

HOME HEALTH SERVICES MANUAL

**SECTION I – INTRODUCTION**

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I. INTRODUCTION

- A. This new edition of the Kentucky Medicaid Program Home Health Services Manual has been formulated with the intention of providing you, the provider, with a useful tool for interpreting the procedures and policies of the Kentucky Medicaid program. It has been designed to facilitate the processing of your claims for services provided to qualified recipients of Medicaid.

This manual is intended to provide basic information concerning coverage, billing, and policy. It will assist you in understanding what procedures are reimbursable, and will also enable you to have your claims processed with a minimum of time involved in processing rejections and making inquiries. It has been arranged in a loose-leaf format, with a decimal page numbering system which will allow policy and procedural changes to be transmitted to you in a form which may be immediately incorporated into the manual (i.e., page 7.6 might be replaced by new pages 7.6 and 7.7).

Precise adherence to policy is imperative. In order that your claims may be processed quickly and efficiently, it is extremely important that you follow the policies as described in this manual. Any questions concerning general agency policy should be directed to the Cabinet for Health and Family Services [~~Human Resources~~], Department for Medicaid Services, Office of the Commissioner, 275 E. Main Street, Frankfort, Kentucky 40621, or phone 1-502-564-4321. Questions concerning the application or interpretation of agency policy with regard to individual services should be directed to the Cabinet for Health and Family Services [~~Human Resources~~, Department for Medicaid Services, Division of [~~Long Term Care and~~] Community Alternatives, 275 E. Main Street, Frankfort, Kentucky 40621, or phone 1-502-564-5560. [~~Questions concerning billing procedures or the specific status of claims should be directed to EDS, P. O. Box 2009 Frankfort, Kentucky 40602, or phone (800) 756-7557 (In State) or (502) 227-2525.~~

~~B. Fiscal Agent~~

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~~Effective December 1, 1983) The Department for Medicaid Services contracts with Electronic Data Systems (EDS) to serve as the fiscal agent for the operation of the Kentucky Medicaid Management Information System (MMIS). EDS receives and processes all claims for medical services provided to Kentucky Medicaid recipients.]~~

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**II. KENTUCKY MEDICAID PROGRAM**

**A. General Information**

The Kentucky Medicaid Program is administered by the Cabinet for Human Resources (CHR), Department for Medicaid Services (DMS). The Medicaid Program, identified as Title XIX of the Social Security Act, was enacted in 1965, and operates according to a State Plan approved by the U.S. Department of Health and Human Services.

Title XIX is a joint Federal and State assistance program which provides payment for certain medical services rendered to Kentucky recipients who lack sufficient income or other resources to meet the cost of such care. The basic objective of the Kentucky Medicaid Program is to aid the medically indigent of Kentucky in obtaining quality medical care.

As a provider of medical services, you must be aware that the DMS is bound by both Federal and State statutes and regulations governing the administration of the State Plan. DMS shall not reimburse for any services not covered by the plan. The state cannot be reimbursed by the federal government for monies improperly paid to providers of non-covered unallowable medical services.

The Kentucky Medicaid Program, Title XIX, is not to be confused with Medicare. Medicare is a Federal provision, identified as Title XVIII, basically serving persons 65 years of age and older, and some disabled persons under that age.

The Kentucky Medicaid Program serves eligible recipients of all ages. The coverage, either by Medicare or Medicaid, will be specified in the body of this manual.

**~~B. Administrative Structure~~**

~~The DMS within the CHR bears the responsibility for developing, maintaining, and administering the policies and procedures, scopes of benefits, and basis for reimbursement for the medical care aspects of the Program. DMS makes the actual payments to~~

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~~the providers of medical services, who have submitted claims to the fiscal agent EDS for services within the scope of covered benefits which have been rendered to eligible recipients.~~

~~Determination of the eligibility status of individuals and families for Medicaid benefits is a responsibility of the Department for Community Based Services/Family Support Offices, located in each county of the state.~~

~~C. Advisory Council~~

~~The Kentucky Medicaid Program is guided in policy making decisions by the Advisory Council for Medical Assistance. In accordance with the conditions set forth in KRS 205.540, the council is composed of eighteen (18) members, including the Secretary of the CHR, who services as an ex-officio member. The remaining seventeen (17) members are appointed by the Governor to four-year terms. Ten (10) members represent the various professional groups providing services to Program recipients, and are appointed from a list of three (3) nominees submitted by the applicable professional associations. The other seven (7) members are lay citizens.~~

