

Health and Recovery Services Administration (HRSA)



Home Health Services (Acute Care Services) Billing Instructions

(WAC 388-551-2000 through 2220)

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About this publication

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Important Contacts

A provider may use DSHS's toll-free lines for questions regarding its programs; however, DSHS's response is based solely on the information provided to the [HRSA] representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern DSHS's programs. [WAC 388-502-0020(2)].

Where do I call for information on becoming a DSHS provider, submitting a provider change of address or ownership, or to ask questions about the status of a provider application?

Call the toll-free line:
1-866-562-3022

Where do I send my claims?

Hard Copy Claims:
Division of Healthcare Services
PO Box 9248
Olympia WA 98507-9246

Magnetic Tapes/Floppy Disks:
Division of Healthcare Services
PO Box 45560
Olympia, WA 98504-5560

Where should I send medical verification of visits, Plan of Care, and Change Orders during Focused Review Period?

Quality Fee-For-Service
Home Health Program Manager
PO Box 45506
Olympia WA 98504-5506

Who do I call to get a list of Interpreter Agencies in my area?

1-800-562-3022 or go to:
<http://hrsa.dshs.wa.gov/> (Numbered Memo, **01-01 MAA**)

Where do I call if I have questions regarding...

Home health policy or medical review questions?

Home Health Program Coverage
Home Health Program Manager

Phone: 1-360-725-1570

FAX requests to: 1-360-586-1471

Long-term care (LTC) needs?

Home Health needing LTC Exceptions

FAX requests to: 1-360-586-1471

Home and Community Services (HCS) Front of local telephone book **or call:** State Reception Line 1-800-422-3263 and ask for local HCS number.

Division of Developmental Disabilities (DDD) Phone Numbers:

Region 1 1-800-462-0624

Region 2 1-800-822-7840

Region 3 1-800-788-2053

Region 4 1-800-314-3296

Region 5 1-800-248-0949

Region 6 1-800-339-8227

Pharmacy Authorization?

Pharmacists Only 1-800-848-2842

Where do I call if I have questions regarding...

Payments, denials, billing questions, or Healthy Options?

Provider Relations
1-800-562-3022

Private insurance or third party liability, other than Healthy Options?

Coordination of Benefits
1-800-562-6136

How do I obtain copies of billing instructions or numbered memoranda?

Go to HRSA's web site at:

<http://hrsa.dshs.wa.gov>

[Click **Provider Publications/ Fee Schedules**, Click **Accept**, then go to **Billing Instructions**.]

Definitions & Abbreviations

This section defines terms and abbreviations (includes acronyms) used in these billing instructions.

Acute care – Care provided by a home health agency for clients who are not medically stable or have not attained a satisfactory level of rehabilitation. These clients require frequent intervention by a registered nurse or licensed therapist.
[WAC 388-551-2010]

Authorization - Official approval for department action.

Authorized Practitioner – An individual 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:

- An injection;
- Blood draw; or
- Placement of medications in containers.

[WAC 388-551-2010]

Case Manager – A social worker or a nurse assigned by the Department of Social & Health Services (DSHS), Aging and Adult Services Administration (AASA) to manage and coordinate the client’s case.

Case Resource Manager (CRM) - An individual who meets with the family and assesses the client’s DDD needs, develops a plan with the family and helps connect to appropriate resources assigned by the Division of Developmental Disabilities (DDD).

Chronic care – Long-term care for medically

stable clients.
[WAC 388-551-2010]

Client – Any individual who has been determined eligible to receive medical or health care services under any medical assistance program.

Department - The state Department of Social and Health Services.
[WAC 388-500-0005]

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medical Benefits (EOMB) – A federal report generated by Medicare for its providers that displays transaction information regarding Medicare claims processing and payments.

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:

- Observation;
- Assessment;
- Treatment;
- Teaching;
- Training;
- Management; and
- Evaluation.

[WAC 388-551-2010]

Healthy Options - See Managed Care.

