




**DELAWARE HEALTH AND SOCIAL SERVICES DIVISION OF
MEDICAID & MEDICAL ASSISTANCE
DELAWARE MEDICAL ASSISTANCE PROGRAM
HOME HEALTH PROVIDER SPECIFIC POLICY MANUAL**

 <p>DELAWARE HEALTH AND SOCIAL SERVICES</p> <p>DIVISION OF MEDICAID & MEDICAL ASSISTANCE</p> <p><i>Delaware Medical Assistance Program</i></p>	<h2>Home Health Provider Specific Policy Manual</h2>
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Revision Date	Sections Revised	Description
7/1/02	All	Complete manual revision to reflect changes related to the MMIS and HIPAA compliance.
10/1/02	6.1.6, 6.1.8, 6.3.10, 7.1.1.3	1) In-home skilled nursing assessments that require more than 2 hours will need to be prior authorized. 2) Skilled nursing visits are limited to 2 per day and each visit must not exceed 45 minutes each. Additional visits must be prior authorized. This applies to all ages. 3) Home health aide services are limited to 2 hours per day. Additional hours must be prior authorized. This applies to all ages.
7/1/02	Opening Disclaimer	The change in language in the opening disclaimer is to make providers aware that there are required forms and procedures related to the Diamond State Partners.
1/18/03	4.2, 4.21, 6.2.9, 7.1.1.9	1) Providers have asked for guidance on how to determine when to round up or down when billing 15 minute increments. A chart is added to assist providers in determining the number of units to bill. 2) Currently, the policy includes the limit for each home health service, but does not include the number of skilled rehab visits covered per day. To be consistent , the skilled rehab limits are being added.
10/16/03	3.2.1, 6.1	1) Clarifying definition of skilled nursing visit. The clarification clearly indicates that behavioral health services are not covered by DMAP as a home health benefit. This clarification of policy is reflected in Sections 3.2.1 and 6.1.4 . 2) In compliance with the Newborns' and Mothers' Health Protection Act of 1996, the early postpartum discharge in-home assessment policy is being updated to include change in hospital stay for vaginal/cesarean delivery. "First-time mom/baby" postpartum visit is being added to Section 6.1.9 which entitles this population to the same services. 3) Portions of Section 6.1 are being renumbered so text can be put in a more appropriate order. Many of the numbers are being removed and replaced a bullet or other identifying symbol. Also, in this section, all mention to specific sections of the manual are being replaced by the Name of the section.
11/5/03	12.0	Home Health agencies must use a HCPCS procedure code

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		along with Revenue Center Codes when billing the DMAP for services. Revenue Center Codes are being added to the HCPCS procedure code table in Appendix B. This addition will assist providers when billing the DMAP.
6/28/04	7.2.1	Corrected phone number for Medical Review Team in the Robscott Building.
8/20/04	8.1.2, 11.0 and 12.0	Providers no longer use local codes to bill for DMAP services. Therefore, Appendix A and all references are removed.
1/26/06	7.2.1	Revised to reflect address change for PAs.
1/26/06	7.2.2	Added reference to the PA form located in the General Policy Manual.
1/26/06	7.2.2.1-7.2.2.4	Deleted
1/26/06	7.2.3	Revised section
1/26/06	7.2.3-7.2.3.4	Renumbered sections to maintain consistency.
1/26/06	7.2.3.2	New section number and placement.
9/18/08	Overview	Removed obsolete numbering.
12/09/08	6.1.9	Clarification made to early postpartum discharge in-home assessment.
4/19/10	6.1.6, 6.2.7.1 and 6.3.11.1	Replaced references to Mentally Retarded with Developmentally Disabled.
12/20/10	3.0 and 5.0	Effective 01/01/2011 the Affordable Care Act mandates the face-to-face encounter requirement.
04/20/11	3.4, 5.2.2, 5.2.3, 5.2.4	Updated the face to face federal requirement which overrides the 01/01/2011 requirement and is effective 04/01/2011.
8/29/11	5.2	Updated the face-to-face policy. The policy changes in 5.2 override the policy updates published on 04/20/2011.
8/9/12	5.2.3	Added provider type to list of practitioners who may perform a face-to-face encounter.
01/01/2016	Introduction	Updated policy manual to reflect the removal of Diamond State Partners (DSP) language, program ended 12/31/2014.
01/01/2019	2.0, 3.5	Updated sections to reflect the acceptance of accreditation in lieu of or in conjunction with Medicare certification in accordance with the State Plan.
01/01/2019	All	Complete manual revision to align with the Delaware Medicaid Enterprise System (DMES) and the Delaware Medical Assistance Portal.
02/15/2020	1,3,5,6 and 7	Sections updated in compliance with 42 CFR 440.70.
02/15/2020	2.1	Section updated in accordance with 42 CFR 484.102 to require Home Health Agencies to comply with all Federal, State and local emergency preparedness statutes as a condition of

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		participation in the DMAP.
02/15/2020	All	In compliance with the registered trademark of the American Medical Association added the ® symbol to each instance of CPT®.

