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Authority

The provisions of this Chapter 1249 issued under sections 403 and 443.2(2) of the Public Welfare Code (62 P. S. §§ 403 and 443.2(2)), unless otherwise noted.

Source

The provisions of this Chapter 1249 adopted December 6, 1980, effective December 1, 1980, 10 Pa.B. 4618, unless otherwise noted.

Cross References

This chapter cited in 55 Pa. Code § 175.73 (relating to requirements); 55 Pa. Code § 1101.31 (relating to scope); and 55 Pa. Code § 1101.95 (relating to conflicts between general and specific provisions).

GENERAL PROVISIONS

§ 1249.1. Policy.

The MA Program provides payment for specific medically necessary home health services rendered to eligible recipients by providers enrolled under the program. Payment for home health services is subject to this chapter, Chapter 1101 (relating to general provisions) and the limitations established in Chapter 1150 (relating to the MA Program payment policies) and the MA Program fee schedule.

Source

The provisions of this § 1249.1 adopted December 6, 1980, effective December 1, 1980, 10 Pa.B. 4618; amended December 23, 1983, effective January 1, 1983, 13 Pa.B. 3932; amended September 30, 1988, effective October 1, 1988, 18 Pa.B. 4418. Immediately preceding text appears at serial page (117528).

§ 1249.2. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Home health agency—A public or private agency or organization, or part of an agency or organization that is licensed by the Commonwealth and certified for participation in Medicare. The agency shall be staffed and equipped to provide skilled nursing care and at least one therapeutic service—physical therapy, occupational therapy or speech pathology—or home health aides to a disabled, aged, injured or sick recipient on a part-time or intermittent basis in his residence.

Home health services—Nursing services, home health aide services, physical therapy, occupational therapy or speech pathology and audiology services provided by a home health agency and medical supplies, equipment and appliances suitable for use in the home. For the purpose of this chapter, medical supplies, equipment and appliances do not include dentures, prosthetic devices, orthoses or eyeglasses.

Residence—A place where the recipient makes his home.

(i) The term includes a personal care home, a hospice, a relative's home or a friend's home.

(ii) The term does not include a hospital, skilled nursing facility or intermediate care facility.

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Usual charge—A home health agency's most frequent charge to the general public within the same calendar month.

Visit—A personal contact in the recipient's residence made for the purpose of providing a covered service by a health care worker on the staff of the home health agency or by others under contract or arrangement with the home health agency.

Authority

The provisions of this § 1249.2 amended under sections 403(a) and (b), 443.2(2) and 509 of the Public Welfare Code (62 P. S. §§ 403(a) and (b), 443.2(2) and 509).

Source

The provisions of this § 1249.2 adopted December 6, 1980, effective December 1, 1980, 10 Pa.B. 4618; amended August 12, 1988, effective September 1, 1988, 18 Pa.B. 3571; amended May 11, 2007, effective May 12, 2007, 37 Pa.B. 2185. Immediately preceding text appears at serial pages (313040) and (251259).

§ 1249.2a. [Reserved].

Source

The provisions of this § 1249.2a adopted September 23, 1988, effective September 26, 1988, 18 Pa.B. 4345; reserved May 11, 2007, effective May 12, 2007, 37 Pa.B. 2215. Immediately preceding text appears at serial pages (251259) to (251260).

SCOPE OF BENEFITS

§ 1249.21. Scope of benefits for the categorically needy.

Categorically needy recipients are eligible for medically necessary home health services covered by the MA Program subject to the conditions and limitations established in this chapter.

Source

The provisions of this § 1249.21 adopted December 6, 1980, effective December 1, 1980, 10 Pa.B. 4618.

§ 1249.22. Scope of benefits for the medically needy.

(a) Medically needy recipients are eligible for medically necessary home health services covered by the MA Program subject to the conditions and limitations established in this chapter.

(b) Although medical supplies, equipment and appliances are not ordinarily included in the scope of benefits for the medically needy, medical supplies, equipment and appliances suitable for use in the home are covered for the medically needy if they are provided in conjunction with nursing or home health aide services and are part of the treatment plan of the physician. Payment for medical supplies, equipment and appliances is made only to participating medical suppliers and is subject to Chapter 1123 (relating to medical supplies).