~~In accordance with the statutes, the Advisory Council meets at least every three (3) months and as often as deemed necessary to accomplish their objectives.~~

~~In addition to the Advisory Council, the statutes make provision for a five (5) or six (6) member technical advisory committee for certain provider groups and recipients. Membership on the technical advisory committees is decided by the professional organization the technical advisory committee represents. The technical advisory committees provide for a broad professional representation to the Advisory Council.~~

~~As necessary, the Advisory Council appoints subcommittees or ad hoc committees responsible for studying specific issues and reporting their findings and recommendations to the Council.~~

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**D. Policy**

~~The basic objective of the Kentucky Medicaid Program is to assure the availability and accessibility of quality medical care to eligible Program recipients.~~

~~The 1967 amendments to the Social Security Law stipulate that Title XIX Programs have secondary liability for medical costs of Program recipients. That is, if the patient has an insurance policy, veteran's coverage, or other third party coverage of medical expenses, that party is primarily liable for the patient's medical expenses. The Medicaid Program has secondary liability. Accordingly, the provider of service shall seek reimbursement for the third party groups for medical services rendered. If you, as the provider, should receive payment from Medicaid before knowing of the third party's liability, a refund of that payment amount shall be made to Medicaid as the amount payable by DMS shall be reduced by the amount of the third party obligation.~~

~~In addition to statutory and regulatory provisions, several specific policies have been established through the assistance of professional advisory committees. Principally, some of these policies are as follows:~~

~~All participating providers shall agree to provide services in compliance with federal and state statutes regardless of sex, race, creed, religion, national origin, handicap or age.~~

~~Providers shall comply with the Americans with Disabilities Act and any amendments, rules and regulations of this act.~~

~~Each medical professional is given the choice of whether or not to participate in the Kentucky Medicaid Program. From those professionals who have chosen to participate, the recipient may choose the one from whom he wishes to receive his medical care.~~

~~When the Department makes payment for a covered service and the provider accepts the payment made by the Department in accordance with the Department's fee structure, the amounts paid~~

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~~shall be considered payment in full; and no bill for the same service shall be tendered to the recipient, or payment for the same service accepted from the recipient. The provider may bill the recipient for services not covered by Kentucky Medicaid; however, the provider must make the recipient aware of the non-covered services prior to rendering them.~~

~~Providers of medical service attest by their signatures (not facsimiles) that the presented claims are valid and in good faith. Fraudulent claims are punishable by fine and /or imprisonment.~~

~~All claims and substantiating records are auditable by both the Government of the United States and the Commonwealth of Kentucky. Claims shall not be paid for services and supplies that require and are not granted prior authorization by the Kentucky Medicaid Program.~~

~~All claims and payments are subject to rules and regulations issued from time to time by appropriate levels of federal and state legislative, judiciary and administrative branches.~~

~~All services to recipients of this Program shall be on a level of care at least equal to that extended private patients, and normally expected of a person serving the public in a professional capacity.~~

~~All recipients of this Program are entitled to the same level of confidentiality accorded patients NOT eligible for Medicaid benefits.~~

~~Professional services shall be periodically reviewed by peer groups within a given medical specialty.~~

~~All services are reviewed for recipient and provider abuse. Willful abuse by the provider may result in his suspension from Program participation. Abuse by the recipient may result in surveillance of the payable services he receives.~~

~~No claim shall be paid for services outside the scope of allowable benefits within a particular specialty. Likewise, no claims shall be paid for services that required, but did not have, prior authorization by the Kentucky Medicaid Program.~~

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~~No claims shall be paid for medically unnecessary items, services, or supplies.~~

~~When a recipient makes payment for a covered service, and that payment is accepted by the provider as either partial payment or payment in full for that service, no responsibility for reimbursement shall attach to Medicaid and no bill for the same service shall be paid by Medicaid.~~

~~E. Public Law 92-603 (As Amended)~~

~~Section 1909 (a) Whoever—~~

~~(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title;~~

~~(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment;~~

~~(3) having knowledge of the occurrence of any event affecting~~

~~(a) his initial or continued right to any such benefit or payment, or~~

~~(b) the initial or continued right to any such benefit or payment or any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or~~

~~(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person.~~

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~~Shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than \$25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than \$10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.~~

- ~~(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind~~
- ~~(a) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or~~
  - ~~(b) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment made be made in whole or in part under this title, shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.~~
- ~~(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person~~

