutive days postoperatively. Use code E0935RR.

Phototherapy

Phototherapy is covered for newborns with a total bilirubin level above 12/dL. Use code E0202RR for phototherapy (bilirubin) light or blanket with photometer. When billing E0202RR, one unit equals one day and is limited to 10 consecutive days per lifetime.

Services/Supplies for Medicare-Eligible Individuals

Modifier GY can be used to designate those services/supplies provided to a Medicare member when the service is reasonably believed by the provider to be noncovered by Medicare. Use modifier GY with the following codes and the codes listed in Appendix II when filing claims to Medicaid for services rendered to Medicare-eligible members:

G0156, G0299, G0300, S0315, S0316, S9128, S9129, S9131, S9460, T1021, T1023, T1030, T1031, T1502, 99600, 99601, 99602

Note: Medicare must be billed first if there is a possibility, they will allow payment on a claim. If Medicare does not allow payment, the claim may be submitted to Medicaid along with the Medicare denial.

Skilled Nursing

- Skilled nursing services must be provided by an RN or a licensed practical nurse (LPN). Skilled nursing services are those services requiring substantial and specialized nursing skill. **Skilled nursing services require a physician's order. The agency is required to maintain plans of care containing the physician's signature on file in the medical record located at the home health agency.** Skilled nursing services must be prior authorized for all members.
- In accordance with Medicare guidelines, a service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a nurse. If a service can be safely and effectively performed by a nonmedical person (or self-administered) without the direct supervision of a nurse, the service cannot be regarded as a skilled nursing service although a nurse provides the service. Similarly, the unavailability of a competent person to provide a nonskilled service, notwithstanding the importance of the service to the member, does not make it a skilled service when a nurse provides the service.

8400. Updated 02/24

Skilled Nursing continued

- New G codes are covered to differentiate RN and LPN skilled nursing visits in the home health agency and hospice settings. Providers can bill the following codes for the KMAP Acute Care Home Health Service Plan for the first 15 minutes of service:
 - G0299 (RN)
 - G0300 (LPN)
 - For members receiving services through the Acute Care Home Health Service Plan, use code G0299 (RN) or G0300 (LPN), up to four 15-minute intervals of a skilled nurse visit in a home health setting. Up to one hour can be prior authorized for skilled nursing visits. Documentation must support the duration of each visit.
- Information on the Long-Term Care Home Health Service Plan and the Diabetes Management Service Plan is documented in **Appendix III** of this manual.
- Skilled nursing responsibilities by an **RN** include but are not limited to the following:
 - Initial and ongoing assessments
 - Initiating and updating care plans
 - Communication with physicians
 - Supervision of aides
 - Medication set-up
 - IV/IM medication administration requiring the skill level of a nurse
 - Invasive procedures requiring the skill level of a nurse
 - Individualized teaching as outlined by the care plan
 - Diabetic nail care
 - Treatment and evaluation of wounds
- Skilled nursing responsibilities by an **LPN** include but are not limited to the following:
 - Ongoing assessments
 - Updating care plan
 - Communication with physicians
 - Medication set-up
 - Venipuncture for blood draws
 - Individual teaching as outlined by the care plan excluding teaching related to parenteral procedures (e.g., IVs, Hickman catheters)
 - Diabetic nail care
 - Treatment and evaluation of wounds
 - **Medication administration requiring the skill of a nurse, excluding IVs***

*LPNs who have successfully completed an IV fluid therapy course may, under the supervision of a registered professional nurse, engage in a limited scope of IV fluid treatment, including the following: 1) monitoring; 2) maintaining; 3) discontinuing IV flow and an IV access device not exceeding three inches in length in peripheral sites only; and 4) changing dressing for IV access devices not exceeding three inches in length in peripheral sites only.

8400. Updated 05/24

Skilled Nursing continued

- Combination of services:
 - A skilled nursing visit and a supervisory visit when performed at the same time constitute one visit.
 - An RN performing both aide and skilled nursing duties constitutes a skilled visit.
 - **A nonskilled visit performed by an RN or LPN constitutes a home health aide visit.**
- Note:** Only one home health aide or restorative aide visit to the same individual may be reimbursed for the same date of service.
- If services in excess of the following limitations on skilled nursing services are desired, documentation of medical necessity is required:
 - Medication set-up - once a week
 - Insulin syringes filling - once a week for a stable patient
 - General assessment - every 60 days for a stable patient
 - Supervisory visits
 - No more often than every two weeks if the patient is **also** receiving skilled services
 - At least every 60 days if the patient is receiving **nonskilled** services only

Home Telehealth

Note: Refer to **Section 2720** of the [General Benefits Fee-for-Service Provider Manual](#) for complete details regarding Telemedicine.

Stockings, Compression and Surgical

The following limitations apply to coverage of compression and surgical stockings:

- Stockings are limited to no more than a combined total of eight units per 365 days for the following codes:

A4490	A4495	A4500	A4510	A6530
A6531	A6532	A6533	A6534	A6535
A6536	A6537	A6538	A6539	A6540
A6541	A6545			
- Stockings are limited to no more than four units per 365 days for code A6544.
- Code A6549 is noncovered.
- Each time new stockings (any kind) are ordered, the provider is required to remeasure the member for proper size.
- Custom-made and lymphedema stockings require PA.

Therapy

- Therapy treatments are not covered for psychiatric diagnosis.
- Habilitative - Therapy is covered for any birth defects/developmental delays only when approved and provided by an Early Childhood Intervention (ECI), Head Start or Local Education Agency

8400. Updated 05/17

Skilled Nursing continued

(LEA) program. Therapy treatments performed in the LEA settings may be habilitative or rehabilitative for disabilities due to birth defects or physical trauma/illness.

- Therapy of this type is covered only for members aged zero to under the age of 21. Therapy **must** be medically necessary. The purpose of this therapy is to maintain maximum possible functioning for children.
- Rehabilitative – All therapies must be physically rehabilitative. Therapies are covered only when rehabilitative in nature and provided following physical debilitation due to an acute physical trauma or physical illness and prescribed by the attending physician or allowed nonphysician practitioner.
- Therapy services are limited to six months for non-KBH-EPSDT members (except the provision of therapy under HCBS), per injury, to begin at the discretion of the provider. There is no limitation for KBH-EPSDT members.
- All therapy services are limited to one unit per day. Therapy services must be prior authorized and these services are included in the combined total Acute Care Home Health Service Plan (nursing and therapy services) limitation of 120 visits per calendar year.

Occupational

Services must be prescribed by a physician or allowed nonphysician practitioner and provided by a registered occupational therapist or by a certified occupational therapy assistant working under the supervision of a registered occupational therapist. Supervision must be clearly documented. This may include, but is not limited to, the registered occupational therapist initializing each treatment note written by the certified occupational therapy assistant, or the registered occupational therapist writing “Treatment was supervised” followed by his or her signature.

Physical

All physical therapy services must be initially prescribed by a physician or allowed nonphysician practitioner and performed by either a registered physical therapist or by a certified physical therapy assistant working under the supervision of a registered physical therapist. Supervision must be clearly documented. This may include, but is not limited to, the registered physical therapist initializing each treatment note written by the certified physical therapy assistant, or the registered physical therapist writing “Treatment was supervised” followed by his or her signature.

Restorative Aide

Restorative aide service is only covered for physical therapy. Services must be restorative and rehabilitative physical therapy provided by a restorative aide under an outpatient physical therapy plan of care developed by a registered physical therapist. Services cannot be billed on the same date of service as a home health aide service. Use T1021.

Services must be prescribed by a physician or allowed nonphysician practitioner and provided by a certified speech pathologist.

8400. Updated 06/12

Skilled Nursing continued

Respiratory

Respiratory therapy is covered for KBH-EPSTD members only.

Urinary Equipment

Insertion Trays

- Codes A4310, A4311, A4312, A4313, A4314, A4315, A4316 and A4354 are limited to a combined total of two units per month.
- One insertion tray is covered per episode of indwelling catheter insertion up to the KMAP limit.
- Catheter insertion trays are not medically necessary for clean, nonsterile, intermittent catheterization and are noncovered.

Irrigation Trays/Bulbs

- Codes A4320 and A4322 are limited to a combined total of up to 15 per month.
- Routine, intermittent irrigations are defined as those performed at predetermined intervals. Routine, intermittent irrigations of a catheter are noncovered. Irrigation solutions containing antibiotics and chemotherapeutic agents are noncovered. Irrigating solutions such as acetic acid or hydrogen peroxide are noncovered.
- When sterile saline, water, syringes, and trays are used for routine irrigation, those items are noncovered. Therapeutic agents for irrigation are noncovered.
- Continuous irrigation is a temporary measure. Continuous irrigation for more than two weeks is rarely medically necessary. The member's medical records should indicate this medical necessity and be maintained in the member's DME file. The member's medical records may be requested by KMAP.

External Catheters and Collection Devices

- Codes A4326 and A4349 are limited to 30 per month.
- Code A4327 is limited to one per 365 days.
- Codes A4328 and A4330 are limited to four per month.
- Male external catheters or female external urinary collection devices are covered for members who have permanent, urinary incontinence when used as an alternative to an indwelling catheter.
- Male external catheters or female external urinary collection devices are noncovered when ordered for members who also use an indwelling catheter.

8400. Updated 06/19

Urinary Equipment continued

Extension/Drainage Tubes

- Code A4331 is limited to two per month.
- Code A4355 is limited to 15 units per month.