Source

The provisions of this § 1249.22 adopted December 6, 1980, effective December 1, 1980, 10 Pa.B. 4618.

§ 1249.23. Scope of benefits for State Blind Pension recipients.

(a) State Blind Pension recipients are eligible for medically necessary home health services covered by the MA Program subject to the conditions and limitations established in this chapter.

(b) Medical supplies are not covered for State Blind Pension recipients.

Source

The provisions of this § 1249.23 adopted December 6, 1980, effective December 1, 1980, 10 Pa.B. 4618.

§ 1249.24. Scope of benefits for General Assistance recipients.

General Assistance recipients, age 21 to 65, whose MA benefits are funded solely by State funds, are eligible for medically necessary basic health care benefits as defined in Chapter 1101 (relating to general provisions). See § 1101.31(e) (relating to scope).

Source

The provisions of this § 1249.24 adopted December 11, 1992, effective January 1, 1993, 22 Pa.B. 5995.

PROVIDER PARTICIPATION

§ 1249.41. Participation requirements.

In addition to the participation requirements established in Chapter 1101 (relating to general provisions) home health agencies shall be certified by the Department of Health as meeting the requirements for Medicare home health agencies.

Source

The provisions of this § 1249.41 adopted December 6, 1980, December 1, 1980, 10 Pa.B. 4618.

§ 1249.42. Ongoing responsibilities of providers.

Ongoing responsibilities of providers are established in Chapter 1101 (relating to general provisions). The home health agency shall:

(1) Have written policies concerning the acceptance of recipients and the feasibility of meeting the recipient's needs in the home care setting, which include, but are not limited to:

(i) An evaluation visit in the recipient's residence to consider the physical facilities available, attitudes of family members and the availability of family members to help in the care of the patient.

(ii) Assessment and documentation of the need for home health agency services.

(2) Establish a plan of care for the recipient that does the following:

(i) Specifies the types of services required.

(ii) Provides long range projection of likely changes in the recipient's condition.

(iii) Includes the diagnosis and a description of the recipient's functional limitations.

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(iv) Includes the type and frequency of nursing services, rehabilitation and therapy services and home health aide services needed.

(v) Includes drugs, medications, special diets, activities permitted and the medical supplies, equipment and appliances necessary for the recipient's use.

Authority

The provisions of this § 1249.42 amended under sections 403(a) and (b), 443.2(2) and 509 of the Public Welfare Code (62 P.S. §§ 403(a) and (b), 443.2(2) and 509).

Source

The provisions of this § 1249.42 adopted December 6, 1980, December 1, 1980, 10 Pa.B. 4618; amended August 12, 1988, effective September 1, 1988, 18 Pa.B. 3571; amended May 11, 2007, effective May 12, 2007, 37 Pa.B. 2185. Immediately preceding text appears at serial pages (251261) to (251262).

PAYMENT FOR HOME HEALTH SERVICES

§ 1249.51. General payment policy.

Payment is made for compensable home health services provided by participating home health agencies subject to the conditions and limitations established in §§ 1249.52—1249.59 and Chapters 1101 and 1150 (relating to general provisions; and MA Program payment policies) and the MA Program Fee Schedule.

Authority

The provisions of this § 1249.51 amended under sections 403(a) and (b), 443.2(2) and 509 of the Public Welfare Code (62 P.S. §§ 403(a) and (b), 443.2(2) and 509).

Source

The provisions of this § 1249.51 adopted December 6, 1980, effective December 1, 1980, 10 Pa.B. 4618; amended December 23, 1983, effective January 1, 1983, 13 Pa.B. 3932; corrected at 14 Pa.B. 165; amended August 12, 1988, effective September 1, 1988, 18 Pa.B. 3571; amended September 30, 1988, effective October 1, 1988, 18 Pa.B. 4418. Immediately preceding text appears at serial page (117530).

§ 1249.52. Payment conditions for various services.

