

Washington Apple Health (Medicaid)

Home Health (Acute Care Services) Billing Guide

July 1, 2017

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and an agency rule arises, the agency rules apply.

About this guide*

This publication takes effect July 1, 2017, and supersedes earlier guides to this program.

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Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

What has changed?

Subject	Change	Reason for Change
<u>Client Eligibility</u>	Effective July 1, 2017, not all Apple Health clients will be enrolled in a BHO/FIMC/BHSO Effective July 1, 2017, AI/AN clients living in the FIMC regions have a change to services available	Policy update

* This publication is a billing instruction.

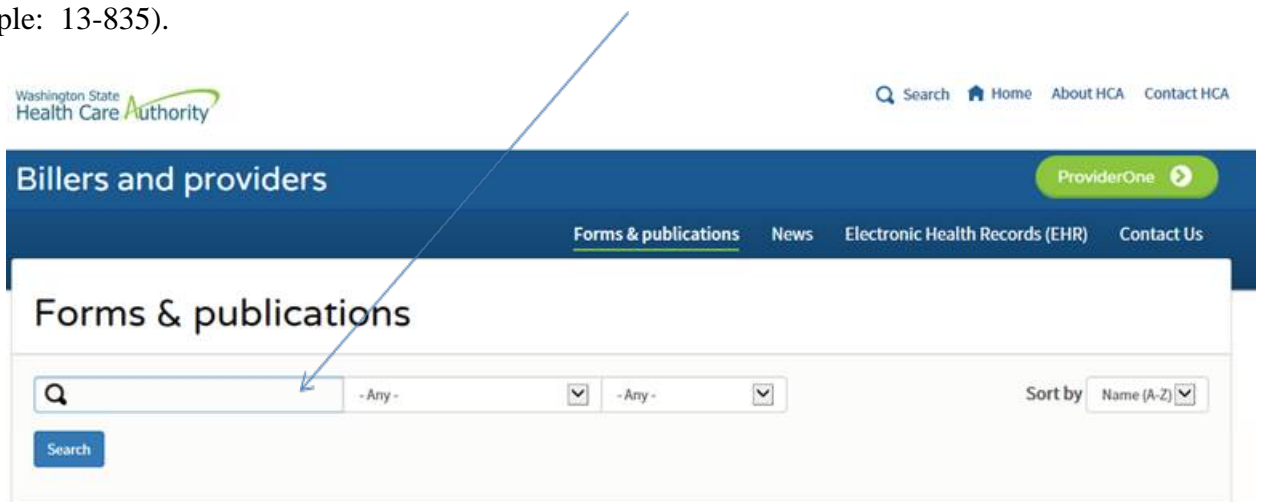
How can I get agency provider documents?

To access Provider Alerts, go to the agency's [Provider Alerts](#) web page.

To access provider documents, go to the agency's [Provider billing guides and fee schedules](#) web page.

Where can I download agency forms?

To download an agency provider form, go to HCA's Billers and providers web page, select [Forms & publications](#). Type the HCA form number into the **Search box** as shown below (Example: 13-835).



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Resources Available

Topic	Contact Information												
Becoming a provider or submitting a change of address or ownership	<p style="text-align: center;">See the agency's Billers and Providers web page.</p>												
Finding out about payments, denials, claims processing, or Medicaid agency contracted managed care organizations													
Electronic billing													
Finding Medicaid agency documents (e.g., billing guides, provider notices, fee schedules)													
Private insurance or third-party liability, other than agency-contracted managed care													
Sending medical verification of visits, plan of care, and change orders during focused review periods	<p>Health Care Benefits and Utilization Management Home Health Program Manager PO Box 45506 Olympia WA98504-5506</p>												
Finding a list of interpreter agencies in my area	<p>Visit the Medicaid agency's Medicaid Interpreter Services website.</p>												
Home health policy or medical review questions.	<p>Home Health Program Coverage Home Health Program Manager Phone: 360-725-1611 FAX requests to: 866-668-1214</p>												
Long-term care (LTC) needs	<p>LTC Exceptions FAX requests to: 866-668-1214</p>												
Home and Community Services (HCS)	<p>Look at the front of the local telephone book or call the Aging and Long-Term Support Administration (AL TSA) State Reception Line 800-422-3263 and ask for the local HCS number.</p>												
Developmental Disabilities Administration (DDA) phone numbers	<table style="margin-left: auto; margin-right: auto;"> <tr><td>Region 1</td><td>800-462-0624</td></tr> <tr><td>Region 2</td><td>800-822-7840</td></tr> <tr><td>Region 3</td><td>800-788-2053</td></tr> <tr><td>Region 4</td><td>800-314-3296</td></tr> <tr><td>Region 5</td><td>800-248-0949</td></tr> <tr><td>Region 6</td><td>800-339-8227</td></tr> </table>	Region 1	800-462-0624	Region 2	800-822-7840	Region 3	800-788-2053	Region 4	800-314-3296	Region 5	800-248-0949	Region 6	800-339-8227
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Region 3	800-788-2053												
Region 4	800-314-3296												
Region 5	800-248-0949												
Region 6	800-339-8227												
Pharmacy Authorization	<p>See the Medicaid agency's Billers and Providers web page.</p>												

Home Health (Acute Care Services)

Topic	Contact Information
First Steps – Maternity Support Services (MSS)	HCA Family Services Program Manager 360-725-1293 Email: FirstSteps@hca.wa.gov First Steps Maternity Support Services and Infant Case Management website
Contacting Aging and Long-Term Support Administration (ALTSA)	If you do not know the local telephone number, you may call: ALTSA State Reception Line: 800-422-3263
How do I obtain prior authorization or a limitation extension or request a noncovered service?	For all requests for prior authorization or limitation extension, the following documentation is required : <ul style="list-style-type: none"> • A completed, TYPED <i>General Information for Authorization</i> form (HCA 13-835). This request form MUST be the cover page when you submit your request. • A completed <i>Home Health Authorization Request</i> form (HCA 13-847), and all the documentation listed on this form and any other medical justification. <p>See Where can I download agency forms?</p> <p>Fax your request to: 866-668-1214</p>
Where do I find the Medicaid agency's maximum allowable fees for services?	See the Medicaid agency's online Provider billing guides and fee schedules web page.

Definitions

This list defines terms and abbreviations, including acronyms, used in this billing guide. Refer to [Chapter 182-500 WAC](#) for a complete list of definitions for Washington Apple Health.

Acute care – Care provided by a home health agency for clients who are not medically stable or who have not attained a satisfactory level of rehabilitation. These clients require frequent intervention by a registered nurse or licensed therapist. (WAC [182-551-2010](#))

Authorized practitioner – A person authorized to sign a home health plan of care.

Brief skilled nursing visit – A registered nurse, or a licensed practical nurse under the supervision of a registered nurse, performs only one of the following activities during a visit to a client for:

- An injection
 - A blood draw
 - A placement of medications in containers
- (WAC 182-551-2010)

Case manager – A social worker or a nurse assigned by the Aging and Long-Term Care Administration (AL TSA) in the Department of Social and Health Services to manage and coordinate the client’s case.

Case resource manager (CRM) – A person who meets with the family and assesses the client’s developmental disability needs, develops a plan with the family, and helps connect to appropriate resources assigned by the Developmental Disabilities Administration (DDA).