Miscellaneous

- Code A4332 is limited to 150 per month.
- Code A4333 is limited to 12 per month.
- Codes A4334, A5113, and A5114 are limited to a combined total of one per month.
- Codes A4335, A4336, A4356, A4360, and A5105 are noncovered.

Catheters

- Codes A4338, A4340, A4344, and A4346 are limited to a combined total of two per month.
- Codes A4351, A4352, and A4353 are limited to a combined total of 150 per month.
- When codes A4340, A4344, A4312, or A4315 are used, there must be documentation in the member's medical record (and DME record) of the medical necessity for that catheter rather than a straight Foley-type catheter with coating (such as recurrent encrustation, inability to pass a straight catheter, or sensitivity to latex). In addition, the particular catheter must be necessary for the member. For example, use of code A4340 in female members is rarely medically necessary. Documentation of medical necessity may be requested by KMAP and must be kept in the member's DME file.
- Codes A4346, A4313, or A4316 are covered only in continuous catheter irrigation if medically necessary.

Drainage Bags and Bottles

- Codes A4357 and A5102 are limited to a combined total of two per month.
- Codes A4358 and A5112 are limited to a combined total of two per month.
- Leg bags are indicated for members who are ambulatory or are chair or wheelchair bound. The use of leg bags for bedridden members is noncovered. Payment is made for either a vinyl leg bag or a latex bag. The use of both is not medically necessary and is noncovered.

The following medical supplies are noncovered:

Urinary Equipment continued

Common Items

Applicators, tongue blades
Arm boards
Band aids, compresses, tape
Denture cup
Emesis basins, bath basins
Enemas and enema equipment
First aid ointments
Footboard/foot cradles
Gloves (rubber, plastic and sterile)
Heating pads
Ice bags, hot water bottles

Lotions and creams (baby oil and lotion)
Paper tissues/cotton balls
Restraints
Thermometers
Water pitchers, glasses, straws
weighing scales

Educational Items:

Tape records
Language boards
Communications items

Wearing Apparel:

Standard shoes
Hosiery
Sleeping gowns or pajamas
Girdles (cosmetic)
Supports (non-RX)

Incontinence Supplies

Incontinence supplies are covered for KMAP members five years of age and older with specified criteria. A brief/diaper is a basic garment consisting of absorbent material placed between the legs and fastened about the waist. A protective underwear/pull-on is an absorbent material pulled up the legs and worn like underwear. A disposable liner/shield/guard/pad/undergarment is a small shield made of absorbent material that is placed within and attaches to the underclothing. The DME provider must obtain a PA from KMAP before dispensing incontinence products. Refer to the Medical Supply Codes in **Appendix II** for a list of the covered codes.

All KMAP members must meet current criteria before PA is considered. All required information must be sent at the same time as the PA request. Only one type of incontinence product (one procedure code) is approved or reimbursed within each PA time period. (No combinations are allowed.) Initial PAs for incontinence supplies begin at the beginning of a month. For existing PAs that require a size change, the PA can be revised at any time during a month.

Incontinence supplies may be approved in quantities to meet members' needs with medical necessity documentation and prior authorizations. The current limit for incontinence supplies without additional documentation is six units per day or \$150 per month per member. This will allow members to receive incontinence supplies as medically necessary with prior authorization.

All members are limited to a combined total of six units per day or a cumulative total not to exceed \$150 per calendar month/per member, whichever is less.

8400. Updated 01/18

Urinary Equipment continued

KBH-EPSDT members must meet the following PA criteria to obtain coverage:

- Be incontinent.
- Demonstrate that toilet training efforts have failed or provide the medical reasons why toilet training or toilet regulation is not possible.
- Be five years of age or older and be KBH-EPSDT-eligible.
- Have a medical diagnosis that shows neurological or physiological damage to the body that is directly causing incontinence.
- Provide a prescription and letter of medical necessity from the attending physician and the school (if applicable) that includes:
 - Height and weight
 - Medical diagnosis
 - Neurological or physiological damage to the body that is a direct cause for the incontinence
 - Explanation of all attempts that have been made to toilet train and/or regulate

If approved, a PA will be issued for up to one year at a time. With each PA renewal, a new prescription (written and dated no more than 30 days prior to the date of request) must be submitted along with a completed PA request form.

The following reasons are not sufficient justification for approval:

- Behavioral incontinence
- Encopresis
- Toilet training
- Toilet regulation
- Enuresis

Coverage of incontinence diapers/briefs/pull-ups for adults (21 years of age and older) must be billed with an acceptable diagnosis code as listed below. The same PA requirements for KBH-EPSDT members will apply.

Covered Incontinence Diagnosis Codes for Ages 21 and Over

F980	F981	N39498	N3942	N3945	R159	R3981
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Vacuum Assisted Wound Closure Therapy

Vacuum assisted wound closure therapy is covered for specific benefit plans. PA is required and criteria must be met. Refer to the *DME Fee-for-Service Provider Manual* for criteria. For questions about service coverage for a given benefit plan, contact Customer Service at 1-800-933-6593. All PA must be requested in writing by a KMAP DME provider. All medical documentation must be submitted to the KMAP DME provider.

APPENDIX I HOME HEALTH AGENCY CODES

Updated 02/18

Appendix I represents a list of home health agency services billable to KMAP.

- Prior authorization (PA) is required for all home health nursing and therapy services.
- Providers cannot bill KMAP for medical supplies unless they first obtain PA for a home health plan of care.
- Home Health Agencies can only bill for medical supplies used during a medically necessary home health visit.
- Medical supply codes require PA.

Please use the following resources to determine coverage and pricing information. For accuracy, use your provider type and specialty as well as the member ID number or benefit plan.

- Information is available on the [public website](#).
- Information is available on the [secure website](#) under Pricing and Limitations.

Charts have been developed to assist providers in understanding how KMAP will handle specific modifiers. The Coding Modifiers Table and Ambulance Coding Modifiers Table are available on both the [public](#) and [secure](#) websites. They are on the [Reference Codes](#) page and under Pricing and Limitations on the secure portion. Information is available on the [American Medical Association](#) website.

For further assistance, contact the Customer Service at 1-800-933-6593. (Refer to **Section 1000** of the *General Introduction Fee-for-Service Provider Manual*.)

COVERAGE INDICATORS

KBH-EPSDT	-	KBH-EPSDT medical participation is required.
MN	-	Medical necessity documentation is required.
PA	-	Prior authorization is required.

Refer to **Section 4300** of the *General Special Requirements Fee-for-Service Provider Manual* for additional PA information and **Section 8400** of this manual for benefits and limitations.

DURABLE MEDICAL EQUIPMENT

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
PA	E0202RR			

MEDICAL SUPPLIES

Refer to **Appendix II** of this manual.

KAN BE HEALTHY SCREENING

Refer to the *KAN Be Healthy – Early and Periodic Screening, Diagnostic, and Treatment Fee-for-Service Provider Manual*.

Appendix I Updated 05/24

HOME HEALTH AIDE SERVICES

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
PA	G0156			

SKILLED NURSING SERVICES

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
PA	G0299		PA	T1030
PA	G0300		PA	T1031
PA	S0315		PA	T1502
PA	S0316		PA	99600
PA	S9460		PA	99601
PA	T1023		PA	99602

HOME TELEHEALTH SERVICES

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
PA	T1030		PA	T1031

Note: Codes T1030 and T1031 are per visit for home telehealth visits. Bill T1030 and T1031 with place of service 02 and modifier GY for telehealth skilled nursing visits for Medicare-eligible members with a Medicaid-covered benefit plan.

THERAPY - OCCUPATIONAL

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
PA	S9129			

THERAPY - PHYSICAL

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
PA	S9131			

THERAPY - RESTORATIVE

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
PA	T1021			

RESPIRATORY THERAPY SERVICES

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
PA	S5181			

SPEECH THERAPY SERVICES

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
PA	S9128			

PREVENTATIVE MEDICINE

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
KBH-EPSDT	99381		KBH-EPSDT	99391
KBH-EPSDT	99382		KBH-EPSDT	99392
KBH-EPSDT	99383		KBH-EPSDT	99393
KBH-EPSDT	99384		KBH-EPSDT	99394
KBH-EPSDT	99385		KBH-EPSDT	99395

Appendix I Updated 12/25

PERSONAL CARE SERVICES

Personal Care Services (PCS) and Private Duty Nursing (PDN) provided for EPSDT members will require Electronic Visit Verification (EVV). These service codes are to be added to those already required to be billed via the Kansas EVV system.

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
KBH-EPSDT	S5125 EP			

PRIVATE DUTY NURSING

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
KBH-EPSDT	T1000 EP			

FAMILY PLANNING

When services provided in conjunction with a KBH-EPSDT screen relates to family planning, complete the family planning block (24H) on the claim form to ensure that federal funding is utilized appropriately.

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
	A4261			A4268
	A4266			A4269
	A4267			

IMMUNIZATION ADMINISTRATION

Providers must bill the appropriate administration code in addition to the vaccine and toxoid code for each dose administered. Reimbursement of *CPT*® codes for vaccines covered under the Vaccines for Children (VFC) program will not be allowed for children 18 years of age and younger.

COVERAGE INDICATORS

ADLT Vaccine covered for adults (19 years of age and older)
VFC Vaccine covered by VFC (18 years of age and younger)
N/A Not Applicable

ADMINISTRATION CODES

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
VFC	90460		VFC, ADLT	90480
VFC, ADLT	90471		VFC	96372 U2
VFC, ADLT	90472		VFC	96380
VFC, ADLT	90473		VFC	96381
VFC, ADLT	90474			

KMAP clarifies that the vaccine administration codes 90471, 90472, 90473, and 90474 can be used for VFC vaccine administration.