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- ~~(a) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or part under this title, or~~
- ~~(b) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title, shall be guilty of a felony and upon conviction thereof shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.~~

~~(3) Paragraphs (1) and (2) shall not apply to—~~

- ~~(a) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and~~
- ~~(b) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.~~
- ~~(c) whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation or a material fact with respect to the conditions or operations of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.~~
- ~~(d) whoever knowingly and willfully—~~

- ~~(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or~~

- ~~(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money,~~

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~~donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)~~

~~(a) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or~~

~~(b) as a requirement for the patient's continued stay in such a facility, when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan, shall be guilty of a felony and upon conviction thereof shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.~~

**F. Appeal Process for Refund Requests**

~~In the event of a refund request subsequent to a post-payment review by DMS or the fiscal agent of DMS, the provider may appeal the Medicaid agency request in writing by providing clarification and documentation that may alter the agency findings.~~

~~If there has been no written response within forty-five (45) days of the refund request, assent to the findings shall be assumed. If no arrangements for payment are made, the amount requested shall be deducted from future payments.~~

~~Written clarification shall be sent to:~~

~~Director, Division of Program Services)  
Department for Medicaid Services  
Cabinet for Human Resources  
Third Floor East]  
275 East Main Street  
Frankfort, Kentucky 40621]~~

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III. CONDITIONS OF PARTICIPATION

A. Definition of Agency

A home health agency is a public agency or private organization, or a subdivision of such an agency or organization, whose primary purpose is to provide nursing services on an intermittent or part-time basis and other therapeutic services such as: physical therapy, speech pathology, occupational therapy, home health aide services, medical social services, nutritional counseling services, and disposable medical supplies. These services are provided within the scope and limitations set forth by the patient's physician within a plan of treatment and in accordance with 907 KAR 1:030.

In order to receive reimbursement from Medicaid for home health services rendered to eligible recipients, the home health agency shall be granted a Certificate of Need, be licensed as a home health agency, and be certified for participation under Title XVIII (Medicare) and Title XIX (Medicaid).

Information and forms necessary to complete an application to participate in Medicaid are available at the following Web site:  
<http://www.chfs.ky.gov/dms/provEnr/>

Additionally, one (1) may call (877) 838-5085 Monday to Friday from 8:00 a.m. to 4:30 p.m. EST or send email to the following email address:  
[Program.Integrity@ky.gov](mailto:Program.Integrity@ky.gov)

~~[1. Application for Participation (MAP-343); and  
2. Provider Information Sheet (MAP-344);  
3. Copy of Medicare Certification;  
4. Electronic Media Billing Agreement, MAP-346 and Provider Agreement Addendum (MAP-380) for electronic billing~~

~~The yellow copy of the Application for Participation (MAP-343) shall be returned to the agency along with a cover letter indicating the provider number, and effective date of participation.~~

~~Questions regarding enrollment may be addressed to the Department for Medicaid Services, Provider Enrollment Section,~~

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~~275 East Main Street, Frankfort, Kentucky 40621, telephone: 1-502-564-3476.]~~

#### B. Out-of-State Providers

The out-of-state provider, in addition to the participation requirements listed in A., shall specify whether services will be provided inside Kentucky or in their own state. If services are provided in Kentucky, the home health agency shall have a Kentucky Certificate of Need and appropriate license. If the services are to be provided in their own state, the home health agency shall be a Medicare-certified home health agency and have a license to operate in that state. **Any Medicaid provider must be enrolled with Kentucky Medicaid as a valid Medicaid provider in order to receive reimbursement for services or supplies provided to Kentucky Medicaid recipients.**

#### C. Change of Ownership

The home health agency shall complete new participation agreement forms whenever the agency has had a change of ownership. The information and forms necessary to complete the application to participate in Medicaid are available by contacting the Division of Program Integrity at (877) 838-5085 Monday to Friday from 8:00 a.m. to 4:30 p.m. EST or by sending email to the following email address:  
Program.Integrity@ky.gov

- ~~1. Application for Participation (MAP-343); and~~
- ~~2. Provider Information Sheet (MAP-344);~~
- ~~3. Copy of Medicare Certification;~~
- ~~4. Electronic Media Billing Agreement, MAP-346 and Provider Agreement Addendum (MAP-380) for electronic billing]~~

The application request shall be submitted along with a cover letter stating that this represents a change of ownership, giving the old agency, the name of the new agency and the effective date of the change.