Chronic care – Long-term care for medically stable clients. (WAC 182-551-2010)

Full skilled nursing services – A registered nurse, or a licensed practical nurse under the supervision of a registered nurse, performs one or more of the following activities during a visit to a client for:

- Assessment
 - Evaluation
 - Management
 - Observation
 - Treatment
 - Teaching
 - Training
- (WAC 182-551-2010)

Home health aide – A person registered or certified as a nursing assistant under chapter 18.88 RCW who, under the direction and supervision of a registered nurse or licensed therapist, assists in the delivery of nursing or therapy related activities, or both. (WAC 182-551-2010)

Home health aide services – Services provided by a home health aide when a client has an acute, intermittent, short-term need for the services of a registered nurse, physical therapist, occupational therapist, or speech therapist who is employed by, or under contract with, a home health agency. Such services are provided under the supervision of the previously identified authorized practitioners, and include, but are not limited to, ambulation and exercise, assistance with self-administered medications, reporting changes in a client’s condition and needs, and completing appropriate records. (WAC 182-551-2010)

Home Health (Acute Care Services)

Home health skilled services – Skilled health care (nursing, specialized therapy, and home health aide) services provided in the client’s residence on an intermittent or part-time basis by a Medicare- certified home health agency with a current Core Provider Agreement. (WAC 182-551-2010)

Long-term care – A generic term referring to various programs and services, including services provided in home and community settings, administered directly or through contract by the Aging and Long-Term Support Administration (AL TSA) or Developmental Disabilities Administration (DDA) with the Department of Social and Health Services. (WAC 182-551-2010)

Plan of Care (POC) – (Also known as plan of treatment (POT)). A written document established and periodically reviewed and signed by both a physician and a home health agency provider. The plan describes the home health care to be provided at the client’s residence. (WAC 182-551-2010)

Residence - A client's home or private place of living. (WAC 182-551-2010)

(For information on clients in residential facilities whose home health services are not covered through the Medicaid agency’s home health program see [When does the Medicaid agency pay for covered home health services?](#))

Review period – The three-month period the Medicaid agency assigns to a home health agency, based on the address of the home health agency’s main office, during which the Medicaid agency reviews all claims submitted by that home health agency. (WAC 182-551-2010)

Specialized therapy – Skilled therapy services provided to clients that include: physical, occupational, and speech/ audiology services. (WAC 182-551-2010)

Supervision - Authoritative procedural guidance given by a qualified person who assumes the responsibility for the accomplishment of a function or activity and who provides initial direction and periodic inspection of the actual act of accomplishing the function or activity.

About the Program

(WAC [182-551-2000](#))

What is the purpose of the home health program?

The purpose of the Medicaid agency's home health program is to provide equally effective, less restrictive quality care to the client in the client's residence when the client is not able to access the medically necessary services in the community, or in lieu of hospitalization.

Home health skilled services are provided for **acute**, intermittent, short-term, and intensive courses of treatment.

Note: See [What home health services are not covered?](#) for information on chronic, long-term maintenance care.

Who is an eligible home health provider?

(WAC [182-551-2200](#))

The following may contract with the Medicaid agency to provide health services through the home health program, subject to the restrictions or limitations in this billing guide and applicable published Washington Administrative Code (WAC):

- A home health agency that:
 - ✓ Is [Title XVIII](#) (Medicare)-certified
 - ✓ Is licensed by the Department of Health (DOH) as a home health agency
 - ✓ Continues to meet DOH requirements
 - ✓ Submits a completed, signed Core Provider Agreement to the Medicaid agency
 - ✓ Has a home health taxonomy on their provider file

- A registered nurse (RN) who:
 - ✓ Is prior authorized by the Medicaid agency to provide intermittent nursing services when a home health agency does not exist in the area a client resides
 - ✓ Is unable to contract with a Medicare-certified home health agency
 - ✓ Submits a completed, signed core provider agreement to the Medicaid agency
 - ✓ Has an RN home health taxonomy on their provider file

Important! Notify the Medicaid agency **within ten days** of any changes in name, address, or telephone number (see [Resources Available](#)).

Client Eligibility

(WAC [182-551-2020\(1\)](#))

How can I verify a patient's eligibility?

Providers must verify that a patient has Washington Apple Health coverage for the date of service, and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

Verifying eligibility is a two-step process:

Step 1. Verify the patient's eligibility for Washington Apple Health. For detailed instructions on verifying a patient's eligibility for Washington Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's current [ProviderOne Billing and Resource Guide](#).

If the patient is eligible for Washington Apple Health, proceed to **Step 2**. If the patient is **not** eligible, see the note box below.

Step 2. Verify service coverage under the Washington Apple Health client's benefit package. To determine if the requested service is a covered benefit under the Washington Apple Health client's benefit package, see the agency's [Program Benefit Packages and Scope of Services](#) web page.

Note: Patients who are not Washington Apple Health clients may submit an application for health care coverage in one of the following ways:

1. By visiting the Washington Healthplanfinder's website at: www.wahealthplanfinder.org
2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)
3. By mailing the application to:
Washington Healthplanfinder
PO Box 946
Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit www.wahealthplanfinder.org or call the Customer Support Center.

What are the restrictions?

(WAC [182-551-2020\(2\)](#))

The CNP–Emergency Medical Only program covers two skilled nursing home health visits for those covered under the cancer treatment program and hemodialysis program.

Are managed care clients covered?

(WAC [182-551-2020\(1\)](#))

Yes. When verifying eligibility using ProviderOne, if the client is enrolled in a Medicaid agency-contracted managed care organization (MCO), managed care enrollment will be displayed on the client benefit inquiry screen. All services must be requested directly through the client’s primary care provider (PCP). Clients can contact their MCO by calling the telephone number provided to them.

All medical services covered under a Medicaid agency-contracted MCO must be obtained by the client through designated facilities or providers. The managed care plan is responsible for:

- Payment of covered services.
- Payment of services referred by a provider participating in the plan to an outside provider.

Note: To prevent billing denials, check the client’s eligibility **prior** to scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained from the plan. See the Medicaid agency’s [ProviderOne Billing and Resource Guide](#) for instructions on how to verify a client’s eligibility.

Are primary care case management (PCCM) clients covered?

For the client who has chosen to obtain care with a PCCM provider, information will be displayed on the client benefit inquiry screen in ProviderOne. These clients must obtain or be referred for services via a PCCM provider. The PCCM provider is responsible for coordination of care just like the PCP would be in a plan setting.

Note: To prevent billing denials, check the client’s eligibility **prior** to scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained from the PCCM provider. See the Medicaid agency’s [ProviderOne Billing and Resource Guide](#) for instructions on how to verify a client’s eligibility.

Are dually-enrolled clients eligible?

Dually-enrolled (Medicare-Medicaid) clients and **Medicare only** clients may be eligible to receive certain home and community based services under the Community Options Program Entry System (COPEs) or Title XIX Personal Care programs. These programs are administered under the Department of Social and Health Services' Aging and Long-Term Support Administration (AL TSA). Contact the local AL TSA field office for more information on these programs (see [Resources Available](#)).

Dually-enrolled clients who do NOT meet Home Bound status criteria per Medicare are eligible for Home Health through Medicaid. Providers must indicate NOT HOMEBOUND in the *Billing Note* section of the electronic institutional claim.

Effective July 1, 2017, not all Apple Health clients will be enrolled in a BHO/FIMC/BHSO.

On July 1, 2017, some Apple Health clients will not be enrolled in a BHO/FIMC/BHSO program. For these clients, SUD services are covered under the fee-for-service (FFS) program.

Effective July 1, 2017, changes to services available to AI/AN clients living in the FIMC regions.

