Washington State Health Care Authority

Medicaid Provider Guide

Home Health Services (Acute Care Services) WAC 182-551-2000 through 2220

October 1, 2013





A Billing Instruction

About this guide

This guide supersedes all previous *Home Health Services Medicaid Provider Guides* published by the Health Care Authority (the Medicaid agency).

What has changed?

Reason for	Effective		
Change	Date	Subject	Change
PN 13-63	10/1/2013	Does the agency cover home health services through telemedicine?	Update with a new revenue code and add CPT® codes to use for delivery of home health services by telemedicine provided by RNs or LPNs.

How can I get agency provider documents?

To download and print agency provider notices and Medicaid provider guides, go to the agency's <u>Provider Publications</u> website.

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Resources Available

Торіс	Contact Information		
Becoming a provider or submitting a change of address or ownership. Finding out about payments, denials, claims processing, or Medicaid agency contracted managed care organizations. Electronic or paper billing. Finding Medicaid agency documents (e.g., provider guides, provider notices, fee schedules). Private insurance or third- party liability, other than agency-contracted managed	See the Medicaid agency's <u>Resources Available</u> web page.		
care. Sending medical verification of visits, plan of care, and change orders during focused review periods.	Health Care Benefits and Utilization Management Home Health Program Manager PO Box 45506 Olympia WA 98504-5506		
Finding a list of Interpreter Agencies in my area.	Visit the Medicaid agency's <u>Medicaid Interpreter Services</u> website.		
Home health policy or medical review questions.	Home Health Program Coverage Home Health Program Manager Phone: (360) 725-1611 FAX requests to: 866-668-1214		
Long-Term Care (LTC) needs.	Home Health needing LTC Exceptions FAX requests to: 866-668-1214		
Home and Community Services (HCS).	Look in the front of the local telephone book or call the Aging and Long-Term Support Administration (ALTSA) State Reception Line 800-422-3263 and ask for local HCS number.		

Topic	Contact Information		
Division of Developmental	Region 1 800-462-0624		
Disabilities (DDD) phone	Region 2 800-822-7840		
numbers.	Region 3 800-788-2053		
	Region 4 800-314-3296		
	Region 5 800-248-0949		
	Region 6 800-339-8227		
Pharmacy Authorization.			
	See the Medicaid agency's <u>Resources Available</u> web page.		
Contacting Aging and Long-	If you do not know the local telephone number, you may call:		
Term Support Administration (ALTSA)	ALTSA State Reception Line: 800-422-3263		
How do I obtain prior authorization or a limitation extension?	For all requests for prior authorization or limitation extension, the following documentation is "Required":		
	• A completed, TYPED General Information for Authorization form (HCA <u>13-835</u>). This request form MUST be the initial page when you submit your request.		
	• A completed Home Health and Hospice (including PPC) Authorization Request form (HCA <u>13-847</u>), and all the documentation listed on this form and any other medical justification.		
	Fax your request to: 866-668-1214.		
	See the Medicaid agency's <u>Resources Available</u> web page.		
Contacting the Medicaid	For all written requests, fax a completed, typed General		
agency regarding requests for	Information for Authorization form (HCA $13-835$), as well as a		
noncovered services.	completed Home Health and Hospice (including PCC) Authorization Request form (HCA <u>13-847</u>), to 866-668-1214.		
	See the Medicaid agency's <u>Resources Available</u> web page.		

Definitions

This section defines terms and abbreviations, including acronyms, used in this provider guide. Refer to the agency's <u>Medical Assistance Glossary</u> for a more complete list of definitions.

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 <u>182-551-2010</u>]

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
- Placement of medications in containers.

[WAC 182-551-2010]

Case Manager – A social worker or a nurse assigned Aging and Long-Term Care Administration (ALTSA), the Department of Social & Health Services 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 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:

- Observation
- Assessment
- Treatment
- Teaching
- Training
- Management
- Evaluation

[WAC 182-551-2010]

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 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 conditions and needs, and completing appropriate records. [WAC 182-551-2010] **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 parttime basis by a Medicare certified home health agency with a current Core Provider Agreement. [WAC <u>182-551-2010</u>].

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 (ALTSA) or Division of Developmental Disabilities (DDD) 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 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 182-551-2010]

Residence - A client's home or private place of living. [WAC 182-551-2010] (See When Does the Medicaid agency Pay for Covered Home Health Services for information on clients in residential facilities whose home health services are not covered through the Medicaid agency's home health program.)

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. [Refer to 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.

Home Health Services

[Refer to WAC <u>182-551-2000</u>]

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 <u>What Home Health Services Are Not Covered</u> for information on chronic, long-term maintenance care.

Who is an eligible home health provider?

[Refer to WAC <u>182-551-2200</u>]

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 provider guide and applicable published Washington Administrative Code (WAC).