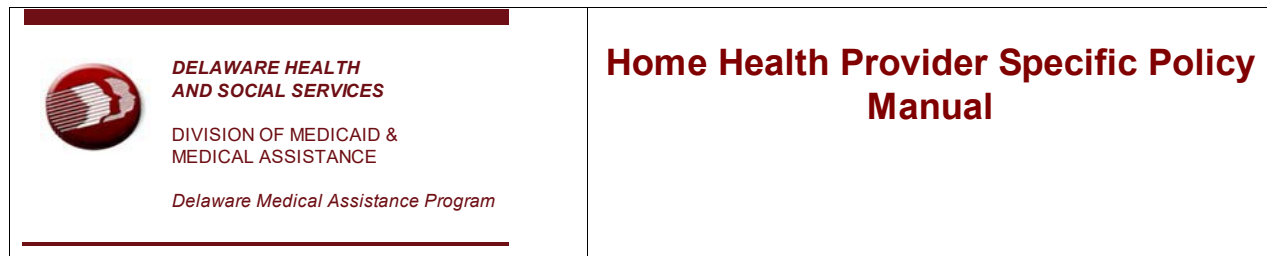


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Home Health Provider Specific Policy

Health care services are provided to the majority of Medicaid members through a Managed Care Organization (MCO). Home health care services are included in the MCO benefits package. All Medicaid members who are enrolled with an MCO must receive home health services through the MCO.

This manual is to be used in conjunction with the [General Policy Manual](#) and the [General Billing Manual](#) which are located on the [Delaware Medical Assistance Portal](#) for providers.

1.0 Overview

1.1 General Information

- 1.1.1 Home health services are required to be provided in accordance with guidelines found in this policy manual. This policy manual implements the following requirements for Home Health Agency (HHA) services and additional requirements considered necessary to ensure the health and safety of patients.
 - 1.1.1.1 The HHA and its staff must operate and furnish services in compliance with all applicable federal, state and local laws and regulations.
 - 1.1.1.2 The HHA will ensure that professional licenses of staff members are current.
 - 1.1.1.3 The HHA and its staff must comply with acceptable standards and principles that apply to professionals furnishing services in a HHA.
 - 1.1.1.4 The HHA will ensure that competency evaluations of staff members are current.
 - 1.1.1.5 In compliance with 42 CFR 440.70, DMAP does not limit home health services to members who are homebound. Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the HHA in the patient's place of residence or any setting in which normal life activities take place (refer to 3.7).
 - 1.1.1.6 Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy or podiatric medicine.
- 1.1.2 It is the responsibility of the HHA to maintain a detailed record that clearly documents the requirements cited in this policy. Claims for payment may be denied or dollars recovered if the record is insufficient.
- 1.1.3 Supplies provided by the HHA and used during the home health visit are included in the reimbursement for the nurse, therapist, or home health aide.

- 1.1.3.1 Supplies are defined as any health care related items that are disposable or consumable or cannot withstand repeated use by more than one individual or are required to address an individual medical disability, illness or injury. Supplies are non-durable medical materials incidental to the skilled nursing, therapist, or aide visit, and provided by the HHA for the treatment or services prescribed by the patient's plan of care. Supplies may not be billed separately by the HHA. Refer to the [Durable Medical Equipment Provider Policy Manual](#) for additional requirements.
- 1.1.4 Travel cost is included in the reimbursement rate. The HHA may not bill the DMAP for travel time. The time billed for the aide or skilled visit may only be for the actual time spent with the patient.
- 1.1.5 When home health services have been established and additional services are requested from another agency, prior authorization is required for the additional services to ensure coordination of care (refer to Section 7.0).
- 1.1.6 The DMAP will not reimburse a HHA for the services of a medical social worker or any other service that is not medical in nature.
- 1.1.7 The DMAP will not reimburse a HHA for providing respite care. Respite care is not a covered service through a home health benefit.

2.0 Qualified Providers

2.1 Requirements

- 2.1.1 Home Health Agencies must be certified by Medicare and/or possess current accreditation from at least one of the national accreditation organizations. A current list of the approved accreditation organizations can be found at the [National Association for Home Care and Hospice](#). Home Health Agencies must be properly licensed by the State in which they are located.
- 2.1.2 **Emergency Preparedness**
As a condition of participation in the DMAP, Home Health Agencies must establish and maintain an emergency preparedness program in accordance to 42 CFR §484.102. The emergency preparedness program must comply with all applicable Federal, State, and local emergency preparedness requirements.
- 2.1.3 Home Health Agencies that provide private duty nursing (PDN) services should request and review the PDN Provider Specific Policy Manual.
- 2.1.4 Home Health Agencies that provide EPSDT Intermittent Nursing Services should review the EPSDT section of the [General Policy Manual](#).

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3.0 Definitions

For the purpose of this policy manual, unless the context indicates otherwise, the following phrases/words are defined as:

3.1 Home Health Services

Those services that are provided to a patient:

3.1.1 At the patient's place of residence or any setting in which normal life activities take place. Home health services cannot be limited to services furnished to members who are homebound. (refer to 3.7).

3.1.2 On an attending physician's order as part of a written plan of care. The plan of care must be reviewed by the attending physician every sixty days or more often if the member's condition(s) suggest a need to alter the plan of care.