Effective July 1, 2017, American Indian/Alaska Native (AI/AN) clients must choose to enroll in one of the managed care plans, either Community Health Plan of Washington (CHPW) or Molina Healthcare of Washington (MHW) under the FIMC model receiving all physical health services, all levels of mental health services and drug and alcohol treatment coordinated by one managed care plan; or they may choose to receive all these services through Apple Health fee-for-service (FFS). If they do not choose, they will be auto-enrolled into Apple Health FFS for all their health care services.

Effective January 1, 2017, some fee-for-service clients who have other primary health insurance will be enrolled into managed care

On January 1, 2017, the agency enrolled some fee-for-service Apple Health clients who have other primary health insurance into an agency-contracted managed care organization (MCO).

This change did not affect all fee-for-service Apple Health clients who have other primary health insurance. The agency continues to cover some clients under the fee-for-service Apple Health program, such as dual-eligible clients whose primary insurance is Medicare.

For additional information, see the agency's [Managed Care](#) web site, under Providers and Billers.

Effective April 1, 2016, important changes to Apple Health

These changes are important to all providers because they may affect who will pay for services.

Providers serving any Apple Health client should always check eligibility and confirm plan enrollment by asking to see the client's Services Card and/or using the ProviderOne Managed Care Benefit Information Inquiry functionality (HIPAA transaction 270). The response (HIPAA transaction 271) will provide the current managed care organization (MCO), fee-for-service, and Behavioral Health Organization (BHO) information. See the Southwest Washington Provider Fact Sheet on the agency's [Regional Resources](#) web page.

New MCO enrollment policy – earlier enrollment

Beginning April 1, 2016, Washington Apple Health (Medicaid) implemented a new managed care enrollment policy placing clients into an agency-contracted MCO **the same month** they are determined eligible for managed care as a new or renewing client. This policy eliminates a person being placed temporarily in fee-for-service while they are waiting to be enrolled in an MCO or reconnected with a prior MCO.

- **New clients** are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health Managed Care.
- **Renewing clients** are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Clients currently in fee-for-service or currently enrolled in an MCO are not affected by this change. Clients in fee-for-service who have a change in the program they are eligible for may be enrolled into Apple Health Managed Care depending on the program. In those cases, this enrollment policy will apply.

How does this policy affect providers?

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder's [Get Help Enrolling](#) page.
- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO's requirements and be compliant with the MCO's new policies.

Behavioral Health Organization (BHO)

The Department of Social and Health Services (DSHS) manages the contracts for behavioral health (mental health and substance use disorder (SUD)) services for nine of the Regional Service Areas (RSA) in the state, excluding Clark and Skamania counties in the Southwest Washington (SW WA) Region. BHOs will replace the Regional Support Networks (RSNs). Inpatient mental health services continue to be provided as described in the inpatient section of the [Mental Health Services Billing Guide](#). BHOs use the [Access to Care Standards \(ACS\)](#) for mental health conditions and [American Society of Addiction Medicine \(ASAM\)](#) criteria for SUD conditions to determine client's appropriateness for this level of care.

Fully Integrated Managed Care (FIMC)

Clark and Skamania Counties, also known as SW WA region, is the first region in Washington State to implement the FIMC system. This means that physical health services, all levels of mental health services, and drug and alcohol treatment are coordinated through one managed care plan. Neither the RSN nor the BHO will provide behavioral health services in these counties.

Clients must choose to enroll in either Community Health Plan of Washington (CHPW) or Molina Healthcare of Washington (MHW). If they do not choose, they are auto-enrolled into one of the two plans. Each plan is responsible for providing integrated services that include inpatient and outpatient behavioral health services, including all SUD services, inpatient mental health and all levels of outpatient mental health services, as well as providing its own provider credentialing, prior authorization requirements and billing requirements.

Beacon Health Options provides mental health crisis services to the entire population in Southwest Washington. This includes inpatient mental health services that fall under the Involuntary Treatment Act for individuals who are not eligible for or enrolled in Medicaid, and short-term substance use disorder (SUD) crisis services in the SW WA region. Within their available funding, Beacon has the discretion to provide outpatient or voluntary inpatient mental health services for individuals who are not eligible for Medicaid. Beacon Health Options is also responsible for managing voluntary psychiatric inpatient hospital admissions for non-Medicaid clients.

In the SW WA region some clients are not enrolled in CHPW or Molina for FIMC, but will remain in Apple Health fee-for-service managed by the agency. These clients include:

- Dual eligible – Medicare/Medicaid
- American Indian/Alaska Native (AI/AN)
- Medically needy
- Clients who have met their spenddown
- Noncitizen pregnant women
- Individuals in Institutions for Mental Diseases (IMD)
- Long-term care residents who are currently in fee-for-service
- Clients who have coverage with another carrier

Since there is no BHO (RSN) in these counties, Medicaid fee-for-service clients receive complex behavioral health services through the Behavioral Health Services Only (BHSO) program managed by MHW and CHPW in SW WA region. These clients choose from CHPW or MHW for behavioral health services offered with the BHSO or will be auto-enrolled into one of the two plans. A [BHSO fact sheet](#) is available online.

Apple Health Core Connections (AHCC)

Coordinated Care of Washington (CCW) will provide all physical health care (medical) benefits, lower-intensity outpatient mental health benefits and care coordination for all Washington State foster care enrollees. These clients include:

- Children and youth under the age of 21 who are in foster care
- Children and youth under the age of 21 who are receiving adoption support
- Young adults age 18 to 26 years old who age out of foster care on or after their 18th birthday

American Indian/Alaska Native (AI/AN) children will **not** be auto-enrolled, but may opt into CCW. All other eligible clients will be auto-enrolled.

AHCC complex mental health and substance use disorder services

AHCC clients who **live in** Skamania or Clark County receive complex behavioral health benefits through the Behavioral Health Services Only (BHSO) program in the SW WA region. These clients will choose between CHPW or MHW for behavioral health services, or they will be auto-enrolled into one of the two plans. CHPW and MHW will use the BHO Access to Care Standards to support determining appropriate level of care, and whether the services should be provided by the BHSO program or CCW.

AHCC clients who **live outside** Skamania or Clark County will receive complex mental health and substance use disorder services from the BHO and managed by DSHS.


Contact Information for Southwest Washington


Beginning on April 1, 2016, there will not be an RSN/BHO in Clark and Skamania counties. Providers and clients must call the agency-contracted MCO for questions, or call Beacon Health Options for questions related to an individual who is not eligible for or enrolled in Medicaid.

If a provider does not know which MCO a client is enrolled in, this information can be located by looking up the patient assignment in ProviderOne.

Home Health (Acute Care Services)

To contact Molina, Community Health Plan of Washington, or Beacon Health Options, please call:

 MOLINA[®] HEALTHCARE	Molina Healthcare of Washington, Inc. 1-800-869-7165
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 COMMUNITY HEALTH PLAN of Washington	Community Health Plan of Washington 1-866-418-1009
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Beacon Health Options	Beacon Health Options 1-855-228-6502
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Coverage/Limits

(WAC [182-551-2030](#))

When does the Medicaid agency pay for covered home health services?

The Medicaid agency pays for covered home health services provided to eligible clients when all of the criteria listed in this section are met. Reimbursement is subject to the restrictions or limitations in this billing guide and other applicable published Washington Administrative Code (WAC).