Providers should submit code 90460 if vaccine counseling was provided or submit codes 90471, 90472, 90473, and 90474 (when applicable) if vaccine counseling was not provided. The reimbursement rate for vaccines provided through the VFC program is the same as code 90460.

Appendix I Updated 02/26

VACCINE CODES

Coverage	Code	Coverage	Code
VFC	90380	ADLT	90683
VFC	90381	ADLT	90684
VFC	90382	VFC	90685
VFC, ADLT	90471	VFC, ADLT	90686
VFC, ADLT	90472	VFC	90687
VFC, ADLT	90611	VFC, ADLT	90688
VFC, ADLT	90619	VFC	90696
N/A	90622	VFC	90697
VFC, ADLT	90623	VFC	90698
VFC, ADLT	90624	VFC	90700
ADLT	90632	VFC	90702
VFC	90633	VFC	90703
VFC	90634	VFC, ADLT	90707
ADLT	90636	VFC, ADLT	90710
VFC	90644	VFC, ADLT	90716
VFC	90645	VFC	90720
VFC	90646	VFC	90723
VFC	90647	VFC, ADLT	90732
VFC	90648	VFC	90733
VFC, ADLT	90649	VFC, ADLT	90734
VFC, ADLT	90650	ADLT	90736
VFC	90651	ADLT	90739
VFC, ADLT	90653	ADLT	90740
VFC	90654	VFC	90743
VFC	90655	VFC	90744
VFC, ADLT	90656	ADLT	90746
VFC	90657	ADLT	90747
VFC, ADLT	90658	VFC	90748
VFC, ADLT	90660	ADLT	90759
VFC, ADLT	90661	VFC, ADLT	91304
VFC, ADLT	90662	VFC	91318
VFC	90669	VFC	91319
VFC, ADLT	90670	VFC, ADLT	91320
VFC, ADLT	90671	VFC	91321
VFC, ADLT	90672	VFC, ADLT	91322
VFC, ADLT	90673	VFC, ADLT	91323
VFC, ADLT	90677	VFC	Q2035
VFC, ADLT	90678	VFC	Q2036
ADLT	90679	VFC	Q2037
VFC	90680	VFC	Q2038
VFC	90681	VFC	Q2039

APPENDIX II MEDICAL SUPPLY CODES

Updated 12/18

The following procedure codes represent a list of medical supply codes billable to KMAP.

- Prior authorization (PA) is required for all home health nursing and therapy services.
- Providers cannot bill KMAP for medical supplies unless they first obtain PA and develop a home health plan of care.
- Home Health Agencies can only bill for medical supplies for members with a home health plan of care.
- Medical supply codes require PA.

Please use the following resources to determine coverage and pricing information. For accuracy, use your provider type and specialty as well as the member ID number or benefit plan.

- Information is available on the [public website](#).
- Information is available on the [secure website](#) under Pricing and Limitations.

Charts have been developed to assist providers in understanding how KMAP will handle specific modifiers. The Coding Modifiers Table and Ambulance Coding Modifiers Table are available on both the [public](#) and [secure](#) websites. They are on the [Reference Codes](#) page and under Pricing and Limitations on the secure portion. Information is available on the [American Medical Association](#) website.

For further assistance, contact the Customer Service at 1-800-933-6593. (Refer to **Section 1000** of the *General Introduction Fee-for-Service Provider Manual*.)

Home Health Supply Codes with Modifier GY

Home health agencies may only bill for supplies for members with a home health plan of care.

- Supplies used must be documented in the nursing notes.
- The date of service for supplies billed must correspond with the date of service the home health visit was provided.
- Supplies may be billed using modifier GY when the member is dually eligible, and the provider is reasonably certain Medicare will not cover the supplies.
- All coverage indicator requirements will still apply.

Coverage Indicators

MN	-	Medical necessity documentation required.
PA	-	Prior authorization is required. Note: DME claims will not bypass PA when there is a partial payment by a third-party payer or Medicare.
HHSPA	-	Home Health Service PA.
INV	-	An itemized retail invoice must be kept available in your files.
KBH-EPSDT	-	KBH-EPSDT medical participation is required.
NC	-	Noncovered KMAP service.
*	-	Reference Section 8400 of this manual for a complete definition of these kits.
KS	-	Modifier indicating noninsulin dependent.
KX	-	Modifier indicating insulin dependent.

Refer to **Section 8400** of this manual for additional benefits and limitations.

Appendix II Updated 12/18

ANTISEPTIC PRODUCTS

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
HHSPA	A4244		INV, HHSPA	A4246
HHSPA	A4245		INV, HHSPA	A4247

BREAST PUMPS

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
HHSPA	A4281		HHSPA	A4286
HHSPA	A4282		HHSPA	E0602
HHSPA	A4283		HHSPA	E0603
HHSPA	A4285			

DRESSINGS/PADS

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
HHSPA	A4553		HHSPA	A6218
HHSPA	A4554		HHSPA	A6219
PA	A4927		HHSPA	A6220
HHSPA	A6010		HHSPA	A6221
HHSPA	A6011		HHSPA	A6222
HHSPA	A6024		HHSPA	A6223
HHSPA	A6154		HHSPA	A6224
HHSPA	A6196		HHSPA	A6228
HHSPA	A6197		HHSPA	A6229
HHSPA	A6198		HHSPA	A6230
HHSPA	A6199		HHSPA	A6231
HHSPA	A6021		HHSPA	A6232
HHSPA	A6022		HHSPA	A6233
HHSPA	A6023		HHSPA	A6234
HHSPA	A6203		HHSPA	A6235
HHSPA	A6204		HHSPA	A6236
HHSPA	A6205		HHSPA	A6237
PA	A6206		HHSPA	A6238
PA	A6207		HHSPA	A6239
PA	A6208		HHSPA	A6240
HHSPA	A6209		HHSPA	A6241
HHSPA	A6210		HHSPA	A6242
HHSPA	A6211		HHSPA	A6243
HHSPA	A6212		HHSPA	A6244
HHSPA	A6213		HHSPA	A6245
HHSPA	A6215		HHSPA	A6246
HHSPA	A6214		HHSPA	A6247
HHSPA	A6216		HHSPA	A6248
HHSPA	A6410		HHSPA	A6251
HHSPA	A6411		HHSPA	A6252
HHSPA	A6412		HHSPA	A6253
HHSPA	A6217		HHSPA	A6254

Appendix II Updated 12/18

DRESSINGS/PADS continued

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
HHSPA	A6231		HHSPA	A6445
HHSPA	A6232		HHSPA	A6446
HHSPA	A6255		HHSPA	A6447
HHSPA	A6256		HHSPA	A6448
HHSPA	A6257		HHSPA	A6449
HHSPA	A6258		HHSPA	A6450
HHSPA	A6259		HHSPA	A6451
HHSPA	A6260		HHSPA	A6452
HHSPA	A6266		HHSPA	A6453
HHSPA	A6402		HHSPA	A6454
HHSPA	A6403		HHSPA	A6455
HHSPA	A6404		HHSPA	A6456
HHSPA	A6441		HHSPA	A6407
HHSPA	A6442		HHSPA	A6457
HHSPA	A6443		HHSPA	A6460
HHSPA	A6444		HHSPA	A6461

ENTERAL THERAPY*

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
PA	B4034		PA, INV	B4150
PA	B4035		PA, INV	B4152
PA	B4036		PA, INV	B4153
HHSPA	B4081		PA, INV	B4154
HHSPA	B4082		PA, INV	B4155
HHSPA	B4083		PA, INV	B4157
HHSPA	B4087		PA, INV	B4158
HHSPA	B4088		PA, INV	B4159
PA	B4100		PA, INV	B4160
PA, INV	B4102		PA, INV	B4161
PA, INV	B4103		PA, INV	B4162
PA, INV	B4149		PA, INV	B9998

Note: Add modifier BO to the base code (XXXXX-BO) and place in field 24D when billing for oral supplemental nutrition.

Appendix II Updated 12/18

GLUCOSE MONITORING SUPPLIES

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
HHSPA	A4253 KS		HHSPA	A4258
HHSPA	A4253 KX		HHSPA	A4259 KS
HHSPA	A4255 KS		HHSPA	A4259 KX
HHSPA	A4255 KX		HHSPA	E2100
HHSPA, INV	A4256 KS		HHSPA	S5560
HHSPA, INV	A4256 KX		HHSPA	S5561

INCONTINENCE SUPPLIES (Diapers, briefs, pull-ups)

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
HHSPA	T4521		HHSPA	T4530
HHSPA	T4522		HHSPA	T4531
HHSPA	T4523		HHSPA	T4532
HHSPA	T4524		HHSPA	T4533
HHSPA	T4525		HHSPA	T4534
HHSPA	T4526		HHSPA	T4535
HHSPA	T4527		HHSPA	T4543
HHSPA	T4528		HHSPA	T4544
HHSPA	T4529		HHSPA	T4545

Note: Incontinence supplies are covered for members 5 to 20 years of age with PA and when criteria is met.