3.2 Home Health Agency Services

Home health agency services include the following services:

3.2.1 Skilled nursing service, as defined in the State Nurse Practice Act that is provided on a part-time or intermittent basis. A skilled nursing visit, for the purpose of providing a behavioral health service, is not covered by DMAP as a home health benefit.

3.2.2 Home health aide service provided by a home health agency.

3.2.3 Physical therapy, occupational therapy, speech pathology, or audiological services.

3.3 Clinical Note

A recording of a contact with a patient that is written, dated and signed. The clinical note describes signs and symptoms, administration of treatments and medications along with the patient's response that includes any changes in the patient's physical and/or mental condition.

3.4 Face-to-Face Encounter

The initial certification documentation in which the certifying physician or specified non-physician practitioner has had a face-to-face encounter with the patient, incident to the services involved. For details and requirements, see section 5.0 Qualifications for Services subsection 5.2.

3.5 Home Health Agency (HHA)

A public or private agency or organization, or part of an agency or organization, that meets the requirements for participation in Medicare and/or any additional

standards legally promulgated by the State that are not in conflict with Federal requirements.

3.6 Medically Necessary Services or the Medical Necessity of Services

Those services required to treat a diagnosed medical condition or the effects of the condition of the beneficiary and is:

- 3.6.1 The most appropriate level of service that can be safely provided
- 3.6.2 The appropriate with regard to standards of professional practice, and
- 3.6.3 Not solely for the beneficiary's or beneficiary's family's convenience, the provider's convenience or the convenience of any other individual.

NOTE: Refer to Appendix H in the General Policy for the DMAP's complete definition of medical necessity.

3.7 Place of Residence

A person's primary permanent dwelling. When medically necessary, skilled nursing services may be provided at other locations when the member is required to be away from their primary permanent dwelling during some part of the day or for a temporary period of time. This section should not be interpreted to prohibit a member from receiving home health services in any setting in which normal life activities take place other than a hospital, nursing home, intermediate care facility for individuals with intellectual disabilities; or any setting in which payment is or could be made under DMAP for inpatient services that include room and board.

A person's place of residence, for the purpose of home health services does not include a hospital, nursing facility, or other places where medical professionals are available to provide the necessary services.

Examples of other places where medical professionals are available to provide the necessary services are, but not limited to, Adult Day Care Centers or Prescribed Pediatric Extended Care Centers (PPEC).

3.8 Professionally Recognized Standards of Health Care

For the purpose of this manual, are statewide or national standards of care, whether in writing or not, that professional peers of the individual or entity whose provision of care is an issue, recognize as applying to those peers practicing or providing care within a State.

Where the Food and Drug Administration (FDA), the Center for Medicare and Medicaid Services (CMS), or the Public Health Service (PHS) has declared a treatment modality not to be safe and effective, practitioners who employ such a treatment modality will be deemed not to meet professionally recognized standards of health care. This definition shall not be construed to mean that all other treatments meet professionally recognized standards.

3.9 Progress Notes

Written notations, dated and signed by a member of the health team, which summarizes facts related to the care provided and includes the patient's response during a given period of time.

3.10 Respite Care

Care given in order to provide intervals of rest and relief to caregivers. Respite care is not a covered service through the home health benefit.

3.11 Summary Report

The compilation of the pertinent factors of a patient's clinical notes and progress notes. The summary report is submitted to the patient's attending physician.

3.12 Supervision

Authoritative procedural guidance by a qualified person for the accomplishment of a function or activity.

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4.0 Reimbursement

4.1 Methodology

- 4.1.1 Providers of home health services will be reimbursed prospectively determined rates based on costs reported by each agency.
- 4.1.2 Providers will be reimbursed prospectively the lower of their usual and customary (U&C) charge or the rate.
- 4.1.3 Reimbursable costs are those allowable by Medicare and are subject to caps and ceilings determined by Medicaid. The cost report used in the rate calculation will represent the most recent State audited provider fiscal year.
- 4.1.4 Providers are required to submit cost reports to Medicaid annually in the Medicare format.
- 4.1.5 Skilled nursing and therapy services are reimbursed per 15-minute increments.
- 4.1.6 Home health aide services are reimbursed in 1/4 hr. (15 minute) units. Providers should bill the number of units that represent the amount of time the aide provided a reimbursable service.
- 4.1.7 The reimbursement includes all supplies used during the provision of service.
- 4.1.8 Travel time is also included in the reimbursement rate.

4.2 Counting of 15-Minute Increments

- 4.2.1 Visits are to be rounded to the nearest 15-minute increment. The following chart is to be used to assist providers in determining the number of units to be billed:

1 unit	1 minute to <23 minutes
2 units	>23 minutes to <38 minutes
3 units	>38 minutes to <53 minutes
4 units	>53 minutes to <68 minutes
5 units	>68 minutes to <83 minutes
6 units	>83 minutes to <98 minutes
7 units	>98 minutes to <113 minutes
8 units	>113 minutes to <128 minutes

NOTE: Unless prior authorized, providers cannot exceed the limited number of units assigned to each home health service (6 units for skilled nursing; 8 units for in-home assessment; 4 units for physical, occupational, and speech therapy; and 8 units for home health aide services).