Home Health Agency - An agency or organization certified under Medicare to provide comprehensive health care on an intermittent or part-time basis to a patient in the patient's place of residence. [WAC 388-551-2010]

Home Health Aide – An individual registered or certified as a nursing assistance 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 388-551-2010]

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 conditions and needs, and completing appropriate records. [WAC 388-551-2010]

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 HRSA provider number. [WAC 388-551-2010]

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 department's Aging and Adult Services Administration (AASA) or Division of Developmental Disabilities (DDD). [WAC 388-551-2010]

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. [WAC 388-538-050]

Maximum Allowable - The maximum dollar amount a provider may be reimbursed by HRSA for specific services, supplies, or equipment.

Medicaid - The federal aid Title XIX program under which medical care is provided to persons eligible for:

- Categorically needy program as defined in WAC 388-503-0310 and 388-511-1105; or
- Medically needy program as defined in WAC 388-503-0320. [WAC 388-500-0005]

Health and Recovery Services

Administration (HRSA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI State Children's Health Insurance Program (SCHIP), Title XVI Supplemental Security Income for the Aged, Blind, and Disabled (SSI), and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.

Medical Identification (ID) card – The document that identifies a client's eligibility for a medical program. This card was formerly known as the medical assistance identification (MAID) card or medical coupon.

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. [WAC 388-500-0005]

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.

Plan of Care (POC) – (Also known as “plan of treatment” [POT]). A written document that is 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 388-551-2010]

Program Support, Division of (DPS) – The division within HRSA responsible for providing administrative services for the following:

- Claims Processing;
- Disease Case Management;
- Family Planning Services;
- First Steps;
- Field Services;
- Managed Care Contracts; and
- Provider Relations.

Provider or Provider of Service - An institution, agency, or person:

- a) Who has a signed agreement with the department to furnish medical care and goods and/or services to clients; and
- b) Is eligible to receive payment from the department. [WAC 388-500-0005]

Provider Number – A seven-digit identification number issued to service providers who have signed the appropriate contract(s) with HRSA.

Remittance and Status Report (RA) - A report produced by the claims processing system in the Division of Program Support, Health and Recovery Services Administration that provides detailed information concerning submitted claims and other financial transactions.

Residence - A client's home or private place of living. [WAC 388-551-2010]
(See page D.1 & D.8 for information on clients in residential facilities whose home health services are not covered through HRSA's home health program.)

Review Period – The three-month period HRSA assigns to a home health agency, based on the address of the agency's main office, during which HRSA reviews all claims submitted by that agency.
[WAC 388-551-2010]

Revised Code of Washington (RCW) - Washington State laws.

Specialized therapy – Skilled therapy services provided to clients that include: physical, occupational, and speech/audiology services. [WAC 388-551-2010]

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.

Third Party - Any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan.
[42 CFR 433.136]

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.

Usual & Customary Fee – The rate that may be billed to the department for a certain service or equipment. This rate may not exceed:

- The usual and customary charge that you bill the general public for the same services; or
- If the general public is not served, the rate normally offered to other contractors for the same services.

Washington Administrative Code (WAC) - Codified rules of the state of Washington.

Home Health Services

What is the purpose of the Home Health Program?

[Refer to WAC 388-551-2000]

The purpose of the Health and Recovery Services Administration (HRSA) home health program is to reduce the costs of health care services by providing 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.

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

Note: Chronic, long-term maintenance care - See page D.7.

Who is an eligible home health provider?

[Refer to WAC 388-551-2200]

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

A home health agency that:

- Is Title XVIII (Medicare) certified;
- Is Department of Health (DOH) licensed as a home health agency;
- Continues to meet DOH requirements;
- Submits a completed, signed Core Provider Agreement to HRSA; and
- Is assigned a Home Health provider number.

A registered nurse (RN) who:

- Is prior authorized by HRSA to provider intermittent nursing services when no home health agency exists 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 HRSA; and
- Is assigned a provider number.

Important! Please notify HRSA at 866.545.0544 **within ten days** of any change in name, address, or telephone number.

