

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Policy and Operations

(Amended at ARRS Committee)

907 KAR 1:030. Home health agency services.

RELATES TO: KRS 205.622, 216.935, 216.936, 216.937, 216.9375, 216.939, 369.101-369.120, 42 C.F.R. 431.17, 440.70, 447.325, 484.115, 45 C.F.R. 164.316, 42 U.S.C. 1396a-d

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the coverage provisions and requirements relating to Medicaid Program home health care services.

Section 1. Definitions.

- (1) "Department" means the Department for Medicaid Services or its designee.
- (2) "Electronic signature" is defined by KRS 369.102(8).
- (3) "Enrollee" means a recipient who is enrolled with a managed care organization.
- (4) "Federal financial participation" is defined by 42 C.F.R. 400.203.
- (5) "Home health agency" or "HHA" means:
 - (a) An agency defined pursuant to 42 C.F.R. 440.70(d); and
 - (b) A Medicare and Medicaid-certified agency licensed in accordance with 902 KAR 20:081.
- (6) "Home health aide" is defined by KRS 216.935(3).
- (7) "Licensed practical nurse" or "LPN" means a person who is licensed in accordance with KRS 314.051.
- (8) "Managed care organization" means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined in 42 C.F.R. 438.2.
- (9) "Medical social worker" means a person who meets the medical social worker requirements as established in 902 KAR 20:081.
- (10) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.
- (11) "Nursing service" means the delivery of medication, or treatment by a registered nurse or a licensed practical nurse supervised by a registered nurse, consistent with KRS Chapter 314 scope of practice provisions and the Kentucky Board of Nursing scope of practice determination guidelines.
- (12) "Occupational therapist" is defined by KRS 319A.010(3).
- (13) "Occupational therapy assistant" is defined by KRS 319A.010(4).
- (14) "Physical therapist" is defined by KRS 327.010(2).
- (15) "Physical therapist assistant" means a skilled health care worker who:
 - (a) Is certified by the Kentucky Board of Physical Therapy; and
 - (b) Performs physical therapy services and related duties as assigned by the supervising physical therapist.
- (16) "Place of residence" means, excluding a hospital or nursing facility, the location at which a recipient resides.
- (17) "Plan of care" means a written plan which shall:
 - (a) Stipulate the type, nature, frequency and duration of a service; and

- (b) At least every sixty (60) days, be reviewed and signed by a HHA staff person and physician, advanced practice registered nurse, or physician assistant.
- (18) "Provider" is defined by KRS 205.8451(7).
- (19) "Qualified medical social worker" means a person who meets the qualified medical social worker requirements as established in 902 KAR 20:081.
- (20) "Qualified social work assistant" means a social work assistant as defined in 42 C.F.R. 484.115.
- (21) "Recipient" is defined by KRS 205.8451(9).
- (22) "Registered nurse" or "RN" is defined by KRS 314.011(5).
- (23) "Speech-language pathologist" is defined by KRS 334A.020(3).
- (24) "Speech-language pathology assistant" is defined by KRS 334A.020(8).

Section 2. Conditions of Participation.

- (1) In order to provide home health services, a provider shall:
- (a) Be an HHA; and
 - (b) Comply with:
 - 1. 907 KAR 1:671;
 - 2. 907 KAR 1:672;
 - 3. 907 KAR 1:673;
 - 4. All applicable state and federal laws; and
 - 5. The Home Health Services Manual.
- (2)
- (a) A home health provider shall maintain a medical record for each recipient for whom services are provided.
 - (b) A medical record shall:
 - 1. Document each service provided to the recipient including the date of the service and the signature of the individual who provided the service;
 - 2. Contain a copy of the plan of care;
 - 3. Document verbal orders from the physician, advanced practice registered nurse, or physician assistant, if applicable;
 - 4. Except as established in paragraph (d) of this subsection, be retained for a minimum of five (5) years from the date a covered service is provided or until any audit dispute or issue is resolved beyond five (5) years;
 - 5. Be kept in an organized central file within the HHA; and
 - 6. Be made available to the department upon request.
 - (c) The individual who provided a service shall date and sign the health record on the date that the individual provided the service.
 - (d)
 - 1. If the secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (b)4. of this section, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.
 - 2. In the case of a recipient who is a minor, the recipient's medical record shall be retained for three (3) years after the recipient reaches the age of majority under state law or the length established in paragraph (b)4 of this subsection or subparagraph 1 of this paragraph, whichever is longest.
- (3) A provider shall comply with 45 C.F.R. Part 164.
- (4)
- (a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.
 - (b) Failure to return a payment to the department in accordance with paragraph (a) of this section may be:

1. Interpreted to be fraud or abuse; and
2. Prosecuted in accordance with applicable federal or state law.

Section 3. Covered Services.