A home health agency that:

- Is <u>Title XVIII</u> (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 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 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 the Medicaid agency.
- Has an RN home health taxonomy on their provider file.

Important! Notify the Medicaid agency within ten days of any change in name, address, or telephone number (see <u>Resources Available</u>).

Client Eligibility

[Refer to WAC <u>182-551-2020</u>(1)]

Who is eligible?

See the Medicaid agency's <u>ProviderOne Billing and Resource Guide</u> for instructions on how to verify a client's eligibility.

Note: Refer to the <u>Scope of Categories of Healthcare Services Table</u> for an up-todate listing of benefit packages.

What are the restrictions?

[WAC <u>182-551-2020</u>(2)]

The Medicaid agency does not cover home health services under the Home Health program for clients in the CNP-Emergency Medical Only

Are managed care clients covered?

[Refer to WAC <u>182-551-2020(1)]</u>

YES! When verifying eligibility using ProviderOne, if the client is enrolled in a Medicaid agencycontracted 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 with 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 <u>ProviderOne Billing and</u> <u>Resource Guide</u> 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, this 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 <u>ProviderOne Billing and</u> <u>Resource Guide</u> 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 (ALTSA). Contact the local ALTSA field office for more information on these programs (see <u>Resources Available</u>).

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" on the UB-04 box 80 REMARKS.

Coverage/Limits

[Refer to WAC <u>182-551-2030</u>]

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 provider guide and other applicable published Washington Administrative Code (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 <u>Definitions</u>).
- 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. 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.
 - ✓ 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 in this provider guide for therapy services, the Medicaid agency will evaluate the need after receiving the request.
- ✓ Refer to the Aging and Long-Term Support Administration's (ALTSA) <u>Residential</u> <u>Care Services</u> web page.
- Be provided by a home health agency that is Title XVIII (Medicare) certified and statelicensed.

Refer to WAC <u>182-551-2100(1)</u>

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 <u>182-501-0165</u>.

Does the agency cover acute care nursing services?

[Refer to WAC <u>182-551-2100</u>(2)(3)]

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

- 1. **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:
 - a. Observation (approximately 3 weeks)
 - b. Assessment (approximately 3 weeks)
 - c. Treatment
 - d. Teaching (approximately 3 days)
 - e. Training (approximately 4 visits unless client remains unstable)
 - f. Management
 - g. Evaluation

- 2. **Brief Skilled Nursing Visit** only if one of the following activities is performed during the visit:
 - a. An injection
 - b. A blood draw
 - c. 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 (whether they are brief or full) per day**.

- 3. **Home Infusion Therapy** only if the client:
 - a. Is willing and capable of learning and managing the client's infusion care.
 - b. Has a volunteer caregiver willing and capable of learning and managing the client's infusion care.

Note: The Medicaid agency does not reimburse for administration of IV therapy through the Home Health program. The Medicaid agency 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 CMS-1500 claim form using the <u>Home Infusion Therapy/Parenteral Nutrition Program</u> <u>Medicaid Provider Guide</u>.

Note: Although Medicaid agency clients may have a paid 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.

- 4. **Infant Phototherapy** for an infant diagnosed with hyperbilirubinemia:
 - a. When provided by a Medicaid agency-approved infant phototherapy agency.
 - b. For up to five (5) 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.**

- 5. **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. Up to **three** home health visits per pregnancy, if:
 - a. Enrollment in or referral to the following providers of First Steps has been verified:
 - i. Maternity Support Services (MSS)
 - ii. Maternity Case Management (MCM)
 - b. The visits are provided by a registered nurse who has either:
 - i. National perinatal certification.
 - ii. A minimum of one year of labor, delivery, and postpartum experience at a hospital within the last five years.

Note: Use revenue code **0551** with diagnosis codes V23 or 630 through 670 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 the Medicaid agency's Criteria for High-Risk Obstetrical.

Additional information required in the plan of care (See <u>Criteria for</u> 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 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:

- 1. Be a Medicaid and Medicare certified Home Health agency.
- 2. Have an established phototherapy program.
- 3. Submit to the Medicaid agency for review, all of the following:
 - a. Six months of documented phototherapy services delivered for infants.
 - b. 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.
 - c. Three letters of recommendation from pediatricians who have utilized 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. Refer to the Medicaid agency's Wheelchairs, Durable Medical Equipment (DME), and Supplies Medicaid Provider Guide for equipment component.

Does the agency cover specialized therapy for clients 20 years of age and younger?

[Refer to WAC <u>182-551-2110(1)(2)]</u>

For eligible clients 20 years of age and younger, the Medicaid agency covers specialized therapy services which includes physical, occupational, or speech/audiology services:

The Medicaid agency reimburses for specialized therapy services only when the client is **not able to access these services in their 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 therapies for clients 21 Years of age and older and clients 19 and 20 years of age in MCS/ALTSA?