5.0 Qualifications for Services

5.1 General Criteria

- 5.1.1 The member of the services must be eligible for Medical Assistance on the dates home health services are delivered. Home health services are included as part of the Managed Care Organization (MCO) benefits package. Members who are enrolled with an MCO must receive home health services through their MCO. The HHA may not bill the DMAP for these services. For additional information, refer to the [General Policy Manual](#), Medical Assistance Card section.
- 5.1.2 The need for home health care must fall into at least one of the three categories of service listed under Specific Criteria (refer to Section 6.0) and meet the technical criteria for that category.
- 5.1.3 The home health service must be provided at the member's place of residence (refer to Section 3.7) or any setting in which normal life activities take place. Home health services cannot be limited to services furnished to members who are homebound.
- 5.1.4 Prior authorization must be obtained in situations where there are multiple members in the same household requiring home health services from the same agency and/or multiple members in the same household requiring home health services from multiple agencies. The service requirements will be evaluated by the Medical Review Team on an individual basis. Medical necessity in these situations will be those services required to identify or treat any illnesses or injuries collectively for the individuals requiring home health services (refer to Section 7.0).
- 5.1.5 The HHA shall assure that all services delivered by the agency are medically necessary and reasonable and that the residence or setting is the most appropriate place to deliver the services.
- 5.1.5.1 The HHA must maintain adequate documentation of the service provided. All entries must be signed and dated by the person rendering the service.
- 5.1.6 The HHA will bear fiscal responsibility for all cases determined to be out of compliance.

5.2 Face-To-Face Encounter Requirement

- 5.2.1 Home health services such as home health aide, skilled nursing, physical, or speech therapy services must comply with the face-to-face encounter requirement. For a definition, see section 3.0 Definitions subsection 3.4.

- 5.2.2 A face-to-face encounter must occur no more than 90 days prior to the home health start-of-care date:
- If there is a significant change to the member's medical condition prior to the start of care date, a second face-to face encounter **must occur within 30 days** of the second home health episode.
 - If the patient has not seen the certifying physician or non-physician practitioner within the 90 days, a face-to-face encounter **must occur within 30 days of the start of the home health care date.**
- 5.2.3 The face-to-face encounter must be performed by a certifying physician or non-physician practitioner defined as: a nurse practitioner, clinical nurse specialist, a certified nurse-midwife, a physician assistant, or a physician signing acute care discharge orders. The certifying physician or non-physician practitioner may not have a financial relationship with the HHA as defined in 42 CFR § 424.22(d).
- 5.2.4 Only the certifying physician can document the face-to-face encounter on the patient's certification. Non-physician practitioners who perform the face to face encounter must document the clinical findings of that encounter and communicate those findings to the certifying physician. Support staff are able to extract the face-to-face documentation for the certifying physician to sign.
- 5.2.5 The patient's face-to-face encounter must be clearly titled, dated, and signed by the certifying physician with documentation indicating who performed the face-to-face encounter. This must be easily identifiable on a separate and distinct area of the certification, or a separate and distinct addendum to the certification.
- 5.2.6 The face-to-face documentation must describe how the clinical findings of that encounter support the findings that the patient was in need of intermittent skilled nursing and/or physical or speech therapy.
- 5.2.7 The patient's initial face-to-face certification remains valid and continuous when primary coverage transitions from Medicare to Medicaid.
- 5.2.8 The face-to-face encounter may occur through telehealth, as implemented by the state.

5.3 Written Plan of Care

- 5.3.1 The HHA must maintain a written plan of care established, signed, and dated by the attending practitioner that documents medical necessity and contains the following components:

- 5.3.1.1 Diagnoses, prognosis, symptoms, complaints and complications that justify that the residence is the most appropriate place to deliver the services
- 5.3.1.2 A description of the mental and physical functional level, rehabilitation potential, activities permitted, and nutritional requirements of the individual
- 5.3.1.3 Orders for medications, treatments, special therapies, supplies and durable medical equipment including the specific procedures and modalities to be used
- 5.3.1.4 Orders for skilled nursing and rehabilitation visits that clearly specify amount, frequency and duration of the required home health services. Orders for home health aide (with or without skilled service) should include units per visit in addition to the above requirements
- 5.3.1.5 Safety measures to protect against injury.
- 5.3.2 Review of the plan of care by the attending physician as often as the severity of the patient's condition requires, but at least every sixty days. The HHA should alert the practitioner to any changes that suggest a need to alter the plan of care.