#### D. Disclosure of Information (42 CFR 405, 420, 413 and 455)

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These are some requirements for disclosure of information by institutions and organizations providing services under Medicare and Medicaid (Titles XVIII and XIX of the Social Security Act). The Federal regulations implement sections 3, 8, 9, and 15 of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 (Public Law 95-142). The portions applicable to Medicaid are outlined for you. The regulations are significant and we suggest your attention to them.

Of particular impact on Medicaid providers are the following:

- (1) The Secretary of the Department of Health and Human Services or the State agency may refuse to enter into or renew an agreement with a provider if any of its owners, officers, directors, agents, or managing employees has been convicted of criminal offenses involving any of the programs under Titles XVIII, XIX, or XX.
- (2) The Secretary or State agency may terminate an agreement with a provider that failed to disclose fully and accurately the identity of any of its owners, officers, directors, agents, or managing employees who have been convicted of a program related criminal offense at the time the agreement was entered into.
- (3) The Secretary may have access to Medicaid provider records.
- (4) Providers are required to disclose certain information about owners, employees, subcontractors, and suppliers.

In addition to these new requirements, the Federal regulations detail revisions to existing sections on bankruptcy or insolvency and provider agreements, and note information which may be requested concerning business transactions.

**E. Patient Consent Forms**

Please be advised that neither the Office of Inspector General nor Medicaid personnel are required to have completed patient consent forms prior to or upon reviewing or investigating patient records or provider records which relate to the Kentucky Medicaid

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Program. (See Section III. H. Medical Records of this Manual regarding inspection of records).

#### F. Termination of Provider Participation

907 KAR 1:671~~[1:220]~~ regulates the terms and conditions of provider participation and procedures for provider appeals. CHFS [CHR] determines the terms and conditions for participation of vendors in the Kentucky Medicaid Program and may suspend, terminate, deny or not renew a vendor's provider agreement for "good cause". "Good cause" is defined as:

- (1) Misrepresenting or concealing facts in order to receive or to enable others to receive benefits;
- (2) Furnishing or ordering services under Medicaid that are substantially in excess of the recipient's needs or that fail to meet professionally recognized health care standard;
- (3) Misrepresenting factors concerning a facility's qualifications as a provider;
- (4) Failure to comply with the terms and conditions for vendor participation in the program and to effectively render service to recipients; or
- (5) Submitting false or questionable charges to the agency.

The Kentucky Medicaid Program may terminate the provider agreement immediately for cause, or in accordance with federal regulations, upon written notice served upon the provider by registered or certified mail with return receipt requested. Otherwise, the Kentucky Medicaid Program shall notify a provider in writing at least thirty (30) days prior to the effective date of any decision to terminate, suspend, deny or not renew a provider agreement. The notice will state:

- (1) The reasons for the decision;
- (2) The effective date;
- (3) The extent of its applicability to participation in the Medicaid Program;
- (4) The earliest date on which the Cabinet will accept a request for re-instatement;

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- (5) The requirements and procedures for re-instatement;  
and
- (6) The appeal rights available to the excluded party.

The provider receiving a notice may request an evidentiary hearing. The request shall be in writing and made within five (5) days of receipt of the notice.

The hearing shall be held within thirty (30) days of receipt of the written request, and a decision shall be rendered within thirty (30) days for the date all evidence and testimony is submitted. Technical rules of evidence shall not apply. The hearing shall be held before an impartial decision-maker appointed by the Secretary of the Cabinet for Health and Family Services [~~Human Resources~~]. When an evidentiary hearing is held, the provider is entitled to the following:

- (1) Timely written notice as to the basis of the adverse decision and disclosure of the evidence upon which the decision was based;
- (2) An opportunity to appear in person and introduce evidence to refute the basis of the adverse decision;
- (3) Counsel representing the provider;
- (4) An opportunity to be heard in person, to call witnesses, and to introduce documentary and other demonstrative evidence; and
- (5) An opportunity to cross-examine witnesses.

The written decision of the impartial hearing officer shall state the reasons for the decision and the evidence upon which the determination is based. The decision of the hearing officer is the final decision of the CHFS [~~CHR~~].

These procedures apply to any individual provider who has received notice from the Cabinet of termination, suspension, denial or non-renewal of the provider agreement or of suspension from the Kentucky Medicaid Program, except in the case of an adverse action taken under Title XVIII (Medicare), binding upon the Medicaid Program. Adverse action taken against an individual provider under Medicare shall be appealed through Medicare procedures.