The following benefit limits for outpatient rehabilitation (occupational therapy, physical therapy, and speech therapy) apply to clients 21 years of age and older and to clients 19 through 20 years of age in MCS/ALTSA. 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)

What are the limits for therapies?

The limits for therapies are **per client, per calendar year**. In order to ensure payment, follow these guidelines:

- 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 limits, by submitting a service limit request to Medical Administration Customer Service Center (MACSC) by using the <u>on-line request</u> <u>form</u>.
- Consult the <u>ProviderOne Billing and Resource Guide</u>: Client Eligibility, Benefit Packages, and Coverage Limits sections.

See <u>expedited prior authorization</u> (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.

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 provider guide. Failure to bill correctly will result in denials or recoupment.

Modality	Home Health Revenue Codes	Home Health Procedure Codes	Description	Modifiers
PT	0421	G0151	Services performed by a qualified physical therapist in the home health or hospice setting each 15 minutes.	GP
ОТ	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 therapy evaluations for clients 21 years of age 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 <u>Therapy evaluation codes</u> table below. Providers bill with revenue code, the CPT code, and the appropriate modifier. Providers must request authorization for a limitation extension if additional evaluations are needed.

Therapy evaluation codes table

Modality	Evaluation Revenue Codes	Evaluation CPT Codes	Description	Modifiers	Limitations	
РТ	0424	97001	Physical Therapy Evaluation	GP	1 per client, per calendar year.	
		97002	Physical Therapy Re- evaluation at time of discharge	GP	1 per client, per calendar year.	
		97542	Wheelchair management	GP	1 per client, per calendar year. Assessment is limited to four 15-min units per assessment. Indicate on claim wheelchair assessment.	
	0434	97003	Occupational Therapy Evaluation	GO	1 per client, per calendar year.	
ОТ		97004	Occupational Therapy Re-evaluation at time of discharge	GO	1 per client, per calendar year.	
		0434	0434	97542	Wheelchair management	GO
ST	0444	92	92506	Speech Language Pathology Evaluation	GN	1 per client, per calendar year.
		S9152	Speech Language Pathology Re-evaluation at time of discharge	GN	1 per client, per calendar year.	
		92610	Evaluate swallowing function (this one would not have any limits)	GN	No Limit.	
		92597	Oral speech device eval	GN	No Limit.	

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

When a client meets the EPA criteria listed in <u>Authorization</u> 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 the limits for home health aide services?

[Refer to <u>WAC 182-551-2120(1)(2)(3)</u>]

- 1. The Medicaid agency limits home health aide visits to **one per day**.
- 2. 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:
 - a. Skilled nursing services.
 - b. Specialized therapy services.
- 3. 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 14 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, 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?

[Refer to WAC <u>182-551-2125</u>]

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

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

Revenue Code	HCPCS Code	Short	Limitation	
		Description		
0780	T1030	RN home care	1 per client per	
		per diem	day	
0780	T1031	LPN home care	1 per client per	
		per diem	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 includes 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.
- Coordination of care with the ordering licensed provider regarding findings from the telemedicine encounter.
- \checkmark Coordination and referral to other medical providers as needed.
- \checkmark 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?

[Refer to WAC <u>182-551-2130</u>]

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

1. 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 (ALTSA) or Division of Developmental Disabilities (DDD).

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 ALTSA or DDD 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 ALTSA 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 provider guide and other published WACs.

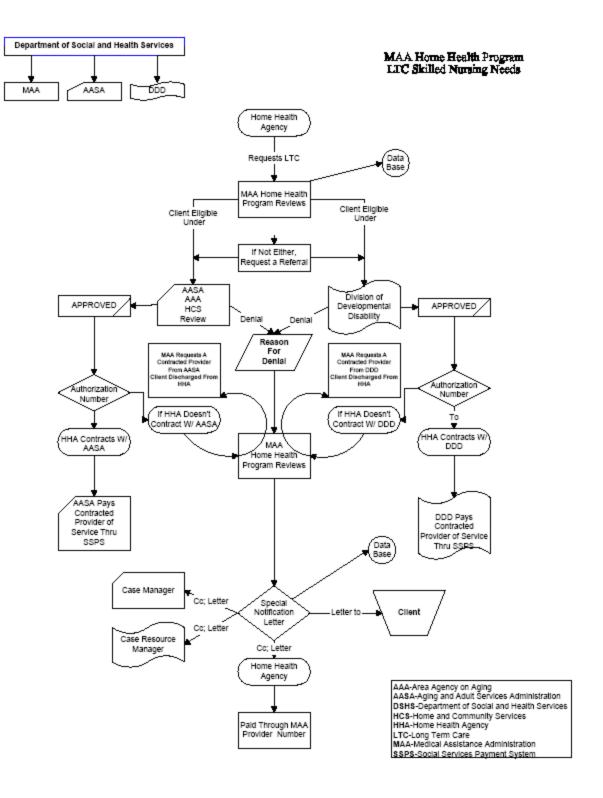
Home Health Agencies

- 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 ALTSA or DDD case manager to see if long-term care skilled nursing services are accessible in the community or through ALTSA 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.