6.0 Specific Criteria

6.1 Skilled Nursing Services

- 6.1.1 The member of skilled nursing services needs part-time or intermittent skilled nursing. Supervision of a home health aide does not qualify as a skilled nursing service.
- 6.1.2 HHA services require a referral that includes a Plan of Care from a doctor of medicine, osteopathy.....(42CFR 484.18). If the attending physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the attending physician is consulted to approve additions or modifications to the original plan and the established written plan of care is signed and dated by the attending physician and HHA personnel every 60 days or as often as the severity of the patient's condition requires or when other changes occur that may impact the patient's care needs. Agency professional staff shall promptly alert the physician to any changes that suggest a need to alter the plan of care.
- 6.1.3 The HHA is responsible for maintaining the following documentation for patients who receive skilled nursing services:
- 6.1.3.1 Clinical note for each contact,
- 6.1.3.2 Appropriate summary notes and progress notes, and
- 6.1.3.3 Initial assessments.
- 6.1.4 If a condition exists that does not meet the requirements noted for skilled nursing services, but requires skilled service, prior authorization must be obtained (refer to Obtaining Prior Authorization section of this manual).
- 6.1.5 Skilled nursing visits are limited to two (2) per day. Each visit is not to exceed forty-five (45) minutes. If a condition exists that requires more than two (2) nursing visits, prior authorization must be obtained for the additional visits (refer to Obtaining Prior Authorization section of this manual).
- 6.1.6 This category of service is available to certain members on a restricted basis through the Long Term Care Community Services Program (LTCCS):
- Services for members in supervised living arrangements (includes neighborhood group homes, staffed and supervised apartments) who receive Medical Assistance through the Division of Developmental Disabilities Services (DDDS) Lifespan Waiver for persons with Intellectual

Developmental Disabilities must receive prior authorization from the DMAP staff (refer to Obtaining Prior Authorization section of this manual).

- Services for members who receive Medical Assistance through the LTCCS must be approved by the program case manager. This includes individuals who are elderly, have physical disabilities (including acquired brain injuries), and other diagnoses (including Acquired Immune Deficiency Syndrome AIDS or HIV-Related Diseases).

6.1.7 Home health services provided to non-waiver members living in rest/residential care (family care) homes (also known as "adult foster care" members) require prior authorization (refer to Obtaining Prior Authorization section of this manual).

6.1.8 Place of residence is a person's primary permanent dwelling or any setting in which normal life activities take place. Nursing visits must be prior authorized. Additional services or service hours may be authorized to account for medical needs that arise in the settings where home health services are provided (refer to [Obtaining Prior Authorization](#) section of this manual). A person's place of residence, for the purpose of home health services does not include a hospital, nursing facility, or other places where medical professionals are available to provide the necessary services.

6.1.9 In order to qualify for skilled nursing services, the patient must meet all General Criteria listed in the Qualifications for Services section 5.1 of this manual plus one or more of the following specific criteria except for early postpartum discharge in-home assessment, bullet number 12.

- Intravenous, intramuscular, or subcutaneous injections and hypodermoclysis or intravenous feeding;
- Levin tube and gastrostomy feedings;
- Tracheostomy care;
- Care of a ventilator dependent patient;
- Nasopharyngeal and tracheostomy aspiration;
- Insertion and sterile irrigation and replacement of catheters;
- Application of dressings involving prescription medications and aseptic techniques;
- Treatment of extensive decubitus ulcers or other widespread skin disorder;
- Initial phases of a regimen involving administration of

oxygen;

- Skilled observation and monitoring of the patient's condition (does not include the observation and monitoring of patient's behavioral health condition);
- Evaluation and initiation of appropriate preventive and rehabilitative nursing procedures, including the related teaching and adaptive aspects of nursing, e.g., implementation and supervision of bowel and bladder training programs;
- Early postpartum discharge in-home assessment does not need to meet all of the general criteria as listed in section 5.1 of this manual but rather must meet the subsequent criteria - Early discharge is defined as a hospital stay less than 48 hours following a vaginal delivery, or 96 hours following a cesarean delivery. The inpatient time count starts at the time of delivery. Early postpartum discharge and "first-time mom/baby" postpartum visit includes the following services.
 1. Assessment includes the mother and infant(s) and must be billed under the mother's Medical Assistance ID number. If the mother is not Medicaid eligible, the assessment must be billed under the infant's Medical Assistance ID number.
 2. Reimbursement for an in-home assessment is limited to no more than two hours (8) units. If an in-home assessment requires more than two hours, the additional units must be prior authorized. The home health agency must submit documentation to the Medical Review Team to support the additional units (refer to Obtaining Prior Authorization section of this manual). The in-home assessment includes, but is not limited, to the following components:
 - a. Visit mother and infant(s) within twenty-four to seventy-two hours of discharge from the hospital or birthing center.
 - b. Conduct complete physical assessment of mother and infant(s) during home visit.
 - c. Observe and assess infant feeding. Check mothers and infants feeding ability and quantity of feedings.
 - d. Assess maternal-infant bonding and family adaptation.
 - e. Assess psycho social and home environmental and safety factors.

- f. Provide family with information/education and support regarding infant feeding, infant care, post partum care, family concerns, and signs/symptoms of complications.
- g. Encourage visit for infant(s) to physician within two weeks of birth.
- h. Draw blood as requested for neonatal screening for inborn errors of metabolism or bilirubin.
- i. Address mother's need for postpartum follow-up care and review family planning measures, if mother is receptive.
- j. Notify attending physician's office of significant variations in infant status as reported upon referral, including:
 - Concern with infant hydration and feeding;
 - Concern with maternal and family adaptation;
 - Infant or mother abnormalities in the physical assessment;
 - Unable to contact for visit or family refuses entry.