Notifying clients of their rights (advance directives)

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; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

Client Eligibility

Who Is Eligible? [Refer to WAC 388-551-2020(1)]

Clients with the following medical program identifiers on their DSHS Medical ID cards are eligible to receive home health services subject to the limitation described in these billing instructions:

Medical Program Identifier	Medical Program Name
CNP	Categorically Needy Program The following clients are eligible for Home Health services and are identified by the CNP identifier on their DSHS Medical ID cards: <ul style="list-style-type: none"> ✓ General Assistance – Expedited – GAX (disability determination pending) clients; and ✓ Pregnant Undocumented Alien
CNP – Children’s Health	Categorically Needy Program – Children’s Health <i>Clients with this identifier on their Medical ID card are <u>not eligible</u> for this, or any Medical Assistance Program.</i>
CNP – CHIP	CNP – Children’s Health Insurance Program
GAU No Out of State Care	General Assistance Unemployable
General Assistance – No Out of State Care	ADATSA, ADATSA Medical Only
LCP-MNP	Limited Casualty Program-Medically Needy Program

Note: Please refer clients to their local Community Services Office (CSO) if they need Home Health services and their DSHS Medical ID card does not list one of the above medical program identifiers. The CSO will evaluate these clients for a possible change in their Medical Assistance program that would enable them to receive Home Health Services.

Restrictions [Refer to WAC 388-551-2020(2)]

HRSA does not cover home health services under the home health program for clients with one of the following medical program identifiers on their Medical ID cards. However, HRSA does evaluate requests for home health skilled nursing visits on a case-by-case basis for clients with “**Emergency Medical Only**” listed on their Medical ID and may cover up to two skilled nursing visits within the eligibility enrollment period for clients on the state-funded Alien Medical (cancer or ESRD on dialysis) program. For more information, visit: <http://hrsa.dshs.wa.gov/News/aem.html>. Refer to page D.9 to further information.

- **CNP - Emergency Medical Only**; and
- **LCP-MNP – Emergency Medical Only**

HRSA does not cover home health services under the home health program for clients whose Medical ID card lists **MIP-EMER Hospital Only – No out-of-state care** (Medically Indigent Program); these clients are **not eligible** for Home Health services.

Managed Care Clients [Refer to WAC 388-551-2020(1)]

Clients with an identifier in the HMO column on their DSHS Medical ID cards are enrolled in one of HRSA’s Healthy Options managed care plans. Clients enrolled in a Healthy Options managed care plan receive all home health services through their designated plan, subject to the plans’ coverages and limitations. Covered home health services for clients enrolled in a Healthy Options managed care plan are paid for by that plan. **Do not bill HRSA.** Contact the plan by calling the telephone number indicated on the client’s Medical ID card.

Primary Care Case Manager (PCCM)/Management Clients

For clients who have chosen to obtain care with a PCCM, the identifier in the HMO column will be “PCCM.” These clients must obtain or be referred for services via the PCCM. The PCCM is responsible for coordination of care just like the Primary Care Provider (PCP) would be in a plan setting. **Please refer to the client’s DSHS Medical ID card for the PCCM.**

Dually-Enrolled Clients

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 by the Aging and Disability Services Administration (ADSA). Please contact your local ADSA field office for more information on these programs. If you do not know the local telephone number, you may call:

**State Reception Line
1-800-422-3263**

Coverage/Limits

When Does DSHS Reimburse for Covered Home Health Services? [Refer to WAC 388-551-2030]

DSHS reimburses 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 instruction and other applicable published Washington Administrative Codes (WAC).

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 Definitions);
- Be reasonable, based on 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 physician’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. DSHS 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.
 - ✓ **Residential facilities** contracted with the state to provide limited skilled nursing services are **not reimbursed** separately for those same services under DSHS’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 in these billing instructions for therapy services, DSHS will evaluate the need after receiving the request.
- ✓ Refer to Aging and Adult Services Administration's Residential Services web page: <http://www.aasa.dshs.wa.gov/Lookup/BHRequestv2.asp>
- Be provided by a home health agency that is Title XVIII (Medicare) certified and state-licensed.

Refer to WAC 388-551-2100(1)
DSHS covers home health acute care skilled nursing services listed in this section when furnished by a qualified provider. DSHS 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 388-501-0165.

What Is Covered? [Refer to WAC 388-551-2100(2)(3)]

Acute Nursing

1. DSHS covers the following home health acute care skilled nursing services:
 - a. **Full Skilled Nursing Services** - that require the skills of a Registered Nurse (RN) **or** a Licensed Practical Nurse (LPN) under the supervision of a Registered Nurse, if the services involve **one or more** of the following:
 - i. Observation (approximately 3 weeks);
 - ii. Assessment (approximately 3 weeks);
 - iii. Treatment;
 - iv. Teaching (approximately 3 days);
 - v. Training (approximately 4 visits unless client remains unstable); and
 - vi. Management; and
 - vii. Evaluation.