See LTC Skilled Nursing Needs flow chart on next page



Long Term Care Skilled Nursing Needs Flow Chart

What Is Not Covered? (continued)

- 2. Social work services
- 3. Psychiatric skilled nursing services
- 4. Pre and postnatal skilled nursing services, except those listed under Covered Acute Nursing Services
- 5. Well-baby follow-up care
- 6. Services performed in hospitals, correctional facilities, skilled nursing facilities, or a residential facility with skilled nursing available
- 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 in this guide)
- 9. 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.
- b. A client requires daily visits in excess of program limitations.
- 10. 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).
- 11. 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).
- 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.
 - b. The document is signed by the physician within 45 days of the order being given.
- 14. 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 $\underline{182-501-0165}$.

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 <u>Resources Available</u>). See <u>Authorization</u> 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 <u>182-501-0165</u>.

Note: A provider may request an exception to rule (ETR) for a noncovered service as described in WAC <u>182-501-0160</u>.

What is a limitation extension (LE)?

An 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 provider guides.

How is LE or ETR authorization obtained?

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 NPI
- 2. Client's name and ProviderOne Client ID
- 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 "<u>homebound</u>" for Home Health services.

Note: 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 <u>homebound</u> 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. See <u>Coverage/Limits</u>.

What forms are required for LE or ETR authorization?

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

- Home Health & Hospice Authorization Request form, <u>13-847</u>
- General Information for Authorization form, <u>13-835</u>

Send or fax your completed forms to the Medicaid agency (see Resources Available).

Note: See the Medicaid agency's <u>ProviderOne Billing and Resource Guide</u> 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
87000008	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

EPA #	ЕРА	Description	Billing Code(s)	Modifier
870000013	Major Joint Surgery	Major joint surgery - partial or total replacement only;	0421- G0151; 0431 - G0152	GP & GO
870000014	Muscular/skeleta l, 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

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 <u>Outcome and Assessment Information Set (OASIS)</u>.

Documentation that must be kept in the client's medical record but does NOT have to be sent to the Medicaid agency 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 in <u>Coverage/Limits.</u>
- 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.
- 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
- 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.
- The client's physical system assessment as identified in the POC.

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

[Refer to <u>WAC 182-551-2220(6)</u>]

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 <u>Coverage/Limits</u>.
- 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. (Refer to <u>WAC 182-502-0020</u>.

About the POC

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.
- Be available to the Medicaid agency staff or its designated contractor(s) on request.

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 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 CMS-1500 claim form using an NPI and taxonomy for which DME/MSE services are allowed. 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.
- A list of medications which indicates:
 - ✓ Any new (**N**) prescription.
 - \checkmark Which medications are changed (C) for dosage or route of administration.

Important information must be included in or attached to the POC:

- The 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.
- 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.

What is the requirement for 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.
- 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:

- 1. Assess the client's condition.
- 2. Teach the client to help maintain her pregnancy to term.
- 3. 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 her 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 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
- 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:

- 1. Assess the client's condition.
- 2. Provide adequate support and education to help the client reduce symptoms of gestational diabetes.
- 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 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.
- 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
- 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:

- 1. Assess the client's condition.
- 2. Provide adequate support and education to help the client maintain her 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 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 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
- 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:

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

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:
 - \checkmark How to monitor blood pressure.
 - \checkmark How to evaluate urine for protein.
 - \checkmark When to notify the obstetrical provider.
- Reinforce education client received from her obstetrical provider's office. This may include:
 - ✓ Etiology and diagnosis of PIH.
 - \checkmark Treatment and rationale.
 - $\checkmark \qquad \text{Nutrition needs.}$
 - $\checkmark \qquad \text{Need for rest.}$
 - ✓ Client monitoring of uterine and fetal activity.

- \checkmark 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
- Education of the client and family on management of the prescribed care

Billing and Claim Forms

What are the general billing requirements?

Providers must follow the agency's <u>ProviderOne Billing and Resource Guide</u>. 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 the UB-04 claim form. 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, cross off all lines on the claim form that the Medicaid agency has already paid.

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

Where is the Home Health Services fee schedule?

You may view the Medicaid agency's Home Health Services Fee Schedule.

How is the UB-04 claim form completing?

Detailed instructions on how to complete and bill according to the official UB-04 Data Specifications Manual is available from the <u>National Uniform Billing Committee</u>.