IV DRUG THERAPY

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
HHSPA	A4221*		HHSPA	A4223
HHSPA	B4222*		HHSPA	J7060

NEEDLES/SYRINGES

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
HHSPA	A4206		HHSPA	A4213
HHSPA	A4207		HHSPA	A4215
HHSPA	A4208		HHSPA	A4657
HHSPA	A4209		HHSPA	S8490
HHSPA	A4212			

Appendix II Updated 03/22

OSTOMY SUPPLIES

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
HHSPA	A4361		HHSPA	A4413
HHSPA	A4362		HHSPA	A4414
HHSPA	A4363		HHSPA	A4415
HHSPA	A4364		HHSPA	A4416
HHSPA	A4366		HHSPA	A4417
HHSPA	A4367		HHSPA	A4418
HHSPA	A4368		HHSPA	A4419
HHSPA	A4369		HHSPA	A4420
HHSPA	A4371		HHSPA	A4422
HHSPA	A4372		HHSPA	A4423
HHSPA	A4373		HHSPA	A4424
HHSPA	A4375		HHSPA	A4425
HHSPA	A4376		HHSPA	A4426
HHSPA	A4377		HHSPA	A4427
HHSPA	A4378		HHSPA	A4428
HHSPA	A4379		HHSPA	A4429
HHSPA	A4380		HHSPA	A4430
HHSPA	A4381		HHSPA	A4431
HHSPA	A4382		HHSPA	A4432
HHSPA	A4383		HHSPA	A4433
HHSPA	A4384		HHSPA	A4434
HHSPA	A4385		HHSPA	A4435
HHSPA	A4387		HHSPA	A4436
HHSPA	A4388		HHSPA	A4437
HHSPA	A4389		HHSPA	A4450
HHSPA	A4390		HHSPA	A4452
HHSPA	A4391		HHSPA	A4455
HHSPA	A4392		HHSPA	A4456
HHSPA	A4393		HHSPA	A5051
HHSPA	A4394		HHSPA	A5052
HHSPA	A4395		HHSPA	A5053
HHSPA	A4396		HHSPA	A5054
HHSPA	A4398		HHSPA	A5055
HHSPA	A4399		HHSPA	A5061
HHSPA	A4400		HHSPA	A5062
HHSPA, INV	A4402		HHSPA	A5063
HHSPA	A4404		HHSPA	A5071
HHSPA	A4405		HHSPA	A5072
HHSPA	A4406		HHSPA	A5073
HHSPA	A4407		HHSPA	A5081
HHSPA	A4408		HHSPA	A5082
HHSPA	A4409		HHSPA	A5083
HHSPA	A4410		HHSPA	A5093
HHSPA	A4411		HHSPA	A5120
HHSPA	A4412			

Appendix II Updated 01/20

OSTOMY SUPPLIES continued

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
HHSPA	A5121		HHSPA	A5131
HHSPA	A5122		HHSPA	A5200
HHSPA	A5126			

OTHER MEDICAL SUPPLIES

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
HHSPA	A7018		HHSPA	A7520
HHSPA	A4614		HHSPA	A7521
HHSPA	A4216		HHSPA	A7522
HHSPA	A4217		HHSPA	A7525
HHSPA	A4623		HHSPA	A7526
HHSPA	A4624		HHSPA	S8096
HHSPA	A4627		HHSPA	S8100
HHSPA	A4628		HHSPA	S8101
HHSPA	A4629		HHSPA	S8185
HHSPA	A4663		HHSPA	S8186
PA	A4483		HHSPA	S8999
HHSPA	A4264			
HHSPA	A4267			
HHSPA	A4268			
HHSPA	A4269			
HHSPA	A4660			

PARENTERAL THERAPY

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
HHSPA	B4164		HHSPA	B4199
HHSPA	B4168		HHSPA	B4216
HHSPA	B4172		HHSPA	B4220
HHSPA	B4176		HHSPA	B4222*
HHSPA	B4178		HHSPA	B4224
HHSPA	B4180		HHSPA	B5000
HHSPA	B4185		HHSPA	B5100
HHSPA	B4187		HHSPA	B5200
HHSPA	B4189		PA, INV	B9999
HHSPA	B4193			
HHSPA	B4197			

Note: Add modifier BA to the base code (XXXXX-BA) and place in field 24D when billing for item supplies in conjunction with total parenteral nutrition.

PASSIVE MOTION EXERCISE DEVICE

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
HHSPA	E0935			

SPLINTS

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
HHSPA	A4565		HHSPA	S8451
HHSPA	A4570			

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SUPPORTS

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
HHSPA, INV	A4490		HHSPA, INV	A6535
HHSPA, INV	A4495		HHSPA, INV	A6536
HHSPA, INV	A4500		HHSPA, INV	A6537
HHSPA, INV	A4510		HHSPA, INV	A6538
HHSPA, INV	A6530		HHSPA, INV	A6539
HHSPA, INV	A6531		HHSPA, INV	A6540
HHSPA, INV	A6532		HHSPA, INV	A6541
HHSPA, INV	A6533		HHSPA, INV	A6544
HHSPA, INV	A6534		HHSPA, INV	A6545

URINARY EQUIPMENT

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
HHSPA	A4250		HHSPA	A4346
HHSPA	A4310		HHSPA	A4351
HHSPA	A4311		HHSPA	A4352
HHSPA	A4312		HHSPA	A4353
HHSPA	A4313		HHSPA	A4354
HHSPA	A4314		HHSPA	A4355
HHSPA	A4315		HHSPA	A4357
HHSPA	A4316		HHSPA	A4358
HHSPA	A4320		HHSPA	A4331
HHSPA	A4322		HHSPA	A5102
HHSPA	A4326		HHSPA	A5112
HHSPA	A4327		HHSPA	A5113
HHSPA	A4328		HHSPA	A5114
HHSPA	A4330		HHSPA	A5121
HHSPA	A4349		HHSPA	A5122
HHSPA	A4332		HHSPA	A5126
HHSPA	A4333			
HHSPA	A4334			
HHSPA	A4338			
HHSPA	A4340			
HHSPA	A4344			

VACUUM ASSISTED WOUND CLOSURE THERAPY

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
HHSPA	97605		HHSPA	97606

APPENDIX III

Updated 05/17

Home Health Criteria

Home Health Services

Skilled nursing, home health aide, and skilled therapy services provided on a part-time or intermittent basis in any setting in which normal activities of life take place are defined as the following:

- Part-time is less than eight hours each day and 28 or fewer hours each week.
- Intermittent is skilled nursing care that is provided or needed fewer than seven days each week or fewer than eight hours per day for 21 days or less.
- Acceptable settings for home health care do not include nursing facilities, hospitals, or ICFs-IID.
- Skilled services are those services requiring the substantial specialized knowledge and skill of a licensed professional nurse.
- According to Medicare guidelines, a service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a nurse. If a service can be safely and effectively performed by a nonmedical person (or self-administered) without the direct supervision of a nurse, the service cannot be regarded as a skilled nursing service although a nurse actually provides the service. Similarly, the unavailability of a competent person to provide a nonskilled service, notwithstanding the importance of the service to the patient, does not make it a skilled service when a nurse provides the service.
- Unskilled services are those services not requiring the skill level of a licensed person.

Goals of Home Health Services

The two main goals of home health services are:

- Maximize independence of the member by teaching/training the member or other caregiver to provide care to maintain the member in the community
- Provide medically related services the member or unpaid caregiver is unable to perform

Medical Supply Codes

- Prior authorization (PA) is required for all home health nursing and therapy services.
- Providers cannot bill KMAP for medical supplies unless they first obtain PA and document a home health plan of care.
- Home health agencies can only bill for medical supplies for conditions documented in the home health plan of care.
- All home health services and supplies require PA.

Prior Authorization Requirements

PA is required for all home health services.

Home health services are prior authorized depending upon the skill level of care, frequency, and duration of visits and chronicity of the member's condition. Providers may use the Acute Care Home Health Service Plan to render services for time-limited conditions and the Long-Term Care Service Plan for members who require assistance to manage chronic conditions. Providers may use the Diabetes Management Home Health Service Plan to care for members with a primary home health need to address diabetes.

Appendix III Updated 07/25

Acute Care Home Health Service Plan

The Acute Care Home Health Service Plan is to be used when members are initially admitted for home health services following an acute injury or illness. This level of care could be warranted after a hospitalization or a surgical procedure. The Acute Care Home Health Service Plan is for the provision of services that are medically predictable.

Although home health services may be provided in any setting in which normal life activities take place, many members in need of acute care home health services experience difficulty leaving home due to physical impairments related to their illness, injury, or postsurgical status.

A face-to-face visit by a physician or nonphysician practitioner within specified time frames, a start of care Outcome and Assessment Information Set (OASIS) assessment, and physician certification of the new plan of care (485) are required to initiate an acute care home health plan of care.

The following apply for the provision of acute care home health services:

- All acute care home health service codes are limited to a combined total of 120 visits per calendar year per member. Acute care visits are granted through PA if there are units remaining that have not been authorized.
- Acute care home health limitations are based on a calendar year.
- Providers use codes 99601, 99602, G0156, G0299, G0300, and T1023 for acute care skilled nursing and home health aide visits. Skilled nursing visits and home health aide visits can be prior authorized for up to one hour with documentation to support that the service is reasonable and necessary.
- Home health aide visits are limited to two (up to one-hour) visits per week with supporting medical necessity documentation. Providers must submit additional documentation supporting medical necessity to exceed two home health visits per week. This is to ensure effective and efficient use and accurate reimbursement. These requests are considered on a case-by-case basis. Providers cannot bill more than one home health aide visit per date of service.
- Home health aide services are noncovered on the same date of service as restorative aid services for the same member.
- Code 99602 is used in circumstances when an IV infusion requires continuous monitoring and cannot be administered in two hours. Providers may use code 99602 for each additional hour of IV infusion. If there is concern about potential side effects, the medication should be administered in an outpatient setting.
- Code T1023 is allowed for skilled nursing visits that include information gathering for OASIS assessments, certifications, or recertifications. This code is limited to six visits per year and can be billed under all three home health service plans.
- OASIS assessments for which a home health visit is not mandated (transfers, death, or unplanned discharge) are not billable with T1023.
- If a member is under 18 years of age or pregnant, an OASIS assessment is not required; therefore, providers should use code G0299 for the admission assessment.
- KMAP will not reimburse providers for non-visit assessments.
- If it becomes evident home health services are needed long-term, the agency may switch the member to the Long-Term Care Home Health Service Plan prior to exhausting all acute care visits.