For information about the Habilitative Services benefit available January 1, 2014, see [What are habilitative services under this program?](#)

Home health skilled services provided to eligible clients must:

- Meet the definition of acute care.
- Provide for the treatment of an illness, injury, or disability.
- Be medically necessary (see [Chapter 182-500 WAC](#) for definition).
- Be reasonable, based on the community standard of care, in amount, duration, and frequency.
- Be provided under a plan of care (POC). Any statement in the POC must be supported by documentation in the client's medical records.
- Be used to prevent placement in a more restrictive setting. **In addition**, the client's medical records must justify the medical reason(s) that the services should be provided in the client's residence instead of a licensed practitioner's office, clinic, or other outpatient setting. This includes justification for services for a client's medical condition that requires teaching that would be most effectively accomplished in the client's home on a short-term basis.
- Be provided in the client's residence. The Medicaid agency does not reimburse for services if provided at the workplace, school, child day care, adult day care, skilled nursing facility, or any other place that is not the client's place of residence.

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Home Health (Acute Care Services)

- ✓ **Residential facilities** contracted with the state to provide limited skilled nursing services are **not reimbursed** separately for those same services under the Medicaid agency's home health program.
 - ✓ It is the home health agencies' responsibility to request coverage for a client when the services are not available to the client in the community or through LTC.
 - ✓ If the client meets the criteria for therapy services in this billing guide, the Medicaid agency will evaluate the need after receiving the request.
 - ✓ Refer to the Aging and Long-Term Support Administration's (AL TSA) [Residential Care Services](#) web page for more information.
- Be provided by a home health agency that is Title XVIII (Medicare) certified and state-licensed

WAC [182-551-2100\(1\)](#)

The Medicaid agency covers home health acute care skilled nursing services when furnished by a qualified provider.

The Medicaid agency evaluates a request for covered services that are subject to limitations or restrictions, and approves such services beyond those limitations or restrictions when medically necessary, under the standard for covered services in WAC [182-501-0165](#).

Does the agency cover acute care services?

(WAC [182-551-2100\(2\)\(3\)](#))

The Medicaid agency covers the following home health acute care services:

- **Full skilled nursing services** that require the skills of a registered nurse (RN) or a licensed practical nurse (LPN) under the supervision of a RN, if the services involve **one or more** of the following:
 - ✓ Observation (approximately three weeks)
 - ✓ Assessment (approximately three weeks)
 - ✓ Treatment
 - ✓ Teaching (approximately three days)
 - ✓ Training (approximately four visits unless client remains unstable)
 - ✓ Management
 - ✓ Evaluation

Note: Use revenue code **0551** when billing for skilled nursing care visits in the home setting.

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Home Health (Acute Care Services)

- **Brief skilled nursing visit** if only one of the following activities is performed during the visit:
 - ✓ An injection
 - ✓ A blood draw
 - ✓ The placement of medications in containers (e.g., envelopes, cups, medisets)

Note: Use revenue code 580 when billing for a brief skilled nursing visit.

The Medicaid agency limits skilled nursing visits provided to eligible clients to **two visits (whether they are brief or full) per day.**

- **Home infusion therapy** only if the client:
 - ✓ Is willing and capable of learning and managing the client's infusion care
 - ✓ Has a volunteer caregiver willing and capable of learning and managing the client's infusion care

Note: The Medicaid agency does not reimburse for any of the following services through the Home Health Program:

- Administration of IV therapy
- Teaching of IV therapy
- Skilled observation of the IV site

Note: All other infusion therapy related services must be billed on a professional claim using the [Home Infusion Therapy/Parenteral Nutrition Program Billing Guide](#).

Note: Although Medicaid agency clients may have a paid caregiver who is willing and capable of performing the skilled task, a paid caregiver cannot bill for these services. The client may want to be involved in self-directed care.

- **Infant phototherapy** for an infant diagnosed with hyperbilirubinemia:
 - ✓ When provided by a Medicaid agency-approved infant phototherapy agency
 - ✓ For up to five skilled nursing visits per infant

Note: If the infant's mother is enrolled in a Medicaid agency-contracted managed care organization (MCO) at the time of the birth, approval must be received from the MCO listed on the mother's eligibility check. **Do not bill the Medicaid agency for these services.**

- **Limited high-risk obstetrical services for all of the following:**
 - ✓ A medical diagnosis that complicates pregnancy and may result in a poor outcome for the mother, unborn, or newborn
 - ✓ Up to three home health visits per pregnancy, if:
 - Enrollment in or referral to the following providers of First Steps has been verified:
 - Maternity Support Services (MSS)
 - Infant Case Management (ICM)
 - The visits are provided by a registered nurse who has either of the following:
 - National perinatal certification
 - A minimum of one year of labor, delivery, and postpartum experience at a hospital within the last five years

Note: Use revenue code **0551** when billing for skilled high-risk obstetrical nursing care visits in the home setting.

Note: The Medicaid agency does not reimburse for high-risk obstetrics if the registered nurse has not met the criteria listed above.

See [Criteria for High-Risk Obstetrical](#).

Additional information required in the plan of care

(See [Criteria for High-Risk Obstetrical](#))

1. Infant's name, mother's name, and ProviderOne Client ID(s)
2. Information regarding the infant's medical condition, and the family's ability to safely provide home phototherapy
3. Name of hospital where the infant was born and discharge date
4. Visit notes that include family teaching and interventions
5. Bilirubin levels

How do I become a Medicaid agency-approved infant phototherapy agency?

You must:

- Be a Medicaid- and Medicare- certified home health agency.
- Have an established phototherapy program.
- Submit to the Medicaid agency for review, all of the following:
 - ✓ Six months of documented phototherapy services delivered for infants
 - ✓ A written policy for home phototherapy submitted to the Medicaid agency for review that includes guidelines, procedures, and job descriptions verifying experience in pediatrics and maternal child health
 - ✓ Three letters of recommendation from pediatricians who have used your program

Note: The Medicaid agency will not cover infant phototherapy **unless** your agency has a pre-approval letter on file from the Medicaid agency noting that you are an approved infant phototherapy agency. See the Medicaid agency's current [Durable Medical Equipment \(DME\) Billing Guide](#) for equipment component.

Does the agency cover specialized outpatient rehabilitative therapy for clients age 20 and younger?

(WAC [182-551-2110](#)(1)(2))

For eligible clients age 20 and younger, the Medicaid agency covers **specialized therapy services, which** include physical, occupational, or speech/audiology services.

The agency covers habilitative services for clients enrolled in the Alternative Benefit Plan (ABP). See [What are habilitative services under this program?](#) for specialized therapy rendered under the habilitative services benefit (see WAC [182-545](#)).

The Medicaid agency reimburses for specialized therapy services only when the client is **not able to access these services in the client's local community**. The Medicaid agency limits specialized therapy visits to one per client, per day, per type of specialized therapy. Documentation must justify the skilled need of the visit.

Under specialized therapy, a client's residence may include a residential care facility with skilled nursing services available.

Note: The maximum number of visits allowed is based on appropriate medical justification. The Medicaid agency does not allow duplicate services for any specialized therapy for the same client when both providers are performing the same or similar procedure (s). If the client requires more than one therapist in the residence on the same day, the Medicaid agency requires the therapist to document the therapeutic benefit of having more than one therapist for specialized therapy on the same day.

Does the agency cover skilled outpatient rehabilitative therapies for clients age 19 and 20 in MCS/ALTSA and clients age 21 and older?

Yes. The following are the short-term benefit limits for outpatient rehabilitation (occupational therapy [OT], physical therapy [PT], and speech therapy [ST]) that apply to clients age 19 and 20 in MCS/ALTSA and all clients age 21 and older. These benefit limits are **per client, per calendar year**, regardless of setting (home health, outpatient hospital, and freestanding therapy clinics.) Authorization is not required.