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G. Withdrawal of Participation

If a provider terminates Medicaid participation, written notice shall be given to the Cabinet for Health and Family Services[Human Resources], Department for Medicaid Services at least thirty (30) days prior to the effective date of withdrawal. Payment may not be made for services or items provided to recipients on or after the effective date of withdrawal.

H. Medical Records

Medical records shall substantiate the services billed to Medicaid by the home health agency. The medical records shall be accurate and appropriate. All records shall be signed and dated.

The Home Health provider shall be required to maintain for each Medicaid home health recipient a clinical record which covers the services provided both directly and those provided through arrangements with other agencies. The documentation must be clear, specific and measurable.

The Home Health clinical record shall:

- (a) contain pertinent current and past medical, nursing and social history;
- (b) contain the written or verbal physician's orders that initiated a home health episode of care
- (c) contain a current and complete plan of care reviewed, signed and dated, at a minimum every 60 days by the recipient's primary care physician. A dated physician's signature shall be obtained within 21 days of the establishment of the plan of care;
- (d) be accurate and appropriate to substantiate the services/supplies billed to Medicaid by the home health agency;
- (e) be maintained in an organized central file accessible to the home health agency;
- (f) contain a prior authorization (PA) letter verifying authorized services;
- (g) comply with 902 KAR 20:081 Section 3;

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- (h) contain documentation of each contact with, or on behalf of, a home health recipient; and
- (i) contain documentation of each service provided which shall include 1) date of service; 2) duration of the service; 3) arrival and departure time of the provider of the services, excluding travel time; 4) description of service(s) provided; and 5) title and signature of the service provider.

Providers shall ensure that agency staff are trained to identify, report and prevent to the extent possible, instances of abuse, neglect and exploitation of recipients. Suspected abuse, neglect or exploitation shall be reported to the DCBS Adult Protective Services located in the recipient's home county and to the attending physician with appropriate documentation of the report in the recipient's case record. Providers should develop a standardized form and instructions to be used by staff when reporting an incident. The incident reports should be kept in a central file and available for Medicaid review for a period of six (6) years.

Providers shall develop a standard procedure which allows a recipient or interested party to file a complaint against the agency. Complaints should be documented with an detailed explanation of the complaint and actions taken to resolve the problem. The complaints should be filed in a centralized location and maintained for review. The provider shall make available to agency staff, recipients or interested parties the Office of Inspector General Hotline number which is 1-800-372-2970.

Medical records shall be maintained for a minimum of six (6) [five (5)] years per HIPAA regulations, except in the case of a minor, whose records shall be retained for three (3) years after the recipient reaches the age of majority under state law, whichever is longer, and for any additional time as may be necessary in the event of an audit or other dispute. The records and any other information regarding payments shall be furnished to the Cabinet upon request and made available for inspection and copying by Cabinet personnel.

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#### I. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

The Health Insurance and Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, is an act to improve portability and continuity of health insurance coverage in group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long term care services and coverage, to simplify the administration of health insurance, and for other purposes.

CHFS is required to maintain the privacy of individually identifiable health information of Medicaid recipients and must give the Medicaid recipient a notice that describes the legal duties and privacy practices with regard to personal health information. In general, when health information is released, only the information needed to achieve the purpose of the disclosure is released. However, with few exceptions, all personal health information will be available for release if the recipient signs an authorization form to authorize release of the information, or due to a legal requirement.

Individually Identifiable Health Information is any information including demographic information, that:

- (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
- (2) Relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and
- (3) Identifies the individual; or
- (4) With respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

#### J. Patient Rights

As required by the Medicare Program: Home Health Agencies: Conditions of Participation (42 CFR part 484) and therefore, also the Medicaid Program, there are certain rights to which home

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health patients are entitled and home health agencies shall promote and protect the rights of each individual under their care, including each of the following rights:

- (1) The right to be fully informed in advance about the care and treatment to be furnished by the home health agency, to be fully informed in advance of any changes in the care or treatment to be furnished by the agency that may affect the individual's well-being, and (except with respect to an individual determined to be incompetent) to participate in planning the care and treatment or changes in care or treatment;
- (2) The right to voice grievances without discrimination or reprisal for voicing grievances with respect to treatment or care that is (or fails to be) furnished;
- (3) The right to confidentiality of the clinical records;
- (4) The right to have one's property treated with respect;
- (5) The right to be fully informed orally and in writing (in advance of coming under the care of the agency) of;

All items and services furnished by (or under arrangements with) the agency for which payment may be made under Medicare or Medicaid;

The coverage available for items and services under Medicare, Medicaid, and any other Federal program of which the agency is reasonably aware;

Any charges for items and services not covered under Medicare or Medicaid and any charges the individual may have to pay regarding items and services furnished by (or under arrangements with) the agency; and any changes in the charges or items and services for which the individual may be liable.