- (1) A home health service shall be:
 - (a) Prior authorized by the department to ensure that the service or modification of the service is medically necessary and adequate for the needs of the recipient;
 - (b) Provided pursuant to a plan of care; and
 - (c) Provided in a recipient's place of residence.
- (2) The following services provided to a recipient by a home health provider who meets the requirements in Section 2 of this administrative regulation shall be covered by the department:
 - (a) A nursing service which shall:
 1. Include part-time or intermittent nursing services; and
 2. If provided daily, be limited to thirty (30) days unless additional days are prior authorized by the department;
 - (b) A therapy service which shall:
 1. Include physical therapy services provided by a physical therapist or a physical therapist assistant who is under the supervision of a physical therapist;
 2. Include occupational therapy services provided by an occupational therapist or an occupational therapy assistant who is under the supervision of an occupational therapist;
 3. Include speech-language pathology services provided by a speech-language pathologist or a speech-language pathology assistant who is under the supervision of a speech-language pathologist;
 4. Be provided pursuant to a plan of treatment which shall be developed by the appropriate therapist and physician, advanced practice registered nurse, or physician assistant;
 5. Be provided in accordance with 907 KAR 1:023; and
 6. Comply with the:
 - a. Physical therapy service requirements established in the:
 - (i) Technical Criteria for Reviewing Ancillary Services for Adults if the therapy service is a physical therapy service provided to an adult; or
 - (ii) Technical Criteria for Reviewing Ancillary Services for Pediatrics if the therapy service is a physical therapy service provided to a child;
 - b. Occupational therapy requirements established in the:
 - (i) Technical Criteria for Reviewing Ancillary Services for Adults if the therapy service is an occupational therapy service provided to an adult; or
 - (ii) Technical Criteria for Reviewing Ancillary Services for Pediatrics if the therapy service is an occupational therapy service provided to a child; or
 - c. Speech-language pathology service requirements established in the:
 - (i) Technical Criteria for Reviewing Ancillary Services for Adults if the service is a speech-language pathology service provided to an adult; or
 - (ii) Technical Criteria for Reviewing Ancillary Services for Pediatrics if the service is a speech-language pathology service provided to a child;
 - (c) A home health aide service which shall:
 1. Include the performance of simple procedures as an extension of therapy services, personal care, range of motion exercises and ambulation, assistance with medications that are ordinarily self-administered, reporting a change in the recipient's condition and needs, incidental household services which are essential to the recipient's health care at home when provided in the course of a regular visit, and completing appropriate records;

2. Be provided by a home health aide who is supervised at least every fourteen (14) days by:
 - a. An RN;
 - b. A physical therapist, for any physical therapy services that are provided by the home health aide;
 - c. An occupational therapist, for any occupational therapy services that are provided by the home health aide; or
 - d. A speech-language pathologist, for any speech-language pathology services that are provided by the home health aide; and
3. Be a service that the recipient is either physically or mentally unable to perform;
- (d) A medical social service which shall:
 1. Be provided by a qualified medical social worker or qualified social work assistant; and
 2. Be provided in conjunction with at least one (1) other service listed in this section;
- (e) A supply listed on the Home Health Schedule of Supplies, which shall be covered if provided to a recipient pursuant to the recipient's plan of care; or
- (f) A supplemental nutritional product listed on the Home Health Schedule of Supplies, which shall:
 1. Be ingested orally or delivered by tube into the gastrointestinal tract;
 2. Provide for the supplemental nutrition of a recipient; and
 3. Require a completed MAP-248 signed by a physician, advanced practice registered nurse, or physician assistant certifying the medical necessity of the supplemental nutritional product.

Section 4. Limitations and Exclusions from Coverage.