Appendix III Updated 07/25

- Providers can change a member from acute care to long-term care during a certification period or at any time it is determined the services will be needed long-term in an effort to preserve acute care units if needed for future acute episodes.
- The provider must fax the Change in Home Health Service Plan or Discharge From Service form to notify the PA department of a change or discharge from a plan within five business days of the event.
- Home health members may have more than one episode of acute care services.
- Acute care home health services can be prior authorized for up to 60 days.
- Providers may use codes S9128, S9129 and S9131 for rehabilitative therapy services rendered under the Acute Care Home Health Service Plan. All therapy visits count toward the 120 visits per year acute care limitation.
- Therapy services involving activities for the general welfare of any member, such as general exercises to promote overall fitness or flexibility and activities to provide diversion or general motivation, do not constitute skilled therapy. Nonskilled individuals without the supervision of a therapist can perform those types of services.

Long-Term Care Home Health Service Plan

The Long-Term Care Home Health Service Plan is to be used for members who receive frequent and brief intervals of home health services for assistance with monitoring chronic conditions. The members often have diagnoses that include asthma, COPD, diabetes, and heart disease. The members are relatively stable and require frequent monitoring to prevent exacerbations of symptoms which would warrant emergent care or hospitalization. Long-term care home health services often include health maintenance services the members cannot provide for themselves due to cognitive or physical limitations.

Although home health services may be provided in any setting in which normal life activities take place, many members receiving services through the Long-Term Care Home Health Service Plan experience difficulty leaving home due to cognitive and physical limitations.

The documentation requirements for the Long-Term Care Home Health Service Plan includes documentation of the face-to-face visit by a physician or nonphysician practitioner within specified time frames and nursing service codes specific to the Long-Term Care Home Health Service Plan. Providers must submit the most current OASIS assessment, 485, and all other required documents to initiate the long-term care home health service. Renewals require the most current 485 and 60-day summary documentation.

The following apply for the provision of long-term care home health services:

- All long-term care home health services are for the provision of reasonable and medically necessary health maintenance tasks to assist members in managing chronic health conditions in any setting in which normal life activities take place as noted in 42 CFR 440.70 and thereby avoid placement in nursing facilities or other institutions.
- Long-term care home health visits must not duplicate other resources available to the member.
- Providers may use codes 99600, 99601, 99602, G0156, S0316, T1023, T1030, T1031, and T1502 for the provision of long-term care home health skilled nursing and home health aide visits.

Appendix III Updated 05/17

- Providers may use code 99600 for brief, routine skilled nursing visits in accordance with the plan of care. This is a per visit code.
- Code 99602 is used in circumstances when an IV infusion requires continuous monitoring and cannot be administered in two hours. Providers may use 99602 for each additional hour of the IV infusion. If there is concern about potential side effects, the medication should be administered in an outpatient setting.
- Code T1023 is allowed for skilled nursing visits that include information gathering for OASIS assessments, certifications, or recertifications. This code is limited to six visits per year and can be billed for all three home health service plans.
- OASIS assessments for which a home health visit is not mandated (transfers, death, or unplanned discharge) are not billable with T1023.
- If a member is under 18 years of age or pregnant, an OASIS assessment is not required; therefore, providers should use S0316 for the long-term care admission assessment.
- KMAP will not reimburse providers for non-visit assessments.
- Providers may use code S0316 for skilled nursing visits of a longer duration, for example, visits that include an assessment and medication setup. This is a per visit code.
- Providers use codes T1030 and T1031 for the provision of telehealth visits under the Long-Term Care Home Health Service Plan. See specific provider requirements for the provision of telehealth services.
- Providers may use code T1502 for medication administration. This is to be used when nonskilled nursing visits are provided by a RN or LPN to assist members with cognitive and physical impairments with their care such as, but not limited to, oral medication administration and nebulizer treatments (treatments that are generally self-administered), when the service cannot be received through other resources.
- Long-term skilled nursing visits are reimbursed per visit.
- Home health aide visits are limited to two (up to one-hour) visits per week with supporting medical necessity documentation. Providers must submit additional documentation supporting medical necessity to exceed two home health visits per week. This is to ensure effective and efficient use and accurate reimbursement. These requests are considered on a case-by-case basis. Providers cannot bill more than one home health aide visit per date of service.
- Home health aide services are not covered on the same date of service as restorative aide services for the same member.
- If the member experiences a separate and distinct acute illness or injury while receiving services through long-term care, the agency may change the member to an acute care episode. Supporting documentation must include a resumption of care or significant change OASIS assessment to support the provision of acute care services.
- Once the acute condition has resolved or stabilized, the agency may change the member back to the Long-Term Care Home Health Service Plan.
- Providers may change a member from acute care to long-term care during a certification period or at any time it is determined the services will be needed long-term in an effort to preserve limited acute care visits for future acute episodes.
- The provider must fax the Change in Home Health Service Plan or Discharge From Service form to notify the PA department of a change or discharge from a plan within five business days of the event.
- Long-term care home health services can be prior authorized for up to six months for members who require this level of care until placement in a nursing facility.

Appendix III Updated 07/25

- Providers may use codes S9128, S9129, and S9131 for rehabilitative therapy services rendered under the Long-Term Care Home Health Service Plan. The same yearly limitations in place for therapy services under the acute care benefit also apply under the long-term care benefit.
- Providers may use code T1021 for restorative aide visits.
- It is anticipated that rehabilitative therapy will rarely be prescribed for a member receiving home health services through the long-term care benefit.
- Therapy services involving activities for the general welfare of any member, such as general exercises to promote overall fitness or flexibility and activities to provide diversion or general motivation, do not constitute skilled therapy. Nonskilled individuals without the supervision of a therapist can perform these services.

Diabetes Management Home Health Service Plan

The Diabetes Management Home Health Service Plan is used for members who receive frequent and brief intervals of home health services for assistance with managing their diabetes. The members and their unpaid caregivers must be unable to manage the diabetes due to cognitive or physical limitations.

The members are relatively stable but require frequent skilled nursing visits for diabetes management, which includes blood glucose monitoring and insulin administration. The members and their caregivers are deemed unable to manage the condition. Home health services are provided to assist the member in maintaining stable blood glucose levels and obtaining periodic assessments according to the current best practice guidelines to prevent or delay costly complications associated with diabetes.

Although home health services may be provided in any setting in which normal life activities take place, many members on the Diabetes Management Home Health Service Plan have other chronic health conditions and experience difficulty leaving the home due to these conditions in addition to their cognitive and physical limitations.

The documentation requirements for the Diabetes Management Home Health Service Plan include documentation of the face-to-face visit by a physician or nonphysician practitioner within specified time frames, nursing service codes specific to diabetes management, and a quality indicator form. Providers must submit the most current OASIS assessment, 485, and all other required documents to initiate the Diabetes Management Home Health Service Plan. Renewals require a current 485 and 60-day summary.

The following apply for the provision of diabetes management home health services:

- All diabetes management home health services are for the provision of reasonable and medically necessary health maintenance tasks to assist members in managing their diabetes and thereby avoiding placement in nursing facilities or other institutions.
- Diabetes management home health visits must be reasonable and necessary and must not duplicate other resources available to the member.
- Providers may use codes 99601, 99602, G0156, S0315, S9460, T1023, T1030, and T1031 for the provision of skilled nursing visits to render diabetes management services.
- Diabetes management skilled nursing visits are reimbursed per visit.

Appendix III Updated 05/17

- Home health aide visits are limited to two (up to one hour) visits per week with supporting medical necessity documentation. Providers must submit additional documentation supporting medical necessity to exceed two home health visits per week. This is to ensure effective and efficient use and accurate reimbursement. These requests are considered on a case-by-case basis. Providers cannot bill more than one home health aide visit per date of service.
- Home health aide services are not covered on the same date of service as restorative aide services for the same member.
- Code 99602 is used in circumstances when an IV infusion requires continuous monitoring and cannot be administered in two hours. Providers may use 99602 for each additional hour of the IV infusion. If there is concern regarding potential side effects, the medication should be administered in an outpatient setting.
- Code T1023 is allowed for skilled nursing visits that include information gathering for OASIS assessments, certifications, or recertifications. This code is limited to six visits per year and can be billed for all three home health service plans.
- OASIS assessments for which a home health visit is not mandated (transfers, death, or unplanned discharge) are not billable with T1023.
- KMAP will not reimburse providers for non-visit assessments.
- Providers may use code T1502 for medication administration. This is to be used when nonskilled nursing visits are provided by a RN or LPN to assist members who have cognitive and physical impairments with their care, such as, but not limited to, oral medication administration and nebulizer treatments (that are generally self-administered), when the service cannot be received through other resources.
- Providers may use code S0315 for skilled nursing visits of a longer duration, for example, visits that include an assessment, medication setup, and periodic assessment in accordance with current best practices for the treatment of diabetes. This is a per visit code.
- Providers may use code S9460 for skilled nursing visits of a brief duration in accordance with the plan of care for blood glucose monitoring in addition to insulin administration. This is a per visit code.
- Providers may use codes T1030 and T1031 for the provision of telehealth visits to assist members in managing their diabetes. See specific provider requirements for the provision of telehealth services.
- If the member experiences a separate and distinct acute illness or injury while receiving services through the Diabetes Management Home Health Service Plan, the agency may switch the member to an acute care episode. Supporting documentation must include a significant change assessment to support the provision of acute care services.
- Once the acute condition has resolved or stabilized, the agency may change the member back to the Diabetes Management Home Health Service Plan.
- Providers may change a member from acute care back to the Diabetes Management Home Health Service Plan during a certification period or at any time the acute care condition is resolved, or it is determined the services will be needed long-term in an effort to preserve limited acute care visits for future acute episodes.
- The provider must fax the Change in Home Health Service Plan or Discharge From Service form to notify the PA department of a change or discharge from a plan within five business days of the event.