(a) Home health agencies are reimbursed for services furnished to MA recipients within the MA Program Fee Schedule limits if the following conditions are met and documented in the recipient's medical record:

(1) The services are ordered by and included in the plan of treatment established by the recipient's attending physician. (*Editor's Note*: Under section 2(5)(i) of the act of October 28, 2022 (P.L. 1632, No. 98) and to the extent permitted under Federal law, § 1249.52(a)(1) is abrogated to the extent that home health services are only covered and reimbursable under the medical assistance program if a physician orders the services and establishes the plan of treatment.)

(2) The attending physician certifies that the recipient requires care in the home and one of the following conditions exist:

(i) The specific home health services would avoid or delay the need for treatment in a hospital or other institutional setting for the condition being treated.

(ii) The recipient has an illness, injury or mental health condition that justifies providing the services at the recipient's residence instead of a physician's office, clinic or other outpatient setting.

(3) The attending physician certifies that the recipient requires the skilled services of a nurse, physical therapist, occupational therapist or speech therapist or the services of a home health aide.

(4) A change in the treatment plan is made in writing and signed by the physician, or if given orally, is put in writing and signed by the health care professional receiving the oral order on behalf of the agency. The order shall be countersigned by the physician within 30 days of the physician's order. The following health care professionals may receive oral orders from the physician:

(i) Registered nurses.

(ii) Licensed practical nurses.

(iii) Physical therapists, occupational therapists and speech therapists. These health care professionals may only receive oral orders that pertain to these specialties.

(5) The plan is reviewed by the attending physician, in consultation with agency professional personnel at least every 60 days. The review of the recipient's plan must contain the signature of the attending physician and the date the review was performed.

(6) The Department has prior authorized the services.

(b) Home health agencies are reimbursed for the following services furnished to MA recipients:

(1) Skilled nursing care.

(2) Home health aide services.

(3) Physical and occupational therapy.

(4) Speech pathology and audiology services.

(5) Medical/surgical supplies listed in the MA Program Fee Schedule.

Authority

The provisions of this § 1249.52 amended under sections 403(a) and (b), 443.2(2) and 509 of the Public Welfare Code (62 P.S. §§ 403(a) and (b), 443.2(2) and 509); § 1249.52(a)(1) is abrogated in part under section 2(5)(i) of the act of October 28, 2022 (P.L. 1632, No. 98).

Source

The provisions of this § 1249.52 adopted December 6, 1980, effective December 1, 1980, 10 Pa.B. 4618; amended August 12, 1988, effective September 1, 1988, 18 Pa.B. 3571; amended August 9, 1991, effective immediately and applies retroactively to May 12, 1990, 21 Pa.B. 3512; amended May 11, 2007, effective May 12, 2007, 37 Pa.B. 2185; § 1249.52(a)(1) is abrogated in part October 28, 2022 (P.L. 1632, No. 98). Immediately preceding text appears at serial pages (413373) to (413374).

Cross References

This section cited in 55 Pa. Code § 1249.51 (relating to general payment policy); and 55 Pa. Code § 1249.59 (relating to limitations on payment).

§ 1249.53. Payment conditions for skilled nursing care.

(a) Skilled nursing care is a covered home health service and is reimbursable under the MA Program if the following conditions are met:

(1) The services are ordered by and included in the plan of treatment established by the recipient's attending physician. (*Editor's Note*: Under section 2(5)(i) of the act of October 28, 2022 (P.L. 1632, No. 98) and to the extent permitted under Federal law, § 1249.53(a)(1) is abrogated to the extent that home health services are only covered and reimbursable under the medical assistance program if a physician orders the services and establishes the plan of treatment.)

(2) The services are performed by a registered nurse or a licensed practical nurse. A home health agency is not reimbursed for personal care services performed by a registered nurse or licensed practical nurse if not provided in conjunction with skilled services.

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(3) The services are reasonable and necessary to the treatment of an illness or injury. To be considered reasonable and necessary, the services furnished shall be:

(i) Consistent with the recipient's particular medical needs as determined by the recipient's attending physician.

(ii) Consistent with accepted standards of medical practice.

(b) Skilled nursing care includes, but is not limited to, the following:

(1) Observation and evaluation.

(2) Teaching and training the recipient or family members to provide care such as, but not limited to:

(i) Giving an injection.