- Physical therapy: 24 units (equals approximately 6 hours)
- Occupational therapy: 24 units (equals approximately 6 hours)
- Speech therapy: 6 units (equals a total of 6 untimed visits)

To ensure payment:

- Bill in a timely manner. Claims will pay in date of service order. If a claim comes in for a previous date of service, the system will automatically pay the earlier date and recoup or adjust the later date.
- Contact the Medicaid agency to check on the limits by submitting the [information request form for providers](#) on the Contact Us web page to the Medical Assistance Customer Service Center (MACSC).
- Consult the [ProviderOne Billing and Resource Guide](#): Client Eligibility, Benefit Packages, and Coverage Limits sections.

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See [expedited prior authorization](#) (EPA) to obtain additional visits for qualifying conditions. If the client does not have a qualifying condition as outlined in the EPA section, the Medicaid agency requires the home health agency to request a limitation extension (LE) from the Medicaid agency.

For Department of Social and Health Services occupational therapy (OT) assessments, see the [Outpatient Rehabilitative Therapy Evaluation Codes Table](#).

How are timed/untimed CPT® codes billed?

For specialized therapies:

- Each 15 minutes of timed CPT® codes equals one unit
- Each non-timed CPT® code equals one unit, regardless of how long the procedure takes

Therapy codes, including evaluations, must be billed as described in this billing guide. Failure to bill correctly will result in denials or recoupment.

Modality	Home Health Revenue Codes	Home Health Procedure Codes	Short Description	Modifiers
PT	0421	G0151	Services performed by a qualified physical therapist in the home health or hospice setting each 15 minutes	GP
OT	0431	G0152	Services performed by a qualified occupational therapist in the home health or hospice setting each 15 minutes	GO
ST	0441	92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder individual	GN

If the client’s outpatient rehabilitation services maximum benefit limit has been reached (initial units and any additional EPA units, when appropriate), a provider may request authorization for a limitation extension from the Medicaid agency.

Does the Medicaid agency pay for outpatient rehabilitative therapy evaluations for clients age 21 and older?

Yes. The Medicaid agency pays for therapy evaluations for physical therapy (PT), occupational therapy (OT), and speech therapy (ST). Evaluations do not count toward the limit, but are subject to annual limits. See the following Outpatient Therapy Evaluation Codes Table. Providers bill with revenue code, the CPT® code, and the appropriate modifier. Providers must request authorization for a [limitation extension](#) (LE) if additional evaluations are needed.

Outpatient Rehabilitative Therapy Evaluation Codes Table

Modality	Evaluation Revenue Codes	Evaluation CPT Codes	Short Description	Modifiers	Limitations
PT	0424	97161	PT eval low complex 20 min	GP	Only one of these codes is allowed, per client, per calendar year
		97162	PT eval mod complex 30 min		
		97163	PT eval high complex 45 min		
		97164	PT re-eval est plan care	GP	One per client, per calendar year
		97542	Wheelchair management	GP	One per client, per calendar year. Assessment is limited to four 15-min units per assessment. Indicate on claim wheelchair assessment.

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Home Health (Acute Care Services)

Modality	Evaluation Revenue Codes	Evaluation CPT Codes	Short Description	Modifiers	Limitations	
OT	0434	97166	Occupational therapy evaluation, personal care for children, 45 min	GO	EPA is required. See EPA# 870001326 . One per client, unless change of residence or condition	
		97165	Occupational therapy evaluation, bed rail assessment, 30 min	GO	EPA is required. See EPA# 870001343 . One per client, unless change of residence or condition	
		97165	OT eval low complex 30 min	GO	Only one of these codes allowed, per client, per calendar year	
		97166	OT eval mod complex 45 min	GO		
		97167	OT eval high complex 60 min	GO		
			97168	OT re-eval est plan care	GO	One per client, per calendar year
			97542	Wheelchair management	GO	One per client, per calendar year. Assessment is limited to four 15-minute units per assessment. Indicate on claim wheelchair assessment.
ST	0444	92521	Evaluation of speech fluency	GN	One per client, per calendar year unless change of condition.	

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Home Health (Acute Care Services)

Modality	Evaluation Revenue Codes	Evaluation CPT Codes	Short Description	Modifiers	Limitations
		92522	Evaluation of speech sound production	GN	One per client, per calendar year unless change of condition
		92523	With evaluation of language comprehension and expression	GN	One per client, per calendar year unless change of condition
		92524	Behavioral and quantitative analysis of voice and resonance	GN	One per client, per calendar year unless change of condition
		S9152	Speech language pathology re-evaluation at time of discharge	GN	One per client, per calendar year
ST	0444	92610	Evaluate swallowing function (this one would not have any limits)	GN	No limit

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What is the expedited prior authorization (EPA) for additional units of outpatient rehabilitative services for clients age 21 and older?

When a client meets the EPA criteria listed in [Authorization](#) for additional benefit units of outpatient rehabilitation, providers must use the expedited prior authorization (EPA) process. When a client's situation does not meet the conditions for EPA, a provider must request prior authorization.

Note: EPA may be requested once, per client, per calendar year, per each therapy type.

What are habilitative services under this program?

Habilitative services are those medically necessary services provided to help a client partially or fully attain or maintain developmental age-appropriate skills that were not fully acquired due to a congenital, genetic, or early-acquired health condition. Such services are required to maximize the client's ability to function in his or her environment.

Clients in the expanded population and covered by the Alternative Benefit Plan (ABP) only, the agency covers outpatient physical, occupational, and speech therapy to treat one of the qualifying conditions listed in the agency's [Habilitative Services Billing Guide](#), under *Client Eligibility*.

How do I bill for habilitative services?

See the [Habilitative Services Billing Guide](#) for details on billing habilitative services provided in the home health setting. To review the appropriate ICD-10 diagnosis codes that are required in the primary diagnosis field on the claim, see the [Approved Diagnosis Codes by Program](#) for Habilitative Services.

What are the limits for home health aide services?

(WAC [182-551-2120\(1\)\(2\)\(3\)](#))

- The Medicaid agency limits home health aide visits to **one per day**.
- The Medicaid agency reimburses for home health aide services only when the services are provided under the supervision of, and in conjunction with, practitioners who provide:
 - ✓ Skilled nursing services
 - ✓ Specialized therapy services
- The Medicaid agency covers home health aide services only when a registered nurse or licensed therapist visits the client's residence at least once every fourteen days to monitor or supervise home health aide services, with or without the presence of the home health aide. The Medicaid agency does not reimburse for services covered by another state administration such as LTC services, Community Options Program Entry System (COPES), CHORE, or CAP services.
- Documentation in the client's file must justify the need for the home health aide visits.

Note: Contact the client's case manager/case resource manager to see if the client is eligible for, or is already receiving, LTC services, COPES, CHORE, or CAP services.

Does the agency cover home health services through telemedicine?

(WAC [182-551-2125](#))

The Medicaid agency covers the delivery of home health services through telemedicine for clients who have been diagnosed with an unstable condition who may be at risk for hospitalization or a more costly level of care. The client must have a diagnosis or diagnoses where there is a high risk of sudden change in medical condition which could compromise health outcomes.

Home Health (Acute Care Services)

When billing the Medicaid agency for home health services delivered through telemedicine, use the following codes:

Revenue Code	HCPCS Code	Short Description	Limitation
0780	T1030	RN home care per diem	One per client per day
0780	T1031	LPN home care per diem	One per client per day

Payment

The Medicaid agency pays for one telemedicine interaction, per eligible client, per day, based on the ordering licensed practitioner's home health plan of care.