Appendix III Updated 08/20

- Diabetes management home health services can be prior authorized for up to six months for members who will probably require this level of care until placement in a nursing facility.
- Providers may use codes S9128, S9129, and S9131 for rehabilitative therapy services rendered under the Diabetes Management Home Health Service Plan. The same yearly limitations in place for therapy services under the acute care benefit also apply under the Diabetes Management Home Health Service Plan.
- Providers may use code T1021 for restorative aide visits.
- It is anticipated that rehabilitative therapy will rarely be prescribed for a member receiving home health services through the Diabetes Management Home Health Service Plan.
- Therapy services involving activities for the general welfare of any member, such as general exercises to promote overall fitness or flexibility and activities to provide diversion or general motivation, do not constitute skilled therapy. Nonskilled individuals without the supervision of a therapist can perform these services.

HCBS Waiver Members

HCBS waiver members are assigned one of the following waivers:

- Intellectual/Developmentally Disabled (I/DD) waiver
- Brain injury (BI) waiver (previously head injury)
- Physical disability (PD) waiver
- Technology assisted (TA) waiver
- Frail elderly (FE) waiver
- Money Follows the Person (MFP), including MFP-FE, MFP-I/DD, MFP-PD, and MFP-TBI
- Work Opportunities Reward Kansans (WORK), should only be needed for acute episodes
- Severely emotionally disturbed (SED) waiver

Note: The SED waiver only provides some mental health services.

Members assigned to the HCBS waivers can receive reasonable and necessary home health services that are not duplicative of waiver services. Most waivers include attendant care services. The personal care attendants perform the same types of services home health aides usually perform.

Health maintenance activities, such as monitoring vital signs, supervision, or training of nursing procedures, ostomy care, catheter care, enteral nutrition, medication administration/assistance, wound care, and range of motion, can be provided to self-directed HCBS waiver members in accordance with K.S.A. 65-6201(b)(2)(A).

Skilled Services Limitations

- Nursing services are RN or LPN level of care. (Home health aide is not skilled.)
 - Occupational therapy (OT), physical therapy (PT), and speech therapy are limited to no more than one unit per day and are included in the combined total acute care service limitation of 120 visits per year.
 - These services must be restorative and rehabilitative and can only be provided following physical debilitation due to acute physical trauma or physical illness. This is limited to six months in duration for adult members.
- Note:** This limit cannot be overridden with PA.
- KBH-EPSTD-eligible members can receive reasonable and necessary rehabilitative therapy services for the duration needed.

Appendix III Updated 05/24

- Respiratory therapy is limited to KBH-EPSDT-eligible members. (Member must be under 21 years of age.) Respiratory therapy is limited to one unit per day. The code S5181 is not subject to the limitations of other home health services due to KBH-EPSDT specifications, reasonable, and necessary services to correct or ameliorate a condition.

Home Telehealth Service Limitations

- Providers must bill T1030 and T1031 with place of service 02 for home telehealth skilled nursing visits. These codes are per visit.
- PAs are entered for no more than 60 days. Home telehealth services cannot be approved for durations of more than 60 days. Additional documentation may be required to support continuation of home telehealth service requests that exceed 60 days.
- Telehealth visits must be provided by a RN or LPN.
- Telehealth visits must use face-to-face, real-time, interactive video contact to monitor members in the home setting as opposed to a nurse visiting the home. This technology can be used to monitor a member's health status and to provide timely assessment of chronic conditions and other skilled nursing services.
- HCBS members eligible for face-to-face skilled nursing visits provided by a home health agency (05-050) may also receive home telehealth visits with documentation of medical necessity and PA. The PA request must include units to cover the duration and frequency of home telehealth visits.
- **Oral medication administration or monitoring is not considered skilled care.**

Nonskilled Services Limitations

Nonskilled (home health aide) level services are rarely approved for persons on an HCBS waiver, due to potential duplication of services and similarities in the scope of services provided by the home health aide and personal care attendants. Nonskilled level services should be provided as noted below:

- FE waiver – Nonskilled services should be provided by FE Level II attendant.
- PD waiver – Nonskilled services should be provided by PD personal services.
- I/DD waiver – Nonskilled services should be provided by attendants or family if the member is receiving supportive care or family individual support or through the facility if the member is receiving residential services.
- BI waiver – Nonskilled services should be provided through BI personal services. Previously traumatic brain injury waiver.
- SED waiver – There may be rare requests for home health services for this waiver. Each request should be judged on its merits. Documentation must support the medical necessity for the requested service.

Nonskilled Services Descriptions and Examples

Home health aide level services include, but are not limited to:

- Administration of routine oral medications, eye drops, and topical ointments (assistance with medications ordinarily self-administered that do not require the skills of a licensed nurse to be provided safely and effectively)
- General maintenance care of colostomy and ileostomy
- Routine services to maintain satisfactory functioning of indwelling bladder catheters
- Simple dressing changes for wounds, noninfected postoperative, or chronic condition

Appendix III Updated 08/20

- Prophylactic and palliative skin care, including bathing and application of creams or treatment of minor skin problems
- Routine care of the incontinent patient, including use of diapers and protective sheets
- General maintenance care in connection with a plaster cast
- Routine care in connection with braces and similar devices
- Periodic turning and positioning in bed
- Assistance with dressing, eating, and going to the toilet
- Routine range of motion (ROM) activities
- Gastrostomy and enteral feedings
- Vital signs

Note: Code T1021 cannot be approved on the same date of service as home health aide visits.

Nonwaiver Members

PA limitations will be determined based upon the level of care and anticipated duration in which services are required, using the Acute Care Home Health Service Plan, Long-Term Care Home Health Service Plan, or Diabetes Management Home Health Service Plan.

Home Health Aide Service

Members not on a waiver can receive reasonable and medically necessary home health aide visits with PA. Home health aide visits are included in the combined total of 120 acute home health visits per year. Long-term care and diabetic management service plans are limited to up to one-hour visits no more than twice per week. Providers must submit documentation supporting medical necessity to exceed two home health visits per week to ensure effective and efficient use and accurate reimbursement. This will be considered on a case-by-case basis. Providers cannot bill more than one home health aide visit per date of service.

Skilled Therapy Services

Speech, occupational, and physical therapy are limited to one unit per day. Services should not exceed six months duration and require PA. Respiratory therapy is limited to KBH-EPSDT-eligible members and is limited to one unit per day.

PRN Visits

PRN visits can be requested at the time they occur or within five working days after a visit has been made. Calls made to the PA department during nonworking hours are considered to be notification of the request. Agencies have 15 working days from the time of the call to submit a physician's order and completed, appropriate home health services PA request form to the PA department. If the required documentation is not submitted within the timeframe, the request will be denied. PRN telehealth visits are noncovered.

Paperwork Requirements

Initial Request

- Completed, appropriate home health services PA request form
- 485 or plan of care that includes physician's orders
- Completed, up-to-date, and current OASIS tool
- Physician assessment form of quality indicators and best practice interventions for members receiving care for diabetes management

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Note: The OASIS tool is a requirement of Medicare and Medicaid with two exceptions. The OASIS assessment tool is not required by Medicare for children (18 years of age and younger) and maternity members, and KMAP will not require the OASIS tool for these members.

The provider must fax the Change in Home Health Service Plan or Discharge From Service form to notify the PA department of a change or discharge from a plan within five business days of the event.

Supporting Documentation for Reconsideration or Renewal Requests

- Completed, appropriate home health services PA request form
- 485 or plan of care that includes physician's orders
- Documentation of the 60-day summary or 486 which includes member's response to treatment and supports continuation of home health services

Recertification summaries should have information from the clinical and progress notes that are communicated to the physician to determine continuation of home health services. The summary should include specifics about the member's health status, any changes in the member's condition, and progress toward established goals. Specific information may include:

- Hospitalizations
- Emergency room visits
- New diagnosis or changes in the severity of current diagnosis
- Medication changes
- Vital sign ranges
- Blood sugar ranges
- Training attempted
- Member and caregiver responses and progress in response to training
- Actions taken to encourage and foster member independence with self-care and health maintenance activities
- Any significant changes which impact the member's care
- Documentation to support continued home health services
- Physician assessment form of quality indicators and best practice interventions for members receiving care for diabetes management

Providers can submit additional documentation to support the need for requested services, such as blood glucose logs and insulin administration records for the most recent 30-day period. The provider must fax the Change in Home Health Service Plan or Discharge From Service form to notify the PA department of a change or discharge from a plan within five business days of the event.

Call In Requests

- Providers must phone or fax the PA department indicating a change in the home health service plan or discharge from service within five business days of the event.
- The paperwork can be mailed to KMAP, Office of the Fiscal Agent, PO Box 3571, Topeka, KS 66601-3571 or faxed to 785-274-5956 or 1-800-913-2229. The Home Health Services Prior Authorization Request Form is also available on the [Forms page](#) of the KMAP website.