(ii) Irrigating a catheter.

(iii) Applying dressings to wounds involving prescription medications and aseptic techniques.

(iv) Teaching the proper use of medications.

(3) Insertion and sterile irrigation of catheters.

(4) Bladder training.

(5) Administering injections.

(6) Administering enteral and intravenous total parenteral nutrition.

(7) Treating decubitus ulcers and other skin disorders.

(c) Activities, such as the administration of eye drops, topical ointments, bathing the skin and applying creams do not constitute skilled care.

Authority

The provisions of this § 1249.53 amended under sections 403(a) and (b), 443.2(2) and 509 of the Public Welfare Code (62 P.S. §§ 403(a) and (b), 443.2(2) and 509); § 1249.53(a)(1) is abrogated in part under section 2(5)(i) of the act of October 28, 2022 (P.L. 1632, No. 98).

Source

The provisions of this § 1249.53 adopted December 6, 1980, effective December 1, 1980, 10 Pa.B. 4618; amended August 12, 1988, effective September 1, 1988, 18 Pa.B. 3571; § 1249.53(a)(1) is abrogated in part October 28, 2022 (P.L. 1632, No. 98). Immediately preceding text appears at serial pages (413374) to (413375).

Cross References

This section cited in 55 Pa. Code § 1249.51 (relating to general payment policy).

§ 1249.54. Payment conditions for home health aide services.

(a) Home health aide service is a covered home health service and is reimbursable under the MA Program if the following conditions are met:

(1) The services of a home health aide are given in conjunction with skilled care or, when skilled care is not needed, when personal care services are medically necessary.

(2) The recipient record contains documentation that, at least every 2 weeks, there has been communication between the home health aide and a supervisory nurse regarding the recipient.

(3) The assignment of a home health aide to a case shall be made in accordance with a written plan of treatment established by the recipient's attending physician. The plan shall indicate the recipient's need for personal care services. The specific personal care services to be furnished by the home health aide shall be determined by a registered nurse and not by the home health aide. If skilled care is not required, the recipient's attending physician shall certify that the personal care services furnished are medically necessary. (*Editor's Note*: Under section 2(5)(ii) of the act of October 28, 2022 (P.L. 1632, No. 98)

and to the extent permitted under Federal law, § 1249.54(a)(3) is abrogated to the extent that home health aide service is only covered and reimbursable under the medical assistance program if a physician establishes the written plan of treatment and, if skilled care is not required, certifies that the personal care services are medically necessary.)

(b) Personal care services that may be performed by a home health aide include, but are not limited to, assisting the recipient with the following:

(1) Bathing and personal hygiene.

(2) Ambulation and transfer.

(3) Exercise.

(4) Administering medications specifically ordered by a physician that are ordinarily self-administered.

(5) Retraining the recipient in necessary self-help skills.

(c) Domestic and housekeeping services which are unrelated to recipient care are not covered home health services. For example, the services include the following:

(1) Vacuuming, dusting, floor mopping, kitchen and bathroom maintenance.

(2) Washing, ironing and mending clothes.

(3) Child care.

Authority

The provisions of this § 1249.54 amended under sections 403(a) and (b), 443.2(2) and 509 of the Public Welfare Code (62 P.S. §§ 403(a) and (b), 443.2(2) and 509); § 1249.54(a)(3) is abrogated in part under section 2(5)(ii) of the act of October 28, 2022 (P.L. 1632, No. 98).

Source

The provisions of this § 1249.54 adopted December 6, 1980, effective December 1, 1980, 10 Pa.B. 4618; amended August 12, 1988, effective September 1, 1988, 18 Pa.B. 3571; § 1249.54(a)(3) is abrogated in part October 28, 2022 (P.L. 1632, No. 98). Immediately preceding text appears at serial pages (413375) to (413376).

Cross References

This section cited in 55 Pa. Code § 1249.51 (relating to general payment policy).

§ 1249.55. Payment conditions for medical supplies.

(a) Home health agencies are reimbursed for medical/surgical supplies listed in the MA Program Fee Schedule. These supplies shall be prescribed by the attending physician and used by the recipient on an ongoing basis.