- b. **Brief Skilled Nursing Visit** - only if one of the following activities is performed during the visit:

- i. An injection;
- ii. Blood draw; or
- iii. Placement of medications in containers (e.g., envelopes, cups, medisets).

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

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

- c. **Coverage for Adult Noncitizens**

Effective for dates of service on and after November 1, 2009, the Department of Social and Health Services (DSHS) revised coverage for adult noncitizens under the following three medical programs:

- i. Federally funded Alien Emergency Medical (AEM) program;
- ii. State-funded Nursing Facility program; and
- iii. State-funded Alien Medical program.

Eligibility criteria for coverage and the services available are different for each medical program listed above. For more information, visit:
<http://hrsa.dshs.wa.gov/News/aem.htm>.

- d. **Home Infusion Therapy** - only if the client:

- i. Is willing and capable of learning and managing the client's infusion care; or
- ii. Has a volunteer caregiver willing and capable of learning and managing the client's infusion care.

Note: DSHS does not reimburse administration of IV therapy through the Home Health program. DSHS does reimburse for the teaching of IV therapy and skilled observation of IV site through the Home Health program.

Note: All other infusion therapy related services must be billed on a 1500 Claim Form using the Infusion Therapy Billing Instructions (see *Important Contacts*).

Note: Although DSHS clients may have a paid a caregiver who is willing and capable of performing the skilled task, as a paid caregiver they may not be paid for this service. The client may want to be involved in self-directed care [Refer to WAC 388-71-0580].

- e. **Infant Phototherapy** – for an infant diagnosed with hyperbilirubinemia:
- i. When provided by a DSHS-**approved**¹ infant phototherapy agency; **and**
 - ii. For up to **five (5)** skilled nursing visits per infant.

Note: If the infant’s mother is enrolled in a DSHS managed care plan at the time of the birth, you must receive approval from the managed care plan listed on the mother’s DSHS Medical ID card. **Do not bill DSHS for these services.**

Additional Information Required in the Plan of Care

(See page E.1 and E.2 for a complete list):

- i. Infant’s name, **mother’s** name, and PIC(s);
- ii. Information regarding the infant’s medical condition, and the family’s ability to safely provide home phototherapy;
- iii. Name of hospital where infant was born and discharge date;
- iv. Visit notes that include family teaching and interventions; **and**
- v. Bilirubin levels.

Note: DSHS will not cover infant phototherapy, **unless** your agency has a pre-approval letter on file from DSHS noting that you are a DSHS-approved infant phototherapy agency. Refer to the DSHS [Wheelchairs, Durable Medical Equipment \(DME\) and Supplies Billing Instructions](#) for equipment component.

¹ **How do I become a DSHS-approved infant phototherapy agency?**

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

f. **Limited High-Risk Obstetrical Services:**

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

Note: Use revenue code **551** with diagnosis codes V23 or 630 through 670 when billing for skilled high-risk obstetrical nursing care visits in the home setting.

DSHS does not reimburse for high-risk obstetrics if the registered nurse has not met the criteria listed above.

See Section F - DSHS's Specific Criteria for High-Risk Obstetrical

Specialized Therapy

[Refer to WAC 388-551-2110(1)(2)]

Specialized therapy services includes: physical, occupational, or speech/audiology services. DSHS reimburses for specialized therapy services only when the client is **not able to access these services in their local community**. DSHS 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. DSHS 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, DSHS requires the therapist to document the therapeutic benefit of having more than one therapist for specialized therapy on the same day.

Home Health Aide Services

[Refer to WAC 388-551-2120(1)(2)(3)]

1. DSHS limits home health aide visits to **one per day**.
2. DSHS reimburses for home health aide services only when the services are provided under the supervision of, and in conjunction with practitioners who provide:
 - a. Skilled nursing services; or
 - b. Specialized therapy services.
3. DSHS covers home health aide services only when a registered nurse or licensed therapist visits the client's residence at least once every 14 days to monitor or supervise home health aide services, with or without the presence of the home health aide. DSHS does not reimburse for services covered by another state administration such as LTC services, 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 DSHS case manager/case resource manager to see if the client is eligible for, or is already receiving, LTC services, COPES, CHORE, or CAP services.