Appendix III Updated 11/18

Physician's Orders

- All home health services require a physician's order. The ordering, referring, attending, prescribing, and sponsoring (ORAPS) requirements apply. (Reference **Section 2000** of the *General Benefits Fee-for-Service Provider Manual*.) Either a physician's order or a verbal order signed by an RN from a physician is acceptable to initiate treatment. Upon postpay review, if the record contains physician's orders that were not signed by the physician, those services are subject to recoupment.
- Documentation of the face-to-face visit by the physician or nonphysician practitioner within the specified time frames must be maintained in the medical record located at the home health agency.
- The agency is required to maintain plans of care containing the physician's signature on file in the medical record located at the home health agency.

GY Modifier

- Providers billing KMAP for home health services rendered to Medicare-eligible members must either bill Medicare first and obtain a denial or use the GY (statutorily excluded) modifier to bypass the Medicare denial requirement. The GY modifier can only be used if the member has a Medicaid-covered benefit plan.
- Providers can request Medicaid coverage for a dually covered member when a member is not "homebound."
- **If a member is a QMB but does not meet eligibility for Medicaid coverage, providers cannot bill KMAP for home health services rendered to a QMB-only member.** The member must have a Medicaid-covered benefit plan such as TXIX in addition to Medicare coverage to be eligible for fee-for-service home health visits.

Adjusting Existing PA

- Adjustments can be made to existing PAs when RN level of care needs to be changed to LPN or vice versa for the Acute Care Home Health Plan.
- The total units should not be increased or decreased without specific documentation as to the need for the increased or decreased units. Requests for this type of adjustment should be accompanied by a completed, appropriate home health services prior authorization request form.

Guidelines

Time Allowed Per Visit

All services performed during the visit are to be considered concurrent. For instance, an RN doing a dressing change would not need an additional hour to do an assessment because the RN should be assessing while doing the dressing change. Consider which services can be combined in determining the total time required for each visit. Documentation provided for each visit must support the amount of time billed.

Licensed Professional Services Defined

Services generally considered to require the skill level of a licensed professional include, but are not limited to:

- Assessments
- Care plan development
- Catheter insertion and replacement

Appendix III Updated 05/11

- Diabetic nail care
- Dressing changes/wound care – complicated
- Infusions
- Injections
- Medication setup
- Observation and assessment of an unstable member
- Parenteral feedings
- Prefilling insulin and other syringes
- Procedures requiring use of sterile technique
- Psychiatric nursing requiring RN level of care
- Supervision
- Teaching and training activities
- Tracheostomy tube changes
- Treatment of extensive decubitus ulcers or other widespread skin disorders
- Venipuncture requiring RN level of care

Aide Level (Non-skilled) Services Defined

Services generally considered not to require the skill level of a licensed professional include, but are not limited to:

- Administration of routine oral medications, eye drops, and topical ointments
- Assistance with bathing, dressing, eating, and toileting
- Bowel and bladder procedures – bowel stimulation, obtaining specimens, performance of enemas, or impaction removal if:
 - Self-directed (HCBS waivers only)
 - Ordered by the physician
 - No contraindications exist
- Chronic bowel condition
- Emptying of ostomy or urine bag
- Gastrostomy and enteral feedings
- General maintenance care of colostomy, ileostomy, and catheters
- Prophylactic and palliative skin care
- Routine ROM activities
- Simple, nonsterile dressing changes
- Treatment of minor skin problems
- Vital signs

Services which generally do not require the skill level of a licensed professional may require a licensed professional if the member's condition is complicated or compromised or if other extenuating circumstances exist. In these circumstances, the documentation must support the use of a licensed professional. Reimbursement for services paid at a skill level higher than the skill level supported by the documentation will be recouped.

Time Frames

- Providers who bill beyond the frequency and duration established by PA may be subject to nonpayment or postpay recoupment if the documentation does not support the services provided.
- All services that can be completed within the same visit should be completed within the same visit rather than scheduling multiple visits to perform different skilled tasks.

Appendix III Updated 02/24

Assessments/Evaluations/Reassessments

- An OASIS assessment, if performed in the absence of any other skilled service, is reimbursable every 60 days to determine the member's skilled service needs and to develop or revise the plan of care.
- If the OASIS assessment is completed during a visit in conjunction with any other skilled service, providers will only be reimbursed for T1023.
- Visits for assessments may be allowed if there is a change in the member's condition or modifications to the plan of care is needed. Providers should use codes such as S0315 and S0316 for such assessments. G0299 should be used for acute care visits.
- The use of T1023 is only billable for comprehensive assessments/reassessments in which the OASIS tool is completed and is used to update the plan of care.
- Providers can request PRN visits to facilitate compliance with Medicare assessment guidelines.
- Providers can adjust the visit schedule to allow recertifications to be conducted at regularly scheduled visits.

Care Plan Development

Care plan development is not a separate billable service. (It is included in the assessment/evaluation reimbursement rate.)

Catheters Insertion and Replacement

- **Foley:** Up to one hour per month plus up to two one-hour PRN visits if ordered by the physician. (Up to 30 minutes once per month plus up to two PRN visits if the member has newly acquired the catheter or has a history of complications.)
- **Straight Catheter:** Up to 30 minutes up to four times daily. Document the efforts to train the member or caregiver to perform the catheterization (up to 30 minutes).

Chronic Illness Monitoring

Up to 60 minutes twice monthly. Skilled nursing services may be provided on a limited basis to chronically ill members with the potential for exacerbation or instability. One-hour visits up to twice monthly for six months may be approved if the documentation supports a history of frequent hospital admissions, exacerbations to acute stages of the chronic disease, or overall debility which puts the member at risk of instability (up to two 30-minute visits per month).

Dressing Changes/Wound Care Non-MRSA

Generally, up to two hours per day; this may be one hour twice a day (BID) for 10 days and up to one hour per day for an additional four days when supported by the physician's order and plan of care (30 minutes BID up to ten days and up to 30 minutes daily for up to four days). Authorization for longer periods can be allowed with proper documentation.

Dressing Changes/Wound Care MRSA or VRE

Up to two 90-minute visits daily for a total of up to three hours daily, for a maximum of 60 days (up to 60 minutes BID up to 60 days). The duration of skilled nursing visits is determined based upon the complexity of the wounds. Documentation must support the time billed.

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Decubitus Ulcers

Treatment of extensive decubitus ulcers will vary depending upon the services needed and the extent of the problem. Documentation must support the time billed.

Note: The duration of skilled nursing visits is determined based upon the complexity of the wounds. Documentation must support the time billed for wound care and must include measurements, status of the wound bed and surrounding area, progress towards wound healing and barriers to wound healing, such as nutrition, low albumin, inadequate pressure relief, and noncompliance. Documentation must support the treatment regimen is periodically reassessed and reviewed to promote continued wound healing.

Diabetic Nail Care

30 minutes monthly. This service should usually be done in conjunction with some other service and rarely as a stand-alone service (20-30 minutes monthly).

Eye Drops

15 minutes per visit. Documentation must support the need for a licensed nurse visit for the purpose of instilling eye drops, such as new post-surgery or newly diagnosed acute medical condition (up to four visits daily, up to 10 minutes).

Glucose Monitoring

Up to four 15-minute visits per day. Generally, this is not a skilled service and is usually performed by the member or caregiver but may be allowed as a skilled nursing service if the documentation demonstrates the member or caregiver is unable to perform glucose monitoring. A skilled visit may also be allowed if the member is unstable and the documentation supports a clinical need for assessment, management, and reporting to the physician of specific conditions and/or symptoms which are unstable or unresolved. (Five minutes up to four times per day for up to two weeks if stand-alone service. If provided with insulin administration, 5 to 10 minutes are allowed.)

Infusion Therapy

Code 99601 (GY) is used for IV infusion therapy for members who have a Medicaid-covered benefit plan. The code description states up to two hours of service. This code is a per visit code. An agency may use this code for each visit made to provide infusion therapy. Agencies providing infusion services will typically be in the home longer and should use 99601. One unit of 99601 is expected to encompass both the initiation and disconnection of an infusion along with performance of other tasks while the IV infuses. If an infusion is started and the nurse leaves while the IV infuses and returns to disconnect the IV, this is one visit. If a nurse performs an infusion in the morning and while the infusion is running does other tasks, such as a dressing change, and must return later in the day to perform another skilled nursing service, such as change the second dressing of the day, the second visit should be billed using appropriate nursing codes.

Code 99602 is used in circumstances when an IV infusion requires continuous monitoring and cannot be administered in two hours. Providers use 99602 for each additional hour of the IV infusion. If there is concern regarding potential side effects, the medication should be administered in an outpatient setting.

Appendix III Updated 05/17

Note: Flushing ports or disconnecting a previously setup infusion is not considered infusion therapy and will not be reimbursed using 99601 or as a separate reimbursable visit. Administration of medications using manual IV push is not considered infusion therapy and will not be reimbursed using 99601. Infusion pumps using syringe cartridges are considered infusions and will be reimbursed using code 99601.

Injections

Up to five minutes for injections, up to 30 minutes for observation for allergy injections. (Allergy injections should not be provided to a person who routinely goes out of the home and could obtain the injection from his or her physician's office or a clinic.)

Insulin Injections/Diabetes Management

Up to 15 minutes up to four times per day, depending upon the physician's orders. Allowed for 5 to 10 minutes up to four times a day (QID) for two weeks during the unstable phase. Allowed for 5 to 10 minutes up to four times a day for two weeks to teach and train once stable.