- (6) The right to be fully informed in writing (in advance of coming under the care of the agency) of the individual's rights and obligations under Medicaid.
- (7) The right to be fully informed of the availability of the State home health agency hotline.

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It shall be the responsibility of the Division for Licensing and Regulations, the Kentucky state survey agency, to assure compliance with the Patients Rights requirements and standards for meeting these requirements under the Medicaid Program.

K. Advanced Directives

Section 4751 of OBRA 1990 requires that adults, eighteen (18) years of age or older, receive information concerning their right to make decisions relative to their medical care. This includes 1) the right to accept or refuse medical or surgical treatment, 2) the right to execute a living will, and 3) the right to grant a durable power of attorney for their medical care to another individual.

These requirements were effective December 1, 1991, as follows, regardless of payer source:

- (1) A hospital shall give information at the time of the individual's admission as an inpatient.
- (2) A nursing facility shall give information at the time of the individual's admission as a resident.
- (3) A provider of home health care shall give information to the individual in advance of the individual's coming under the care of the provider.
- (4) A hospice program provider shall give information at the time of initial receipt of hospice care by the individual.

Additionally, providers shall

- (a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;
- (b) Provide written information to all adult individuals on the provider's policies concerning implementation of these rights;

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- (c) Document in the individual's medical records whether or not the individual has executed an advance directive;
- (d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;
- (e) Ensure compliance with requirements of State Law (whether statutory or recognized by the courts) concerning advance directives; and
- (f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.

State law allows for a health care provider or agent of the provider to object to the implementation of advance directives. For additional information, refer to KRS 311.634 and KRS 311.982 or consult an attorney.

NOTE: Advanced directives apply for all home health recipients, even those who are "supply only" recipients through the Home Health Program.



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Home health care is the provision of medical care and supportive services to a sick or disabled person in his place of residence. The home health agency is responsible for delivering this care to an eligible Medicaid recipient. A large part of the medical care involves teaching the patient or family, whenever possible, to be able to provide the care. Recipients shall be accepted for treatment by the home health agency on the basis of a reasonable expectation that the recipient's health needs may be adequately met by the agency in the recipient's place of residence. All services shall be medically reasonable and necessary to the treatment of the recipient's illness or injury, and it shall be reasonable and necessary that the service be provided in the home setting. All recipients shall have a home health plan of care and medical records which indicate that the above requirements have been met. Home health services shall be ordered by a physician.

~~[To be covered by the Department for Medicaid Services a service shall be:~~

- ~~(1) Medically reasonable and medically necessary pursuant to 907 KAR 3:130 to the treatment of the recipient's illness or injury;~~
- ~~(2) Effective August 1, 2006, clinically appropriate pursuant to the criteria established via 907 KAR 3:130; and~~
- ~~(3) Reasonable and necessary that the service be provided in the home setting.~~

~~All recipients shall have a home health plan of care and medical records which indicate that the above requirements have been met.]~~

B. Eligibility for Services

Home health services are available to eligible Kentucky Medicaid recipients regardless of age based on medical necessity. Recipients of Home Health services do not need to meet the nursing facility level of care determination in order to qualify for Home Health services. Eligibility for home health aide services is not limited to recipients requiring nursing or therapy services. A recipient, who requires only home health aide services with the supervision, evaluation, and coordination by the registered nurse, may be considered for coverage. The supervision requirements for

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home health aide services shall be met; however, with the supervisory visits considered as an administrative cost. In order to be eligible to receive medical social services, the recipient must also be receiving either nursing, therapy, or home health aide services (refer to Specific Service Covered Section IV, C for additional information regarding medical social services).