Telemedicine

[Refer to WAC 388-551-2125]

What Is Covered?

Effective for dates of service on and after January 1, 2010, DSHS will cover home health services delivered through telemedicine (see below):

Revenue Code	Maximum Allowable Fee
0559	\$77.00

Who Is Eligible?

DSHS 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(es) where there is a high risk of sudden change in medical condition which could compromise health outcomes.

What Does DSHS Pay for?

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

Requirements for Payment

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 includes assessment of response to previous changes in the plan of care; and
 - ✓ Detection of condition changes based on the telemedicine encounter that may indicate the need for a change in the plan of care; and

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

What Does DSHS Not Pay for?

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

Prior Authorization

DSHS does not require prior authorization for the delivery of home health services through telemedicine.

What Is Not Covered? [Refer to WAC 388-551-2130]

1. DSHS 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 placed through the Department of Social and Health Services, Aging and Disability Services Administration (ADSA) or Division of Developmental Disabilities (DDD).

- i. **DSHS 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 ADSA or DDD to implement a long-term care skilled nursing plan or specialized therapy plan; and

- ii. On a case-by-case basis, DSHS may authorize long-term care skilled nursing visits or specialized therapy visits for a client for a limited time until an ADSA or DDD 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 instruction and other published WACs. (Refer to page D.9.). Fax DSHS forms 13-847 and 13-756 with requests to: 1-360-586-1471.

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 DSHS and request coverage** through the home health program (refer to page D.9);

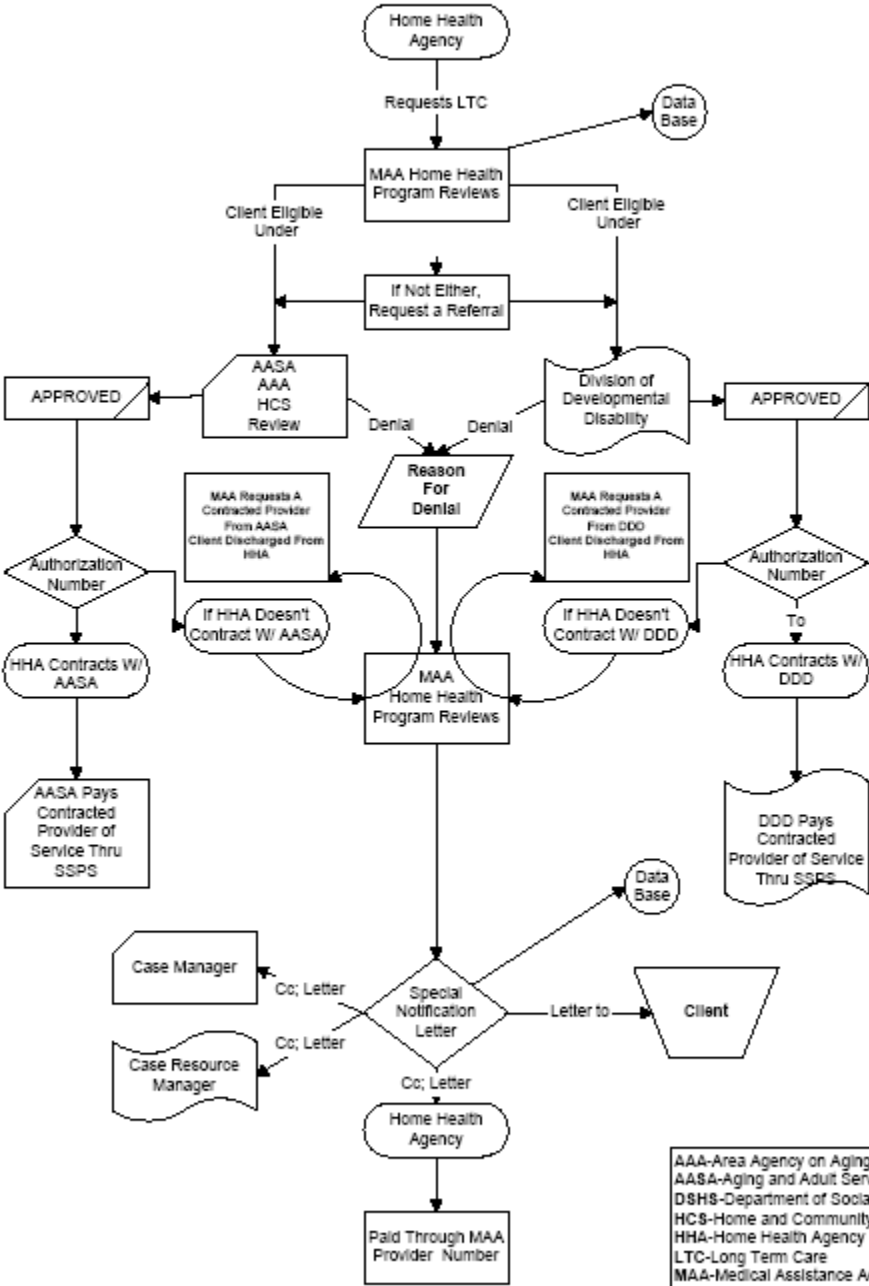
DSHS will first contact the client’s ADSA or DDD case manager to see if long-term care skilled nursing services are accessible in the community or through ADSA or DDD.