- Insulin injections may be allowed if the member is unable to self-inject, there is no other person available to give the injection and attempts to use other technology or to teach the patient to self-inject have failed. Documentation must demonstrate the member and/or caregiver is unable to administer the injections.
- Documentation must support the need for diabetes management and reporting specific conditions or symptoms which are unstable or unresolved.

Medication Administration

Routine oral medication administration is a home health aide level service and should not require skilled nursing services. Exceptions may exist when the member is compromised or requiring assessment prior to medication administration, or when medications must be crushed or administered through a G-tube. Inhalers should be administered by the waiver attendants (HCBS waiver members), or the member should be taught to self-administer inhalers. In rare cases, a member may not be able to self-administer an inhaler and home health services may be authorized.

Note: If a patient is on a waiver, medication administration is content of the waiver service and should not require home health services.

Medication Setup

- Medications should be obtained setup from the pharmacy or in unit dose packs to aid in the proper administration of routine oral medications by the member, caregiver, attendants, or aides.
- When a nurse must set up medications for a member, the nurse should perform the medication setup in conjunction with other skilled activities. Rarely should it be necessary for a nurse to perform a skilled visit solely for the purpose of medication setup.
- When possible, medications should be set up for more than a one-week period of time.
- Time allowed to set up medications depends on the number and complexity of the medications and the number of weeks being set up.
- Prefilling insulin syringes should be included as part of medication setup. If this is the only medication required by the member to be set up, prefilled syringes should be obtained from the pharmacy, if possible.

Appendix III Updated 05/17

Ostomy Care

- Rarely should ostomy care require a licensed professional but could be indicated in a situation such as the acute postoperative period or in the presence of complications.
- Ostomy care should occur in conjunction with other services, such as teaching or training rather than as a stand-alone service.
- Documentation must support the need for the licensed professional.
- Insertion/replacement of a gastrostomy or urostomy tube may be approved up to one hour every month with a maximum of two additional one-hour PRN visits per month.

Psychiatric Nursing

- Documentation should support the time spent. Assessments, mental status exams, and other therapeutic interventions designed to relieve psychiatric symptoms are considered psychiatric nursing.
- Psychiatric nursing services provided by home health agencies may take place in any setting in which normal activities of life take place that is not a nursing facility, hospital, or ICF-IDD. Patients should be encouraged to use community mental health centers.
- Psychiatric nursing services must be provided by a RN.
- In accordance with Medicare guidelines, the evaluation, psychotherapy, and teaching needed by a patient suffering from a diagnosed psychiatric disorder requiring active treatment by a psychiatrically trained nurse and the costs associated with the psychiatric nurse's services may be covered as a skilled nursing service. Psychiatrically trained nurses are nurses who have special training and/or experience beyond the standard curriculum required for a RN. The services of the psychiatric nurse are to be provided under a plan of care established and reviewed by a physician.
- Because the law precludes agencies primarily providing care and treatment of mental diseases from participating as a home health agency, psychiatric nursing must be furnished by an agency not primarily providing care and treatment of mental diseases. If a substantial number of a home health agency's members attend partial hospitalization programs or receive outpatient mental health services, verification is required to determine whether the patients meet the eligibility requirements specified and whether the home health agency is primarily engaged in care and treatment of mental diseases.
- Services of a psychiatric nurse would not be considered reasonable and necessary to assess or monitor use of psychoactive drugs being used for nonpsychiatric diagnoses or to monitor the condition of a member with a known psychiatric illness who is on treatment but is considered stable. A person on treatment would be considered stable if his or her symptoms were absent or minimal or if symptoms were present but relatively stable and did not create a significant disruption in the patient's normal living situation.

(Medicare Benefit Policy Manual, Chapter 7 – Home Health Services: 40.1.2.15)

Supervision

- Nursing visits for the purpose of supervising aides are not a separate billable service. Supervisory visits should occur during visits scheduled for other skilled services such as medication setup, assessment, catheter change, and so forth.
- Supervision of home health aides is required every two weeks only if the patient is receiving skilled nursing services. If the patient is receiving only home health aide level of care, supervision is only required every 60 days.

Appendix III Updated 05/11

Teaching and Training

- Teaching and training activities requiring skilled nursing personnel to teach a member, the member's family, or caregivers how to manage the member's treatment regimen constitute skilled nursing services as long as the services are appropriate to the member's functional loss, illness, or injury.
- All teaching and training should be associated with the performance of an actual service, such as wound care, ostomy care, or glucose monitoring.
- Documentation must support the need for teaching and training and member, family, or caregiver response to teaching. If the member, family, or caregivers are unable to be trained, further teaching and training would cease to be reasonable and necessary. Documentation in the record should note why training was unsuccessful.
- Three types of teaching and training are recognized:
 - Initial teaching of a new skill
 - Reinforcement of teaching or training previously provided in an institutional setting
 - Reteaching when there is a change in the member's condition, or the task is being carried out incorrectly
- Teaching and training activities requiring the skill of a licensed nurse include, but are not limited to, the following teaching:
 - Self-administration of injectable medications or complex range of medications
 - Newly diagnosed diabetic or caregiver all aspects of diabetes management, including how to prepare and administer insulin injections, to prepare and follow a diabetic diet, to observe foot care precautions, and to recognize and understand signs of hyperglycemia and hypoglycemia
 - Self-administration of nebulizer and breathing treatments
 - Wound care where the complexity of the wound, the overall condition of the member, or the ability of the caregiver makes teaching necessary
 - Care for a recent ostomy or reinforcement of ostomy care when needed
 - Self-catheterization
 - Self-administration of gastronomy or enteral feedings
 - Care for and maintenance of peripheral and central venous lines and administration of IV medications through such lines
 - Bowel or bladder training when bowel or bladder dysfunction exists
 - How to perform the activities of daily living when the member or caregiver must use special techniques and adaptive devices due to a loss of function
 - Transfer techniques such as from bed to chair, needed for safe transfer
 - Proper body alignment, positioning, and timing techniques for a bedridden member
 - Ambulation with prescribed assistive devices (such as crutches, walker, or cane) which are needed due to a recent functional loss
 - Use and care of braces, splints, and orthotics and associated skin care
 - Preparation and maintenance of a therapeutic diet
 - Proper administration of oral medication, including signs of side effects, and avoidance of interaction with other medications and foods
 - Proper care and application of any special dressings or skin treatments (such as dressings or treatments needed due to severe or widespread fungal infections, active and severe psoriasis or eczema, or skin deterioration from radiation treatments)

Appendix III Updated 05/11

Occupational Therapy

Occupational therapy must be restorative and rehabilitative and provided by a registered occupational therapist. It may only be provided following physical debilitation due to acute physical trauma or physical illness and is limited to six months duration for non-KBH-EPSDT members. This service is limited to one unit per day and other limitations of the Acute Care Home Health Service Plan.

Physical Therapy

Physical therapy must be restorative and rehabilitative and provided by a registered physical therapist. Physical therapy can only be provided following physical debilitation due to acute physical trauma or physical illness and is limited to six months duration for non-KBH-EPSDT members. This service is limited to one unit per day and other limitations of the Acute Care Home Health Service Plan.

Respiratory Therapy

Respiratory therapy is limited to KBH-EPSDT members. The limit is one unit per day.

Speech Therapy

Speech therapy must be restorative and rehabilitative and provided by a licensed speech language pathologist. Speech therapy can only be provided following physical debilitation due to acute physical trauma or physical illness and is limited to six months duration for non-KBH-EPSDT members. This service is limited to one unit per day and other limitations of the Acute Care Home Health Service Plan.

Restorative Aide

Restorative aides may only provide restorative and rehabilitative physical therapy services under the physical therapy plan of care developed by a registered physical therapist. Restorative aide services may not be billed on the same date of service as a home health aide service. Restorative aide services may only be provided following physical debilitation due to acute physical trauma or physical illness and is limited to six months duration for non-KBH-EPSDT members. One unit of restorative aide service is allowed per day.

Venipuncture

Venipuncture service should rarely, if ever, be provided as a stand-alone service and will generally be included with other services during a home visit.

Demonstration Criteria for Provider Type and Specialty (PT/PS) 05-051

1. Providers must meet all the regulatory requirements and conditions of participation and operate as a Medicare-certified home health agency, with a PT 05 and PS 050.
2. Providers must be able to demonstrate that the equipment used to render home telehealth services meets program specifications (real-time, interactive, audio and video telecommunication) and is HIPAA compliant.
3. Providers must submit literature to the fiscal agent's Provider Enrollment team pertaining to the telecommunication equipment the agency has chosen that will allow thorough physical assessments such as: assessment of edema, rashes, bruising, skin conditions, and other significant changes in health status.

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4. Providers must be able to obtain and maintain telecommunication devices to render home telehealth visits.
5. When the provider has satisfied all the enrollment/demonstration requirements and a site visit is performed by the state program manager, KMAP will approve enrollment of PT/PS 05-051.
6. Providers are eligible for reimbursement of home telehealth services that meet the following criteria:
 - Prescribed by a physician or allowed nonphysician practitioner
 - Considered medically necessary
 - Signed member consent for telehealth services
 - Skilled nursing service
 - Does not exceed program limitations (limited to two visits per week for non-HCBS members)

Upon completion of the enrollment process and approval of the telehealth demonstration, home health agencies should refer to home telehealth prior authorization criteria as noted in this appendix for further guidance.

Note: Providers must obtain PA for member participation in the demonstration process, as PA is required for all fee-for-service home health visits.