6.2 Skilled Rehabilitation Services

- 6.2.1 The member of skilled rehabilitation services needs part-time or intermittent skilled rehabilitation services. Supervision of a home health aide does not qualify as a skilled rehabilitation service.
- 6.2.2 HHA services require a referral that includes a Plan of Care from a doctor of medicine, osteopathy.....(42CFR 484.18). If the attending physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the attending physician is consulted to approve additions or modifications to the original plan and the established written plan of care is signed and dated by the attending physician and HHA personnel every 60 days or as often as the severity of the patient's condition requires or when other changes occur that may impact the patient's care needs. Agency professional staff shall promptly alert the physician to any changes that suggest a need to alter the plan of care.
- 6.2.3 The HHA must complete the following documentation requirements for patients who receive skilled rehabilitation services:
- 6.2.3.1 Clinical note for each contact;

- 6.2.3.2 Appropriate summary notes and progress notes;
- 6.2.3.3 Initial assessment.
- 6.2.4 In order to qualify for skilled rehabilitation services, the patient must meet all General Criteria listed (refer to Section 5.0) plus one or more of the following specific criteria.
- 6.2.5 The following services qualify as skilled rehabilitation services and must be performed by a qualified/licensed physical, occupational, or speech therapist. Skilled rehabilitation services may also be performed by qualified/licensed physical, occupational, and speech therapy assistants under the supervision of a qualified/licensed physical or occupational therapist, or speech pathologist or audiologist (42 CFR 484.32).
- 6.2.5.1 On-going assessment of rehabilitation needs and potential - Services that are concurrent with the management of a patient care plan, including tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, activities of daily living, perceptual deficits, speech and language or hearing disorders.
- 6.2.5.2 Therapeutic exercises or activities - Therapeutic exercises or activities which, because of the type of exercises employed or the condition of the patient, must be performed by a qualified physical therapist or occupational therapist to ensure safety of the patient and the effectiveness of the treatment.
- 6.2.5.3 Gait evaluation and training - Gait evaluation and training furnished to restore function in a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality.
- 6.2.5.4 Range of motion exercises - Range of motion exercises that are part of the active treatment of a specific disease state which has resulted in a loss of, or restriction of, mobility (as evidenced by a therapist's notes, or progress notes, showing the degree of motion lost and the degree to be restored).
- 6.2.5.5 Speech Therapy - Services of a speech therapist when necessary for the restoration of function.
- 6.2.6 If a condition exists that does not meet the requirements noted for skilled rehabilitation services, but requires a skilled service, prior authorization must be obtained.
- 6.2.7 This category of service is available to certain members on a restricted basis through the Long Term Care Community Services Program (LTCCS):

- 6.2.7.1 Services for members in supervised living arrangements (includes neighborhood group homes, staffed and supervised apartments) who receive Medical Assistance through the DDDS Lifespan Waiver for persons with Intellectual Developmental Disabilities must receive prior authorization from the DMAP staff (refer to Section 7.0).
- 6.2.7.2 Services for members who receive Medical Assistance through the LTCCS must be approved by the program case manager. This includes individuals who are elderly, have physical disabilities (including acquired brain injuries), and other diagnoses (including Acquired Immune Deficiency Syndrome AIDS or HIV-Related Diseases).
- 6.2.8 Home health services provided to non-waiver members living in rest/residential care (family care) homes (also known as “adult foster care” members) require prior authorization (refer to Section 7.0).
- 6.2.9 Skilled rehabilitation visits are limited to 1 per day and are not to exceed 1 hour per visit (4 units of service). If a condition exists that requires more than 1 visit per day or that will exceed 1 hour in duration, prior authorization must be obtained for the additional time (refer to Section 7.0 of this manual).

6.3 Home Health Aide Services

- 6.3.1 The member of home health aide services needs part-time or intermittent services by a home health aide (extended home health aide program).
- 6.3.2 Home health aides must function under the supervision of a registered nurse and must meet the certification requirements specified in 42 CFR 484.36.
- 6.3.2.1 Supervision of a home health aide does not qualify as a skilled nursing or skilled rehabilitation service. Reimbursement for the nursing supervision of a home health aide is rolled into the reimbursement for aide service and may not be billed separately. The home health aide supervisory visit includes:
- 6.3.2.1.1 Reviewing the plan of care;
- 6.3.2.1.2 Evaluating the home health aide;
- 6.3.2.1.3 Assessing the member.
- 6.3.3 The home health aide must have written instructions for the member’s care that are prepared by a registered nurse or therapist.
- 6.3.4 The home health aide must complete the following documentation requirements for patients who receive home health aide services:

- 6.3.4.1 Documentation indicating time that care was initiated and completed.
- 6.3.4.2 Documentation of specific care that was provided.
- 6.3.5 In order to qualify for home health aide services, the member must meet all General Criteria listed (refer to Section 5.0), have a medical diagnosis, and need one of the following medically oriented services:
 - 6.3.5.1 Assistance to the patient in self-administering of medications;
 - 6.3.5.2 General maintenance care of colostomy and ileostomy;
 - 6.3.5.3 Routine services to maintain satisfactory functioning of indwelling bladder catheters;
 - 6.3.5.4 Non-sterile changes of dressing for non-infected post-operative or chronic conditions;
 - 6.3.5.5 Prophylactic and palliative skin care;
 - 6.3.5.6 Assistance in bathing, dressing, eating, and going to the toilet;
 - 6.3.5.7 Periodic turning and positioning in bed;
 - 6.3.5.8 Therapeutic exercises or activities performed under the supervision of a qualified therapist.
- 6.3.6 If conditions exist that are not listed above, prior authorization must be obtained (refer to Section 7.0).
- 6.3.7 The HHA may only bill the DMAP for time spent in the actual delivery of care as per criteria. The HHA may not bill the DMAP for services that are non-medical in nature.
- 6.3.8 Travel cost is included in the reimbursement rate. The HHA may not bill the DMAP for travel time. The time billed for the aide or skilled visit may only be for the actual time spent with the patient.
- 6.3.9 HHA services require a referral that includes a Plan of Care from a doctor of medicine, osteopathy..... (42CFR 484.18). If the attending physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the attending physician is consulted to approve additions or modifications to the original plan and the established written plan of care is signed and dated by the attending physician and HHA personnel every 60 days or as often as the severity of

the patient's condition requires or when other changes occur that may impact the patient's care needs. Agency professional staff shall promptly alert the physician to any changes that suggest a need to alter the plan of care.

- 6.3.10 Medicaid reimbursement for home health aide services is limited to a maximum of two hours per day. The number of weeks/days/hours that the service is medically necessary must be prescribed. If a condition exists that requires more than the maximum, prior authorization must be obtained for additional units (refer to Section 7.0 of this manual).
- 6.3.11 This category of service is available to certain members on a restricted basis through the Long Term Care Community Services Program (LTCCS):
 - 6.3.11.1 Services for members in supervised living arrangements (includes neighborhood group homes, staffed and supervised apartments) who receive Medical Assistance through the DDDS Lifespan Waiver for persons with Intellectual Developmental Disabilities must receive prior authorization from the DMAP staff (refer to Section 7.0).
 - 6.3.11.2 Services for members who receive Medical Assistance through the LTCCS must be approved by the program case manager. This includes individuals who are elderly, have physical disabilities (including acquired brain injuries), and other diagnoses (including Acquired Immune Deficiency Syndrome AIDS or HIV-Related Diseases).
- 6.3.12 Home health services provided to non-waiver members living in rest/residential care (family care) homes (also known as "adult foster care" members) requires prior authorization (refer to Section 7.0).

7.0 Obtaining Prior Authorization

7.1 Requirements

- 7.1.1 Prior authorization is required for the following home health services:
- 7.1.1.1 Where there are multiple members in the same household requiring home health services from the same agency and/or multiple members in the same household requiring home health services from multiple agencies;
 - 7.1.1.2 If skilled nursing visits exceed two per day;
 - 7.1.1.3 Members who may require home health aide service for more than two hours per day;
 - 7.1.1.4 If a medical condition exists that is not listed in the Specific Criteria (refer to Section 6.0);
 - 7.1.1.5 When additional home health services are requested for the same member from a second agency;
 - 7.1.1.6 DDDS Lifespan Waiver for Persons with Intellectual Developments Disabilities members needing skilled nursing, therapy, or aide services;
 - 7.1.1.7 For individuals residing in adult foster/residential homes;
 - 7.1.1.8 Members who may require more than one skilled rehabilitation visit per day or more than one hour (4 units) in duration.

7.2 Prior Authorization Requests

- 7.2.1 The attending physician, family, member, or the HHA should direct requests for prior authorization to:

DMMA Prior Authorization/Lewis Building 1901 N. DuPont Highway, PO BOX 906 New Castle DE, 19720 Phone (302) 255-9654 Fax (302) 255-4481

- 7.2.2 The request must include a completed Prior Authorization Form (refer to Appendix M in the General Policy Manual).
- 7.2.3 The following information may also be needed:
- 7.2.3.1 Nursing assessment and plan of care. Plan of care includes rehabilitation goals and objectives designed to restore, improve, or maintain the patient's optimal level of functioning, self-care, self-responsibility, independence, and quality of life. Assessment includes, but is not limited to the following components:
- 7.2.3.1.1 Physical assessment and diagnosis;
- 7.2.3.1.2 Psycho-social assessment including home, family and environmental factors;
- 7.2.3.1.3 Level of function (physical, mental, developmental);
- 7.2.3.1.4 Availability and ability of caretaker to maintain member in the home (e.g., knowledge of emergency procedures).
- 7.2.3.2 Detailed medical history that documents the need for the home health service requested.
- 7.2.4 It is the responsibility of the HHA to obtain a copy of the attending physician's plan of care prior to the delivery of services.
- 7.2.5 The HHA will receive a letter that will detail prior authorization information. This notification must be retained in the agency's medical record.

8.0 Procedure Codes

8.1 CPT®/HCPCS Codes

- 8.1.1 The DMAP uses CPT®/HCPCS procedure codes as it's listing of descriptive terms and identifying codes for reporting medical services and procedures performed by practitioners. The purpose of the terminology is to provide a uniform language that will accurately designate medical, surgical, and diagnostic services.
- 8.1.2 When billing the DMAP for home health services, the HHA provider must use procedure/revenue codes found in Appendix B.