Payment requirements

To receive payment for the delivery of home health services through telemedicine, the services must involve:

- A documented assessment, identified problem, and evaluation, which includes:
 - ✓ Assessment and monitoring of clinical data including, but not limited to, vital signs, pain levels and other biometric measures specified in the plan of care. Also included is an assessment of response to previous changes in the plan of care.
 - ✓ Detection of condition changes based on the telemedicine encounter that may indicate the need for a change in the plan of care
- Implementation of a documented management plan through one or more of the following:
 - ✓ Education regarding medication management as appropriate, based on the findings from the telemedicine encounter
 - ✓ Education regarding other interventions as appropriate to both the patient and the caregiver
 - ✓ Management and evaluation of the plan of care, including changes in visit frequency or the addition of other skilled services

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- ✓ Coordination of care with the ordering licensed provider regarding findings from the telemedicine encounter
- ✓ Coordination and referral to other medical providers as needed
- ✓ Referral to the emergency room as needed

Telemedicine-related costs

The Medicaid agency does not pay for the purchase, rental, repair, or maintenance of telemedicine equipment and associated costs of operation of telemedicine equipment.

Prior authorization

The Medicaid agency does not require prior authorization for the delivery of home health services through telemedicine.

What home health services are not covered?

(WAC [182-551-2130](#))

The Medicaid agency does not cover the following home health services under the Home Health program, unless otherwise specified:

- Chronic long-term care skilled nursing visits or specialized therapy visits for a medically stable client when a long-term care skilled nursing plan or specialized therapy plan is in place through the Department of Social and Health Services Aging and Long-Term Support Administration (AL TSA) or Developmental Disabilities Administration (DDA).
 - ✓ **The Medicaid agency may consider requests** for interim chronic long-term care skilled nursing services or specialized therapy services for a client while the client is waiting for AL TSA or DDA to implement a long-term care skilled nursing plan or specialized therapy plan.
 - ✓ On a case-by-case basis, the Medicaid agency may authorize long-term care skilled nursing visits or specialized therapy visits for a client for a limited time until an AL TSA or DDA long-term care skilled nursing plan or specialized therapy plan is in place. Any services authorized are subject to the restrictions and limitations in this billing guide and other published WACs.

Home Health Agencies

- The client must have a stable, chronic skilled nursing need.
- The client's skilled nursing need cannot be met in the community (e.g., the client is unable to access outpatient services in the community).
- The home health provider must **contact the Medicaid agency and request coverage** through the home health program.

The Medicaid agency will first contact the client's AL TSA or DDD case manager to see if long-term care skilled nursing services are accessible in the community or through AL TSA or DDD.

If there are no other options, the Medicaid agency will send a notification letter to the client, home health agency, and case manager notifying them that the chronic, long-term care skilled nursing visits will be reimbursed through the Medicaid agency for a limited time until a long-term care plan is in place.

- Social work services
-
- Psychiatric skilled nursing services
- Pre and postnatal skilled nursing services, except those listed under Covered – Acute Nursing Services
- Well-baby follow-up care
- Services performed in hospitals, correctional facilities, skilled nursing facilities, or a residential facility with skilled nursing available
- Home health aide services that are not provided in conjunction with skilled nursing or specialized therapy services
- Home health care for a medically stable client (e.g., one who does not have an acute episode, a disease exacerbation, or treatment change, unless the client meets the applicable criteria in this guide)
- Skilled nursing visits for a client when a home health agency cannot **safely** meet the medical needs of that client within home health services program limitations

Examples:

- ✓ The client or caregiver is not willing and/or capable of managing the client's infusion therapy care.
- ✓ A client requires daily visits in excess of program limitations.
- More than one of the same type of specialized therapy and/or home health aide visit per day. The Medicaid agency does not reimburse for duplicate services for any specialized therapy for the same client when both providers are performing the same or similar procedure(s).
- Any home health services covered by another state administration such as LTC services, COPEs, CHORE, or CAP services.
- Home health visits made without a written licensed practitioner order, unless the verbal order is:
 - ✓ Documented prior to the visit
 - ✓ The document is signed by the licensed practitioner within 45 days of the order being given
- Additional administrative costs billed above the visit (these costs are included in the visit rate and will not be paid separately)

The Medicaid agency evaluates a request for any service that is listed as noncovered under the provisions of WAC [182-501-0165](#).

Requests must include the following:

1. Name of agency and NPI
2. Client's name and ProviderOne Client ID
3. Copy of the plan of care
4. Explanation of client-specific medical necessity

Send requests for noncovered services to the Medicaid agency (see [Resources Available](#)). See [Authorization](#) for information regarding Limitation Extensions.

Authorization

The Medicaid agency evaluates a request for covered services that are subject to limitations or restrictions, and approves such services **beyond** those limitations or restrictions when medically necessary, under the standard for covered services in WAC [182-501-0165](#).

Note: A provider may request an exception to rule (ETR) for a noncovered service as described in WAC [182-501-0160](#).

What is a limitation extension (LE)?

A limitation extension (LE) is authorization for cases when a provider can verify that it is medically necessary to provide **more units of service** than allowed in the Medicaid agency's Washington Administrative Code (WAC) and Medicaid billing guides.

How is LE authorization obtained?

LE may be obtained by using the written/fax authorization process.

Your request must include the following:

- Name of agency and NPI
- Client's name and ProviderOne Client ID
- Copy of the plan of care
- Explanation of client-specific medical necessity to exceed limitation

What forms are required for LE authorization?

The Medicaid agency requires **both** of the following forms to request LE authorization:

- A completed, TYPED *General Information for Authorization* form (**HCA 13-835**). This request form **MUST** be the cover page when you submit your request. See [Where can I download agency forms?](#)
- A completed *Home Health Authorization Request* form (**HCA 13-847**), and all the documentation listed on this form and any other medical justification. See [Where can I download agency forms?](#)

Fax your request to: 866-668-1214

Note: See the Medicaid agency's [ProviderOne Billing and Resource Guide](#) for more information on requesting authorization.

What does expedited prior authorization (EPA) do?

EPA is designed to eliminate the need for written authorization from the Medicaid agency. The Medicaid agency establishes clinical criteria for the provider to apply and determine if the client's condition is medically necessary and qualifies for additional services. The Medicaid agency assigns each criteria-set a specific numeric code.

Enter the appropriate 9-digit EPA code on the billing form in the authorization number field, or in the **Authorization or Comments** field when billing electronically.

EPA numbers and/or limitation extensions (LE) do not override the client's eligibility or program limitations. Not all eligibility groups receive all services.

Note: The Medicaid agency denies claims submitted without a required EPA number.

The Medicaid agency denies claims submitted without the appropriate diagnosis, procedure code, or service as indicated by the last three digits of the EPA number.

The billing provider must document in the client's file how EPA criteria were met and make this information available to the Medicaid agency upon request. If the Medicaid agency determines the documentation does not meet the criteria, the claim will be denied.

What are the EPA guidelines for documentation?

The provider must verify medical necessity for the services billed using the EPA number submitted. The client's medical record documentation must support the medical necessity and be available upon the Medicaid agency request. If the Medicaid agency determines the documentation does not meet EPA criteria, the claim will be denied.

Note: When medical necessity for the service cannot be established using the EPA clinical criteria, prior authorization is required.

Which services require EPA?