- (1) A domestic or housekeeping service which is unrelated to the health care of a recipient shall not be covered.
- (2) A medical social service shall not be covered unless provided in conjunction with another service pursuant to Section 3 of this administrative regulation.
- (3) Supplies for personal hygiene shall not be covered.
- (4) Drugs shall not be covered.
- (5) Disposable diapers shall not be covered for a recipient age three (3) years and under, regardless of the recipient's medical condition.
- (6) Except for the first week following a home delivery, a newborn or postpartum service without the presence of a medical complication shall not be covered.
- (7) A recipient who has elected to receive hospice care shall not be eligible to receive coverage under the home health program.
- (8)
 - (a) There shall be an annual limit of twenty (20):
 1. Occupational therapy service visits per recipient per calendar year except as established in paragraph (b) of this subsection;
 2. Physical therapy service visits per recipient per calendar year except as established in paragraph (b) of this subsection; and
 3. Speech-language pathology service visits per recipient per calendar year except as established in paragraph (b) of this subsection.
 - (b) The limits established in paragraph (a) of this subsection may be exceeded if services in excess of the limits are determined to be medically necessary by the:
 1. Department if the recipient is not enrolled with a managed care organization; or
 2. Managed care organization in which the enrollee is enrolled if the recipient is an enrollee.
 - (c) Prior authorization by the department shall be required for each visit that exceeds the limit established in paragraph (a) of this subsection for a recipient who is not

enrolled with a managed care organization.

Section 5. No Duplication of Service.

(1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider of any program in which the service is covered during the same time period.

(2) For example, if a recipient is receiving a speech-language pathology service from a speech-language pathologist enrolled with the Medicaid Program, the department shall not reimburse for a speech-language pathology service provided to the same recipient during the same time period via the home health services program.

Section 6. Third Party Liability. A provider shall comply with KRS 205.622.

Section 7. Use of Electronic Signatures.

(1) The creation, transmission, storage, and other use of electronic signatures and documents shall comply with the requirements established in KRS 369.101 to 369.120.

(2) A provider that chooses to use electronic signatures shall:

(a) Develop and implement a written security policy that shall:

1. Be adhered to by each of the provider's employees, officers, agents, or contractors;
2. Identify each electronic signature for which an individual has access; and
3. Ensure that each electronic signature is created, transmitted, and stored in a secure fashion;

(b) Develop a consent form that shall:

1. Be completed and executed by each individual using an electronic signature;
2. Attest to the signature's authenticity; and
3. Include a statement indicating that the individual has been notified of his or her responsibility in allowing the use of the electronic signature; and

(c) Provide the department, immediately upon request, with:

1. A copy of the provider's electronic signature policy;
2. The signed consent form; and
3. The original filed signature.

Section 8. Auditing Authority. The department shall have the authority to audit any claim, medical record, or documentation associated with any claim or medical record.

Section 9. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

- (1) Receipt of federal financial participation for the coverage; and
- (2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 10. Appeal Rights.

(1) An appeal of an adverse action taken by the department regarding a service and a recipient who is not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.

(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010.

Section 11. Incorporation by Reference.

(1) The following material is incorporated by reference:

- (a) "MAP-248", August 2021;
 - (b) "Home Health Services Manual", May 2014;
 - (c) "Technical Criteria for Reviewing Ancillary Services for Adults", February 2000;
 - (d) "Technical Criteria for Reviewing Ancillary Services for Pediatrics", April 2000;
- and

(e) "Home Health Schedule of Supplies", May 2014.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at:

(a) The Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday 8 a.m. to 4:30 p.m.; or

(b) The Web site located at <https://chfs.ky.gov/agencies/dms/dpo/bpb/Pages/hh.aspx> .

(2 Ky.R. 108; eff. 9-10-1975; 3 Ky.R. 522; eff. 2-2-1977; Recodified from 904 KAR 1:030, 5-2-1986; 15 Ky.R. 2458; eff. 8-5-1989; 21 Ky.R. 141; eff. 8-17-1994; 29 Ky.R. 1409; 1819; 2108; eff. 1-15-2003; 40 Ky.R. 1941; 2709; eff. 7-7-2014; Cert eff. 5-27-2021; 48 Ky.R. 1411, 2096; eff. 1-13-2022.)

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