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9.0 Medicare/Medicaid Coverage

9.1 Specific Billing Instructions

9.1.1 There are specific billing procedures for members who are eligible for both Medicare and Medicaid. Patients who are confined to their homes because of illness or injury and need skilled health services only on a part-time basis may be covered by Medicare for services such as:

9.1.1.1 Part-time skilled nursing care;

9.1.1.2 Physical therapy;

9.1.1.3 Speech therapy;

9.1.1.4 Occupational therapy;

9.1.1.5 Part-time home health aide services.

9.1.2 Whether covered by Medicare Part A or Part B, specific conditions relevant to each part must be met in full before Medicare can pay for the services provided. Reference your Medicare manual or contact the Medicare Intermediary for specific conditions.

9.1.3 Medicare does NOT cover home health services furnished primarily to assist patients meeting personal needs. Services that include skilled nursing and rehabilitation must be billed to Medicare first. Any deductible and coinsurance must be billed according to the instructions noted in the Billing Section.

9.1.4 Home health aide services may be billed directly to Medicaid according to the instructions in the Billing Section.

9.1.5 As a provider of these various services, skilled and non-skilled, you will know and must distinguish between the types of services you are providing to each patient:

9.1.5.1 For skilled services (previously addressed) bill Medicare first before submitting a claim to Medicaid.

9.1.5.2 For home health aide services, which are not covered by Medicare, bill Medicaid directly.

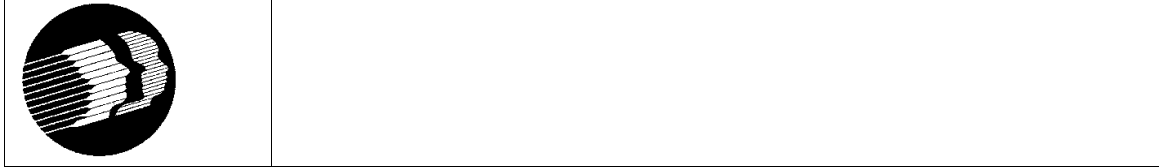
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10.0 Long Term Services and Supports Program (LTSS)

10.1 Prior Authorization Requests

- 10.1.1 Home health services provided to members who are eligible for the LTSS must be prior authorized by the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD)LTSS nurse/case manager. The attending physician, family, consumer, home health agency, or private duty nurse should direct request for prior authorization to the appropriate DSAAPD location as listed in the front of the Index in the back of General Policy. The request should include the following information:
- 10.1.1.1 Name of consumer;
 - 10.1.1.2 Consumer's Medical Assistance ID number;
 - 10.1.1.3 Date of birth;
 - 10.1.1.4 Detailed medical history that documents the need for the home health or private duty nursing service requested;
 - 10.1.1.5 Nursing assessment and plan of care;
 - 10.1.1.6 Physical assessment and diagnosis;
 - 10.1.1.7 Psycho-social assessment including home, family and environmental factors;
 - 10.1.1.8 Level of function (physical, mental, developmental). Availability and ability of caretaker to maintain member in the home (e.g., knowledge of emergency procedures);
- 10.1.2 The DSAAPD will forward a letter detailing the prior authorization to the home health agency. This notification must be retained in the home health agency's medical record. Prior authorization from the DSAAPD nurse/case manager does not relieve the HHA from responsibility of conducting an independent assessment that meets the DMAP policy.
- 10.1.3 The DMAP does not cover home health services provided to an assisted living consumer on a non-medical/social leave of absence outside the State of Delaware.
- 10.1.4 The DMAP may cover medically necessary home health services to an assisted living consumer on a non-medical/social leave of absence within the State of Delaware. Prior authorization must be obtained through the DSAAPD nurse for nursing aide services and/or skilled nursing services.

- 10.1.5 The DMAP does not cover home health aide visits in the assisted living agency.
- 10.1.6 The DMAP may cover medically necessary skilled nursing visits in the assisted living agency. Prior authorization must be obtained through the DSAAPD nurse.



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HCPCS Procedure Codes for Home Health Services

12.0 Appendix B – HCPCS Procedure /Revenue Codes

The following HCPCS procedure codes replace the previously assigned local codes. When billing the DMAP for dates of service on and after 7/1/02 Home Health agencies must use a HCPCS procedure code along with the appropriate Revenue Center Code as listed below.

HCPCS Code	Description	Revenue Code	Description
G0151	Services of physical therapist in home health setting, each 15 minutes	0422	Physical therapy, hourly charge
G0152	Services of occupational therapist in home health setting, each 15 minutes	0432	Occupational therapy, hourly charge
G0153	Services of speech and language pathologist in home health setting, each 15 minutes	0442	Speech/language pathology, hourly charge
G0154	Services of skilled nurse in home health setting, each 15 minutes. Note: This code shall be used for ALL nursing services including nursing services provided to Assisted Living Waiver members and early postpartum discharge in-home assessment.	0552	Skilled nursing, hourly charge
G0156	Services of home health aide in home health setting, each 15 minutes. Note: This code shall be used for ALL home health aide services including home health aide services provided to Assisted Living Waiver members.	0572	Home health aide (Home Health), hourly charge

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