R414. Health and Human Services, Health Care Financing, Coverage and Reimbursement Policy.
R414-14. Home Health Services.
R414-14-1. Introduction and Authority.

(1) Home health services are part-time intermittent health care services based on medical necessity and provided to eligible persons in their places of residence when the home is the most appropriate and cost-effective setting consistent with the member's medical need. The goals of home health care are to minimize the effects of disability or pain, maintain or protect health, and prevent premature or inappropriate institutionalization.

(2) This rule is authorized under Section 26B-3-108 and governs the services allowed under 42 CFR 440.70 and 42 CFR, Part 484. 42 U.S.C. Secs. 1395u, 1395x, and 1395y also authorize home health services.

R414-14-2. Definitions.

(1) "Plan of care" means a written plan developed cooperatively by home health agency staff and an attending physician. The plan is designed to meet specific needs of an individual, is based on orders written by an attending physician, and is approved and periodically reviewed and updated by an attending physician.

(2) "Home health services" as defined in 42 CFR 440.70(b).

(3) "Home health agency visit" means a personal contact in the member's place of residence to provide a covered service.

(4) "Home health agency" means a public agency or private organization licensed to provide home health services.

(5) "Home health aide" means an individual who meets state and federal requirements of a home health aide, including those outlined in this rule, Rule R432-725, 42 CFR 440.70 and 484.80, and Sections R432-700-22 through R432-700-23.

(6) "Home health assessment visit" means a visit by a registered nurse initially or at recertification to assess the member's overall condition to determine the adaptability of the member's place of residence for the provision of health care and the capability of the member to participate in self-care. The visit also identifies family support systems or individuals willing to assume responsibility for care when the member cannot.

(7) "Skilled nursing" means services used in the treatment of an acute illness, injury, or exacerbation of a chronic illness.

(8) "Supervision" means authoritative procedural guidance by a qualified healthcare professional for the accomplishment of a function or activity.

(9) "Supportive maintenance home health" means a level of hands-on service that requires minimal assistance, observation, teaching, or follow-up essential to health care.

R414-14-3. Member Eligibility Requirements.

Home health services are available to categorically eligible and medically needy individuals.

R414-14-4. Program Access Requirements.

(1) A home health agency may only provide home health services to an individual who is under the care of a physician. An attending physician shall write the orders on which a plan of care is established and certify the necessity for home health services.

(2) A home health agency may only accept a member for home health services if there is a reasonable expectation the agency can meet the member's needs.

(3) The attending physician and home health agency personnel must review and sign a total plan of care as often as the severity of the member's condition requires, but at least once every 60 days in accordance with 42 CFR 440.70.

(4) The home health agency must provide quality, cost-effective care and a safe environment in the home through registered or licensed practical nurses who have adequate training, knowledge, judgment, and skill.

(5) The home health agency may only provide home health aide services pursuant to written instructions and under the supervision of a registered nurse by a person selected and trained to assist with routine care not requiring specialized nursing skills.

(6) Over the long-term service period, the cost to provide the required service in the member's home must be no greater than the cost to meet the member's medical needs in an alternative setting.

(7) A home health agency may provide an initial assessment visit without prior authorization to assess the member's needs and establish a plan of care. After the initial visit, home health care and service must be based on prior authorization.

(8) The home health agency must meet the face-to-face requirement, as stated in Section R414-1-30, or the Department may deny or recover reimbursement.

R414-14-5. Service Coverage.

(1) The Department covers the following two levels of home health services:

(a) skilled home health services; and

(b) supportive maintenance home health services.

(2) Skilled nursing services encompass the expert application of nursing theory, practice and techniques by a registered professional nurse to meet the needs of members in their place of residence through professional judgments, through independently solving member care problems, and through application of standardized procedures and medically delegated techniques.

(3) Home health aide service encompasses assistance with, or direct provision of, routine care not requiring specialized nursing skill. The home health aide is closely supervised by a registered, professional nurse to assure competent care. The aide works under written instructions and provides necessary care for the member.

(4) Supportive maintenance home health care serves members with a stabilized medical condition who continue to demonstrate health problems that require minimal assistance, observation, teaching, or follow-up. A certified home health agency may provide this assistance through the knowledge and skill of a licensed practical nurse (LPN) or a home health aide with periodic supervision by a registered nurse. A physician continues to provide direction.

(5) Home health agencies provide IV therapy, enteral and parenteral nutrition therapy either in conjunction with skilled or maintenance care or as the only service to be provided. Specific policy is outlined in the Medical Supplies and Durable Medical Equipment Utah Medicaid Provider Manual, and requirements of the home health program must be met in relation to orders, plan of care, and 60-day review and recertification.

(6) Physical therapy and speech-language pathology services are occasionally indicated and approved for a member who needs home health services. Any therapy services offered by the home health agency directly or under arrangement must be ordered by a physician and provided by a qualified licensed therapist in accordance with the plan of care. Occupational therapy and speech-language pathology services in the home are available only to members who are pregnant women or who are eligible under the Early and Periodic Screening, Diagnostic and Treatment Program (EPSDT).

(7) Medical supplies utilized for home health service must be consistent with physician orders, and approved as part of the plan of care.

(8) Medical supplies provided by the home health agency do not require prior approval, but are limited to:

(a) supplies used during the initial visit to establish the plan of care;

(b) supplies that are consistent with the plan of care; and

(c) non-durable medical equipment.

(9) Supportive maintenance home health services are limited in time equal to one visit a day determined by care needs and caregiver participation.

(10) A registered nurse employed by an approved, certified home health agency must supervise home health services. An appropriate licensed professional must provide nursing and approved therapy services.

(11) Only one home health provider may provide service to a member during any period. A subcontractor of a home health provider, however, may provide services if the original agency is the only provider that bills for services. The Department shall deny a second provider or agency that requests approval of services.

(12) Medicaid does not cover home health care provided to a member capable of self-care.

(13) Medicaid does not cover personal care services, except as determined necessary in providing skilled care.

(14) Medicaid does not cover housekeeping or homemaking services.

(15) Medicaid does not cover occupational therapy except for children covered under the Child Health Evaluation and Care Program (CHEC) for medically necessary services.

(16) Home health nursing services beyond the initial evaluation visit require prior authorization.

(17) Home health services beyond the initial visit, including supplies and therapies, must be in the plan of care that the home health agency submits for prior authorization. After initial authorization, if level of service needs change and additional services are required, the home health agency must submit a new prior authorization request.

(18) A home health agency may provide therapy services only in accordance with medical necessity and after receiving prior authorization.

R414-14-6. Reimbursement for Services.

(1) Pursuant to Section 26B-3-116, the Department may not reimburse a home health agency, as defined by Section 26B-2-201, for home health services unless the agency has liability coverage of at least $500,000 for each incident.

(2) Home health agencies shall provide proof of liability coverage compliant with Subsection (1) within 30 days of request by the Department.

(3) In addition to other remedies allowed by law, the Department may withhold payment and end a provider agreement if a home health agency does not provide proof of liability coverage compliant with Subsection (1).

(4) The Department shall reimburse for home health services in accordance with Attachment 4.19-B of the Medicaid State Plan.

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