If there are no other options, DSHS 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 DSHS for a limited time until a long-term care plan is in place.

See LTC Skilled Nursing Needs flow chart on next page



**MAA Home Health Program
LTC Skilled Nursing Needs**



AAA-Area Agency on Aging
 AASA-Aging and Adult Services Administration
 DSHS-Department of Social and Health Services
 HCS-Home and Community Services
 HHA-Home Health Agency
 LTC-Long Term Care
 MAA-Medical Assistance Administration
 SSPS-Social Services Payment System

What Is Not Covered? (continued)

2. Social work services;
3. Psychiatric skilled nursing services;
4. Pre- and postnatal skilled nursing services, except those listed on page D.4;
5. Well-baby follow-up care;
6. Services performed in hospitals, correctional facilities, skilled nursing facilities, or a residential facility with skilled nursing available (refer to page D.9);
7. Home health aide services that are not provided in conjunction with skilled nursing or specialized therapy services;
8. 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 on page D.1);
9. Home health specialized therapies and home health aide visits for clients in the following programs:
 - a. CNP – emergency medical only; and
 - b. LCP-MNP – emergency medical only.
10. 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:

- a. The client or caregiver is not willing and/or capable of managing the client's infusion therapy care; or
 - b. A client requires daily visits in excess of program limitations.
11. More than one of the same type of specialized therapy and/or home health aide visit per day. **DSHS 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).
 12. Any home health services covered by another state administration such as LTC services, COPEs, CHORE, or CAP services.

13. Home health visits made without a written physician order, unless the verbal order is:
- a. Documented prior to the visit; and
 - b. The document is signed by the physician within 45 days of the order being given.

DSHS does not cover additional administrative costs billed above the visit rate (these costs are included in the visit rate and will not be paid separately).

DSHS evaluates a request for any service that is listed as noncovered under the provisions of WAC 388-501-0165.

Requests must include the following:

- 1. Name of agency and provider number;
- 2. Client's name and PIC number;
- 3. Copy of the plan of care; and
- 4. Explanation of client-specific medical necessity.

Send requests for noncovered services to:

DSHS - Division of Healthcare Services
Home Health Services Program Manager
PO Box 45506
Olympia, WA 98504-5506
1-360-725-1570
FAX: 1-360-586-1471

See Authorization on next page for information regarding Limitation Extensions.

Authorization

HRSA 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 388-501-0165.

Note: A provider may request an exception to rule (ETR) for a noncovered service as described in WAC 388-501-0160.

Limitation Extension and Exception to Rule (ETR)

What is a Limitation Extension?

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 DSHS's Washington Administrative Code (WAC) and billing instructions.

How do I get LE or ETR authorization?

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

Your request must include the following:

1. Name of agency and provider number;
2. Client's name and PIC number;
3. Copy of the plan of care;
4. Explanation of client-specific medical necessity to exceed limitation or why it is an exception to rule.