(b) Home health agencies are not reimbursed for supplies routinely needed as part of furnishing home health care services. Payment for these supplies is included in the comprehensive fee. Examples of the supplies are:

(1) Blood pressure equipment.

(2) Tubes for blood.

(3) Enemas.

(4) Soap.

(5) Steri-towels.

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(6) Gauze roll and pads.
(7) Adhesive tape.
(8) Gloves, sterile and nonsterile.
(9) Tongue depressors.
(10) Cotton balls.

Authority

The provisions of this § 1249.55 amended under sections 403(a) and (b), 443.2(2) and 509 of the Public Welfare Code (62 P. S. §§ 403(a) and (b), 443.2(2) and 509).

Source

The provisions of this § 1249.55 adopted December 6, 1980, effective December 1, 1980, 10 Pa.B. 4618; amended December 23, 1983, effective January 1, 1983, 13 Pa.B. 3932; amended August 12, 1988, effective September 1, 1988, 18 Pa.B. 3571; amended September 30, 1988, effective October 1, 1988, 18 Pa.B. 4418. Immediately preceding text appears at serial pages (117531) to (117532).

Cross References

This section cited in 55 Pa. Code § 1249.51 (relating to general payment policy).

§ 1249.55a. Use of the Medicare Form HCFA-485—statement of policy.

(a) Home health agencies may use Form HCFA-485 as verification of the physician's prescription for medical/surgical supplies.

(b) The requirement that medical/surgical supplies must be ordered by the attending physician on the physician's prescription pad has not changed. See Medical Assistance Bulletin No. 23-88-02, effective September 1, 1988, and § 1249.2a (relating to clarification of conditions under which MA recipients may be considered homebound—statement of policy).

Source

The provisions of this § 1249.55a adopted June 8, 1990, effective upon publication and applies retroactively to June 8, 1990, 20 Pa.B. 3085.

§ 1249.56. Payment conditions for physical therapy, occupational therapy, speech pathology and audiology services.

Home health agencies are reimbursed for physical therapy, occupational therapy, speech therapy and audiology services if the following conditions are met:

(1) The service is prescribed by the recipient's attending physician.

(2) The service is performed by a physical therapist, occupational therapist, speech therapist or audiologist currently licensed to practice in this Commonwealth.

(3) The service is reasonable and necessary for the treatment of the recipient's illness or injury. To be considered reasonable and necessary, the services furnished shall be:

(i) Consistent with the recipient's particular medical needs as ordered by the recipient's attending physician.

(ii) Consistent with accepted standards of medical practice.

Authority

The provisions of this § 1249.56 amended under sections 403(a) and (b), 443.2(2) and 509 of the Public Welfare Code (62 P. S. §§ 403(a) and (b), 443.2(2) and 509).

Source

The provisions of this § 1249.56 adopted December 6, 1980, effective December 1, 1980, 10 Pa.B. 4618; amended December 23, 1983, effective January 1, 1983, 13 Pa.B. 3932; amended August 12, 1988, effective September 1, 1988, 18 Pa.B. 3571; amended September 30, 1988, effective October 1, 1988, 18 Pa.B. 4418. Immediately preceding text appears at serial pages (117532) to (117533).

Cross References

This section cited in 55 Pa. Code § 1249.51 (relating to general payment policy).

§ 1249.57. Payment conditions for maternal/child services.

(a) *Maternal/child services*. Home health agencies are reimbursed for maternal/child services if the following conditions are met:

(1) The service is prescribed by the recipient's attending physician.

(2) The services are reasonable and necessary to the treatment of the pregnancy, illness or injury. To be considered reasonable and necessary, the services furnished must be consistent with:

(i) The recipient's particular medical needs as ordered by the recipient's attending physician.

(ii) Accepted standards of medical practice.

(b) *Postpartum and child services*. When the mother no longer requires postpartum visits for medical reasons, but the child continues to need medical services, payment will be made for the additional visits for care of the child only if the services are ordered by the attending physician and are part of a written plan of care written specifically for the child.

Authority

The provisions of this § 1249.57 issued under sections 403(a) and (b), 443.2(2) and 509 of the Public Welfare Code (62 P. S. §§ 403(a) and (b), 443.2(2) and 509).