EPA #	EPA	Description	Billing Code(s)	Modifier
870000008	Lymphedema Therapy	Lymphedema management	0421- G0151 0431 - G0152	GO, GP
870000009	CNS Injury (Brain Injury - Traumatic and non-Traumatic, CVA - new onset)	Cerebral vascular accident with residual functional deficits within the past twenty-four months	0421- G0151 0431 - G0152 0441 - 92507	GN, GP & GO
870000010	Swallowing	Swallowing deficits due to injury or surgery to face, head, or neck	0431 - G0152, 0441 - 92507	GN, GO
870000011	Botox	As part of a botulinum toxin injection protocol when botulinum toxin has been prior authorized by the agency	0421- G0151 0431 - G0152	GP & GO
870000012	Spinal Injury/Surgery (para, quad & spinal surgery- new onset)	Spinal cord injury resulting in paraplegia or quadriplegia within the past twenty-four months	0421- G0151 0431 - G0152 0441 - 92507	GN, GP & GO
870000013	Major Joint Surgery	Major joint surgery - partial or total replacement only	0421- G0151 0431 - G0152	GP & GO

Home Health (Acute Care Services)

EPA #	EPA	Description	Billing Code(s)	Modifier
870000014	Muscular/skeletal, other (open fractures, ORIF)	New onset muscular-skeletal disorders such as complex fractures which required surgical intervention or surgeries involving spine or extremities (e.g., arm, hand, shoulder, leg foot, knee, or hip), Reflex sympathetic dystrophy	0421- G0151 0431 - G0152 0441 - 92507	GN, GP & GO
870000015	Burns/Wounds (complex)	Acute, open, or chronic non-healing wounds Burns - second or third degree only	0421- G0151 0431 - G0152 0441 - 92507	GN, GP & GO
870000016	Neurological Disorders - Adult Onset	New onset neuromuscular disorders which are affecting function (e.g., amyotrophic lateral sclerosis (ALS), active infective polyneuritis (Guillain-Barre)	0421-G0151 0431-G0152 0441-92507	GN, GP & GO
870000017	Speech deficit	Due to injury or surgery to face, head, or neck	0441-92507	GN
870001326	Bed Rails	Assess for bed rails and bed rail safety	0434-97165	GO
870001343	Personal Care for Children	Hours required for in-home care	0434-97166	GO

Provider Requirements

What are the Medicaid agency's documentation requirements?

The Medicaid agency requires home health providers to keep individual medical records for each client and report to Medicare's [Outcome and Assessment Information Set \(OASIS\)](#).

Documentation to keep in the client's medical record in the event of a Medicaid agency request

The individual client medical record must comply with community standards of practice, and must include documentation of:

- Visit notes for every billed visit.
- Supervisory visits for home health aide services as described in [Coverage/Limits](#).
- All medications administered and treatments provided.
- All licensed practitioner orders, new orders, and change orders, with notation that the order was received prior to treatment.
- Signed licensed practitioner new orders and change orders.
- Home health aide services as indicated by a registered nurse or licensed therapist in a home health aide care plan.
- Interdisciplinary and multidisciplinary team communications.
- Inter-agency and intra-agency referrals.
- Medical tests and results.
- Pertinent medical history.
- Notations and charting with signature and title of writer.

Visit notes

At a minimum, the provider must document:

- Skilled interventions per the plan of care (POC)
- Client response to POC
- Any clinical change in the client status
- Follow-up interventions specific to a change in status with significant clinical findings
- Any communications with the licensed practitioner

In addition, when appropriate:

- Any teachings, assessment, management, evaluation, client compliance, and client response
- **Weekly** documentation of wound care, size (dimensions), drainage, color, odor, and identification of potential complications and interventions provided
- If a client's wound is not healing, the client's licensed practitioner has been notified, the client's wound management program has been appropriately altered and if possible, the client has been referred to a wound care specialist
- The client's physical system assessment as identified in the POC

Will insufficiently documented home health care service cause a denial of claims?

(WAC [182-551-2220\(6\)](#))

The Medicaid agency may take back or deny payment for any insufficiently documented home health care service when the Medicaid agency determines that:

- The service did not meet the conditions listed in [Coverage/Limits](#).
- The service was not in compliance with program policy.

What are the plan of care (POC) requirements?

For any delivered home health service to be payable, the Medicaid agency requires home health providers to develop and implement an individualized POC for the client.

Note: Home health providers are required to comply with audits and/or site visits to ensure quality of care and compliance with state rule. All documentation in the client record, including the signed plan of care, must be made available to the Medicaid agency upon request. (See WAC 182-502-0020)

General requirements

The POC must:

- Be documented in writing and be located in the client's home health medical record.
- Be developed, supervised, and signed by a licensed registered nurse or licensed therapist.
- Reflect the licensed practitioner's orders and client's **current** health status.
- Contain specific goals and treatment plans.
- Be reviewed and revised by the licensed registered nurse or licensed therapist and the client's licensed practitioner at least every 60 calendar days.
- Signed by the licensed practitioner within 45 days of the verbal order.
- Returned to the home health agency's file.
- Be available to the Medicaid agency staff or its designated contractor(s) on request.

Information that must be in the POC

The POC must include:

- The client's name and date of birth
- The start of care
- The date(s) of service
- The primary diagnosis (the diagnosis that is **most related to the reason** the client qualifies for home health services, and the reason for the visit frequency)

Home Health (Acute Care Services)

- All secondary medical diagnosis including date(s) of onset (**O**) or exacerbation (**E**)
- The prognosis
- The type(s) of equipment required

Note: Durable Medical Supplies & Equipment (DME) must be billed on a separate claim using an NPI and taxonomy for which DME/MSE services are allowed. Do not bill DMEs on a Home Health claim.

- A description of each planned service and goals related to the services provided
- Specific procedures and modalities
- A description of the client's mental status
- A description of the client's rehabilitation potential
- A list of permitted activities
- A list of safety measures taken on behalf of the client
- A list of medications which indicates:
 - ✓ Any new (N) prescription.
 - ✓ Which medications are changed (C) for dosage or route of administration.

The following important information must be included in or attached to the POC:

- The client's address, including the name of the residential care facility where the client is residing (if applicable)
- A description of the client's functional limits and the effects
- Documentation that justifies why the medical services should be provided in the client's residence instead of a licensed practitioner's office, clinic, or other outpatient setting
- Significant clinical findings
- The dates of recent hospitalization
- Notification to the home health agency's designated case manager of admittance

- A discharge plan, including notification to the home health agency's designated case manager of the planned discharge date and client disposition at time of discharge
- A short summary of:
 - ✓ What is happening with the client
 - OR-
 - ✓ What has happened since last review

Is it required that clients be notified of their rights (Advance Directives)?

[\(42 CFR, Subpart I\)](#)

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions. Keep a copy of the written information in the client's record.

Clients have the right to:

- Accept or refuse medical treatment
- Make decisions concerning their own medical care
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care

Criteria for High-Risk Obstetrical

When is home care for hyperemesis gravidarum (HG) initiated?

Home care for the client with HG may be initiated when weight loss and significant metabolic changes require fluid and nutritional replacement therapy that can be managed in the home setting. The client or caregiver must be willing and capable of learning and managing the client's intravenous therapy.