Clients who have Medicare as their primary insurance must meet Medicare's definition of "home bound" for Home Health services.

Note: Please indicate on your request if the client does not meet Medicare's definition of "home-bound" when submitting the ETR request.

Clients who don't meet Medicare's definition of home bound may be eligible for Medicaid to cover Home Health services as an Exception to Rule (ETR). These clients must still meet Medicaid's Home Health coverage requirements listed above.

What forms are required?

DSHS requires both of the following forms to request LE or ETR authorization:

- DSHS form 13-847 HRSA Home Health & Hospice Authorization Request; and
- DSHS form 13-756 Fax/Written Request Basic Information.

Please send or fax your completed forms to the following:

HRSA – Division of Healthcare Services
Home Health Services Program Manager
PO Box 45506
Olympia, WA 98504-5506
1-360-725-1570
FAX: 1-360-586-1471

Provider Requirements

Documentation Requirements

HRSA requires home health providers to keep individual medical records for each client.

Documentation That Must be Kept in the Client's Medical Record but Does NOT Have to be Sent to HRSA Unless Requested

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 on page D.6, #3;
- All medications administered and treatments provided;
- All physician orders, new orders, and change orders, with notation that the order was received prior to treatment;
- Signed physician 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; and
- Notations and charting with signature and title of writer.

What documentation must be kept in the visit notes?

The provider must document at least the following in the client's medical record:

- Skilled interventions per the 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; and
- Any communications with the attending physician.

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 physician 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; and
- The client's physical system assessment as identified in the POC.

Insufficiently Documented Home Health Care Service [Refer to WAC 388-551-2220(6)]

HRSA may take back or deny payment for any insufficiently documented home health care service when the HRSA Medical Director or designee determines that:

- The service did not meet the conditions listed in the Coverage/Limitation section; or
- The service was not in compliance with program policy.

Plan of Care Requirements

For any delivered home health service to be payable, HRSA requires home health providers to develop and implement an individualized Plan of Care (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 HRSA upon request. (Refer to WAC 388-502-0020)

About the Plan of Care

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 physician'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 physician at least every 60 calendar days;
- Signed by the physician within 45 days of the verbal order;
- Returned to the home health agency's file; and
- Be available to department staff or its designated contractor(s) on request.

What must be included in the Plan of Care?

The provider must include in the POC all of the following:

- 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 is the reason for the visit frequency;
- 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 (MSE) must be billed on a separate 1500 Claim Form using the DME provider number assigned by HRSA. Do not bill Durable MSEs 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; and
- A list of medications which indicates:
 - ✓ Any new (**N**) prescription; and
 - ✓ Which medications are changed (**C**) for dosage or route of administration.

Important Information to Send with the Plan of Care if not Already Included

The provider must include in, or attach to the POC:

- Client's address including 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 physician's office, clinic, or other outpatient setting;
- Significant clinical findings;
- Dates of recent hospitalization;
- Notification to the DSHS case manager of admittance;
- A discharge plan, including notification to the DSHS case manager of the planned discharge date and client disposition at time of discharge; and
- A short summary of what is happening with the client or what has happened since last review.

Criteria for High-Risk Obstetrical

Hyperemesis Gravidarum

GOALS:

1. Assess the client's condition;
2. Teach the client to help maintain her pregnancy to term; **and**
3. Reduce the signs and symptoms of fluid, nutritional and electrolyte imbalances.

Home care for the client with hyperemesis gravidarum (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.

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 her care in the home and may include:

- Education about the factors that may contribute to hyperemesis gravidarum, 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); **and**
- Education concerning when to notify the obstetrical provider.

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

- Estimated date of confinement;
- Gravidity/parity;
- History of symptoms of hyperemesis gravidarum (HG)
- Evaluation of clinical status of mother and fetus, including maternal weight and vital signs;
- Evaluation of the obstetrical provider's plan of care;
- Referral to a Maternity Support Service provider; **and**
- Education of the client and family regarding management of the prescribed care for a medically high-risk pregnancy.

Gestational Diabetes

GOALS:

1. Assess the client's condition;
2. Provide adequate support and education to help the client reduce symptoms of gestational diabetes; **and**
3. Maintain the pregnancy to planned delivery.