Source

The provisions of this § 1249.57 adopted August 12, 1988, effective September 1, 1988, 18 Pa.B. 3571; amended May 11, 2007, effective May 12, 2007, 37 Pa.B. 2185. Immediately preceding text appears at serial pages (251267) to (251268).

Cross References

This section cited in 55 Pa. Code § 1249.51 (relating to general payment policy).

§ 1249.58. Payment conditions for travel costs.

A separate rate per mile will be paid, in addition to the visit fee, to cover the cost of travel to and from a recipient's home when the distance from the agency exceeds 5 miles, if transportation costs are not included in the agency's usual charge to the general public. The first 5 miles of travel cost from the agency to and from a recipient's home is included in the comprehensive per visit fee.

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Authority

The provisions of this § 1249.58 issued under sections 403(a) and (b), 443.2(2) and 509 of the Public Welfare Code (62 P. S. §§ 403(a) and (b), 443.2(2) and 509).

Source

The provisions of this § 1249.58 adopted August 12, 1988, effective September 1, 1988, 18 Pa.B. 3571.

Cross References

This section cited in 55 Pa. Code § 1249.51 (relating to general payment policy).

§ 1249.59. Limitations on payment.

The following limits apply to payment for covered services:

(1) Only one fee will be paid per home health agency visit. Payment for a visit pertains to a separate service, by a separate caregiver, to a recipient. More than one visit can be billed to the same recipient on the same day but only for separate care.

(2) After the first 28 days of unlimited home health care, payment is limited to the number of home visits specified on the MA Program Fee Schedule. A new period of unlimited care begins following hospitalization, the onset of a new primary diagnosis or the exacerbation of an existing diagnosis which causes a change in the recipient's condition and requires a change in the plan of treatment, subject to § 1249.52(a)(4) (relating to payment conditions for various services).

(3) For prenatal and postpartum care, the following limits apply:

(i) Payment for prenatal care is limited to the number of visits specified on the MA Program Fee Schedule. Complications of pregnancy are not counted as prenatal care but are classified for invoicing purposes as acute illness.

(ii) Payment for a postpartum visit includes payment for care provided the newborn child.

(4) Payment for hypodermic or intramuscular therapy provided during a home visit is included in the visit fee. If this service is provided during a recipient's visit to the home health agency, the agency will be paid at the rate specified in the MA Program Fee Schedule.

Authority

The provisions of this § 1249.59 issued under sections 403(a) and (b), 443.2(2) and 509 of the Public Welfare Code (62 P. S. §§ 403(a) and (b), 443.2(2) and 509).

Source

The provisions of this § 1249.59 adopted August 12, 1988, effective September 1, 1988, 18 Pa.B. 3571; amended May 11, 2007, effective May 12, 2007, 37 Pa.B. 2185. Immediately preceding text appears at serial pages (251268) to (251269).

Cross References

This section cited in 55 Pa. Code § 1249.51 (relating to general payment policy).

UTILIZATION CONTROL

§ 1249.71. Scope of claims review procedures.

Claims submitted for payment under the MA Program are subject to the utilization review procedures established in Chapter 1101 (relating to general provisions).

Source

The provisions of this § 1249.71 adopted December 6, 1980, effective December 1, 1980, 10 Pa.B. 4618.

ADMINISTRATIVE SANCTIONS

§ 1249.81. Provider misutilization.

Providers determined to have billed for service inconsistent with MA Program regulations, to have provided services outside the scope of customary standards of medical practice, or to have otherwise violated the standards set forth in provider agreement, are subject to the sanctions described in Chapter 1101 (relating to general provisions).

Source

The provisions of this § 1249.81 adopted December 6, 1980, effective December 1, 1980, 10 Pa.B. 4618.

APPENDIX A
[Reserved]

Source

The provisions of this Appendix A adopted December 6, 1980, effective December 1, 1980, 10 Pa.B. 4618; reserved December 23, 1983, effective January 1, 1983, 13 Pa.B. 3932. Immediately preceding text appears at serial page (75126).

[Next page is 1251-1.]

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