Goals:

- Assess the client's condition
- Teach the client to help maintain the pregnancy to term
- Reduce the signs and symptoms of fluid, nutritional and electrolyte imbalances

Therapeutic Skilled Nursing Services may be initiated with the obstetrical provider's request for care. These services are designed to reinforce the clinic, hospital and/or provider's teaching. The nursing services assist the client and family in managing the client's care in the home and may include:

- Education about the factors that may contribute to HG, such as stress and coping with pregnancy
- Education on the symptoms related to dehydration and electrolyte disturbances and their effects on the mother and fetus (e.g., parenteral fluids and nutritional supplements)
- Assurance that the client is able to follow the treatment regimen (parenteral fluids and nutritional supplements) and comply with medications (antiemetics)
- Reinforcement of the obstetrical provider's plan of care, including the plan for resuming oral intake
- Demonstration of the ability to manage and administer the infusion treatment ordered by the obstetrical provider (hydration or total parenteral nutrition)
- Education concerning when to notify the obstetrical provider

Documentation in the client record is not limited to, but must include:

- An estimated date of confinement
- The gravidity/parity
- A history of symptoms of hyperemesis gravidarum (HG)
- An evaluation of clinical status of mother and fetus, including maternal weight and vital signs
- An evaluation of the obstetrical provider's plan of care
- A referral to a maternity support services (MSS) provider
- Education of the client and family regarding management of the prescribed care for a medically high-risk pregnancy

When are skilled nursing services used for clients with gestational diabetes?

Therapeutic Skilled Nursing Services may be initiated when there is a documented reason for teaching gestational diabetes management in the home. It should reinforce the obstetrical provider's or clinic's teaching.

Goals:

- Assess the client's condition
- Provide adequate support and education to help the client reduce symptoms of gestational diabetes
- Maintain the pregnancy to planned delivery

Whenever possible, education should be given at suitable diabetes teaching centers. A more complete and comprehensive training is available at these sites. A few cases may merit skilled nursing services. For example, skilled nursing may be provided to a client who is unable to get to a diabetes educational center or to a client who has special learning needs.

Therapeutic Skilled Nursing services may include:

- Assuring the client understands the plan of care

- Managing insulin injections
- Diet and exercise
- Demonstrating and teaching the blood glucose monitoring techniques, and the necessary times to test and documentation of testing results
- Explaining the differences between normal and abnormal blood glucose test results
- Explaining protocols for results of abnormal blood glucose, ketones and protein in the urine
- Planning with the client for emergency treatment of hyper/hypoglycemia
- Explaining when to notify the obstetrical provider about symptoms

Documentation in the client record is not limited to, but must include:

- The estimated date of confinement
- The gravidity/parity
- A history of symptoms of gestational diabetes
- An evaluation of clinical status of mother and fetus
- An evaluation of obstetrical provider's plan of care
- Rationale for in-home gestational diabetes education
- A referral to a maternity support services (MSS) provider
- Education of the client and family in the management of the prescribed treatment for a medically high-risk pregnancy.

When is home care for clients in preterm labor initiated?

Home care for preterm labor (PTL) symptoms may be initiated with the obstetrical provider's prescription for care and when there is an assurance of a viable newborn.

Goals:

- Assess the client's condition
- Provide adequate support and education to help the client maintain the pregnancy to term

Preventive services may be initiated between 20-25 weeks when an eligible client has a history of preterm births and/or has a multiple gestation and has been started on oral tocolytics.

Therapeutic Skilled Nursing Services may be initiated between 25-36 weeks gestation or birth (whichever comes first) or until the tocolytics are discontinued. Cervical changes should be documented at the start of care.

Skilled nursing care reinforces the medical protocol and assures that:

- The client comprehends and is compliant with the medication.
- The client can manage the restricted activity plan.
- The plan of care is coordinated with maternity support services (MSS) so that childcare and transportation services are readily available, if needed.
- The client education includes fetal movement count, signs and symptoms of preterm labor, and when to notify the obstetrical provider.

Documentation in the client record is not limited to, but must include:

- The estimated date of confinement
- The gravidity/parity
- A history of pre-term labor (PTL)
- Documentation of cervical change
- The obstetrical provider's plan of care
- An assessment of maternal and fetal clinical status
- A list of medications
- A referral to an MSS provider
- Education of the client and family in management of the prescribed care for a high-risk pregnancy

When is home care used for clients with pregnancy-induced hypertension?

Home care for Pregnancy-Induced Hypertension (PIH) may be initiated after 20 weeks gestation when:

- Blood pressure readings have increased by 30 mm Hg (systolic pressure) /15 mm Hg (diastolic pressure) over the baseline
- The client has accompanying symptoms (e.g., lab changes, proteinuria, and a weight gain greater than two lbs. / week). Late signs/symptoms may include hyperreflexia, epigastric pain, and/or visual changes.

Goals:

- Assess the client's condition
- Provide adequate support and education to help the client reduce symptoms of pregnancy induced hypertension
- Maintain the pregnancy to term

Therapeutic Skilled Nursing Services may be initiated at the prescribing medical provider's request and when documented signs and symptoms indicate the PIH may be safely managed in the home setting, **and** the:

- Client requires bed rest with bathroom privileges.
- Client understands and is able to comply with bed rest or reduced activities in the home.
- Assessment includes vital signs, fetal heart tones, fundal height, deep tendon reflexes, and a check for proteinuria, edema, and signs and symptoms of PIH.
- Client and family members receive education on:
 - ✓ How to monitor blood pressure
 - ✓ How to evaluate urine for protein
 - ✓ When to notify the obstetrical provider
- Skilled nursing service provider reinforces education that the client received from the obstetrical provider's office. This may include:
 - ✓ Etiology and diagnosis of PIH
 - ✓ Treatment and rationale
 - ✓ Nutrition needs

Home Health (Acute Care Services)

- ✓ Need for rest
 - ✓ Client monitoring of uterine and fetal activity
 - ✓ The role of medication in reducing symptoms (if provided)
- Plan of care is coordinated with the MSS provider so that childcare and transportation services are readily available.

Documentation in the client record is not limited to, but must include:

- The gravidity/parity
- A history of symptoms of PIH
- An evaluation of clinical status of mother and fetus
- An obstetrical provider's plan of care
- Frequency of clinic visits
- Activity level
- List of medication, if prescribed
- A referral to a maternity support services (MSS) provider
- Education of the client and family on management of the prescribed care

Billing

Effective for claims billed on and after October 1, 2016

All claims must be submitted electronically to the agency, except under limited circumstances.

For more information about this policy change, see [Paperless Billing at HCA](#).

For providers approved to bill paper claims, see the agency's [Paper Claim Billing Resource](#).

What are the general billing requirements?

Providers must follow the agency's [ProviderOne Billing and Resource Guide](#). These billing requirements include:

- What time limits exist for submitting and resubmitting claims and adjustments.
- When providers may bill a client.
- How to bill for services provided to primary care case management (PCCM) clients.
- How to bill for clients eligible for both Medicare and Medicaid.
- How to handle third-party liability claims.
- What standards to use for record keeping.

Note: When billing on an institutional claim, services provided on different days are required to be listed separately along with revenue code, procedure code, modifier, dates of service, and units.

Medical review rebilling: Prior to rebilling, remove all lines on the claim that have already been paid by the Medicaid agency.

ATTN: Special Handling
Home Health Services Program Manager
PO Box 45506
Olympia, WA98504-5506

Where is the Home Health Services fee schedule?

See the Medicaid agency's [Home Health Services Fee Schedule](#) web page.

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on the agency's [Billers and Providers](#) web page, under [Webinars](#).

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the [HIPAA Electronic Data Interchange \(EDI\)](#) web page.

External cause codes (V00-Y99) are required to be submitted in groups of three in order for a claim to be processed.