Whenever possible, education should be given at suitable diabetic 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 diabetic educational center or to a client who has special learning needs.

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.

Therapeutic skilled nursing services may include:

- Assuring the client understands her 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; **and**
- Explaining when to notify the obstetrical provider about symptoms.

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

- Estimated date of confinement;
- Gravidity/parity;
- History of symptoms of gestational diabetes;
- Evaluation of clinical status of mother and fetus;
- Evaluation of obstetrical provider's Plan of Care;
- Rationale for in-home gestational diabetes education;
- Referral to a Maternity Support Service provider; **and**
- Education of the client and family in the management of the prescribed treatment for a medically high-risk pregnancy.

Preterm Labor

GOALS:

1. Assess the client's condition; **and**
2. Provide adequate support and education to help the client maintain her pregnancy to term.

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.

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 so that childcare and transportation services are readily available, if needed; **and**
- The client education includes fetal movement count, signs and symptoms of preterm labor and when to notify obstetrical provider.

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

- Estimated date of confinement;
- Gravidity/parity;
- History of pre-term labor (PTL);
- Documented cervical change;
- Obstetrical provider's plan for care;
- Assessment of maternal and fetal clinical status;
- Medications;
- Referral to a Maternity Support Service (MSS) provider; **and**
- Education of the client and family in management of the prescribed care for a high-risk pregnancy.

Pregnancy-Induced Hypertension

GOALS:

1. Assess the client's condition;
2. Provide adequate support and education to help the client reduce symptoms of pregnancy induced hypertension; **and**
3. Maintain the pregnancy to term.

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; **and**
- 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.

Therapeutic Skilled Nursing Services may be initiated at the prescribing medical provider's request and 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/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; **and**
 - ✓ When to notify the obstetrical provider.
- Reinforce education client received from her obstetrical provider's office. This may include:
 - ✓ Etiology and diagnosis of PIH;
 - ✓ Treatment and rationale;
 - ✓ Nutrition needs;
 - ✓ Need for rest;
 - ✓ Client monitoring of uterine and fetal activity; **and**
 - ✓ The role of medication in reducing symptoms (if provided).
- The plan of care is coordinated with the MSS provider so that childcare and transportation services are readily available.

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

- Estimated date of confinement;
- Gravidity/parity;
- History of symptoms of PIH;
- Evaluation of clinical status of mother and fetus;
- Obstetrical provider's plan for care;
- Frequency of clinic visits;
- Activity level;
- Medication, if prescribed;
- Referral to a Maternity Support Service provider; **and**
- Education of the client and family on management of the prescribed care.

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Billing

What are the general billing requirements?

Providers must follow the general billing requirement in DSHS's [General Information Booklet](http://maa.dshs.wa.gov/download/BillingInstructions/General_Information_BI.pdf) (http://maa.dshs.wa.gov/download/BillingInstructions/General_Information_BI.pdf). These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims;
- What fee to bill DSHS for eligible clients;
- When providers may bill a client;
- How to bill for services provided to primary care case management (PCPM) clients;
- Billing for clients eligible for both Medicare and Medicaid;
- Third-party liability; and
- Record keeping requirements.

Medical Review Rebilling:

Prior to rebilling, please cross off all lines on the claim form that HRSA has already paid.

ATTN: Special Handle
Home Health Services Program Manager
PO Box 45506
Olympia, WA 98504-5506

Fee Schedule

You may view HRSA's **Home Health Services** on-line at:

<http://hrsa.dshs.wa.gov/RBRVS/Index.html>

UB-04 Claim Form

Attention! HRSA accepts only the new UB-04 Claim Form.

- **On March 1, 2007**, HRSA began accepting both the new UB-04 and the old UB-92 claim forms.
- **As of May 23, 2007**, HRSA accepts only the new UB-04 claims form. HRSA will return all claims submitted on the UB-92 claim forms.

Detailed instructions on how to complete and bill according to the official UB-04 Data Specifications Manual is available from the National Uniform Billing Committee at: <http://www.nubc.org/index.html>.

For more information, read # Memorandum [06-84](#).

To see a sample of the UB-04 Claim Form, see the [General Information Booklet](#).