If a Home Health agency provides services to an individual with a pending Medicaid application, the agency does so at their own financial risk. Medicaid cannot guarantee that recipient eligibility will be established. Home health services provided to a Medicaid pending applicant can receive a retroactive prior authorization if the provider submits a prior authorization request to the QIO within thirty (30) calendar days from the date Medicaid eligibility is determined. **If the thirty (30) days should lapse, a request for retro-PA shall not be granted.**

(1) Eligibility Considerations – Condition of Recipient, Services Provided, and Absences from the Home

The Medicaid Home Health Program does not require that the recipient be labeled “homebound” in order to be eligible to receive home health services. The medical condition of the recipient and the services to be provided shall be considered when determining if it is reasonable to request Medicaid reimbursement for home health services. Recipients may be eligible for home health based on the following considerations:

(a) Medical condition of the recipient

The medical condition of the recipient [~~including whether services are medically necessary pursuant to 907 KAR 3:130 and whether services are clinically appropriate pursuant to 907 KAR 3:130~~] shall be considered when determining if it is reasonable and necessary to request Medicaid reimbursement for home health services. There shall be a diagnosis of illness or injury and there shall be medical care needs related to that diagnosis. Consideration shall be given to the degree of difficulty and medical hardship the recipient has in mobility within and outside the home (e.g. degree of fatigue, shortness of breath, sensory problems, and functional limitations);

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consideration shall be given to the amount of assistance necessary to transport the recipient; and consideration shall be given to the mental condition of the recipient. Outpatient services, including physician office or clinic visits, should be utilized when the recipient is medically able to do so.

Home Health services are intended to provide skilled intervention with an emphasis on recipient/caregiver teaching. These services are not intended for long term maintenance care. When the physician or the Home Health agency determines that no further health improvement can be anticipated for the Home Health recipient, patients with long term health care needs may be referred for services through the Home and Community Based Waiver (HCB) program. HCB is designed to meet the long-term health care needs of aged or disabled individuals who wish to remain in the community.

~~[Examples of these considerations would be: a recipient who is paralyzed from a stroke and confined to a wheelchair could require considerable assistance on the part of another person or a special van; a recipient who is blind or senile could require the assistance of another person in leaving his place of residence; the recipient who has returned from a hospital stay involving surgery could be suffering from resultant weakness and pain; and therefore, have had his activities restricted by the physician or by his medical condition; a recipient with arteriosclerotic heart disease of such severity that he must avoid all stress and physical activity; and a recipient with psychiatric problems whose illness is manifested in part by a refusal to leave his home environment or have his illness be of such a nature that it would not be considered safe for him to leave his place of residence unattended even if he has no physical limitations.]~~

(b) Services to be Provided

The services to be provided shall also be considered when determining if it is reasonable to request Medicaid reimbursement for home health service. There are instances when it is appropriate that the service be provided in the home setting. There are instances when neither the fact that a

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recipient's ability to be away from his home with difficulty nor the purpose of his trips away from home would have a bearing upon the appropriateness of providing home health services under the Medicaid Program.

Examples of this consideration would be: A recipient requires only personal care service which could be provided by the home health aide; the patient needs to be taught to perform a procedure that most appropriately should be taught in the home setting where the procedure is to be performed, such as colostomy irrigation or self-catherization; pre-filling insulin syringes when the recipient is unable to do this and there are no family members who can be taught[; ~~or providing medically reasonable and necessary supplies~~].

(c) Absences from the home shall be considered:

Evaluations are to be made of the frequency and purpose of the trips, in light of the services required as a result of the medical condition. Absences from the home for the purpose of receiving medical services do not necessarily preclude the provision of in home services.

~~[Some examples of specific considerations are: a recipient is required to go to dialysis three days a week but also needs diabetic monitoring and insulin syringes filled once a week; a recipient who is very functionally involved needs to go to the hospital outpatient department for physical therapy because of the special equipment available but also needs to continue to receive occupational therapy at home; a recipient requires person care services which are only available in the home setting.]~~

Absences from the home for educational purposes would not prevent the recipient from receiving home health services if other requirements have been met.

Lack of transportation is not a consideration for seeking Medicaid reimbursement for home health services.

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It is not the intent of the Medicaid Program that recipients never leave their home for non-medical reasons. It is recognized that people must be able to leave their homes on occasion even though it does require a considerable and taxing effort.

It is the intent of the program, however, that reimbursement for the more expensive in home services not be requested if the recipient is able to be away from his home and could receive these services in an outpatient setting. To achieve this objective, a considerable amount of responsibility rests with the home health agency to screen the referrals received and assure that only those recipients who qualify are accepted for services.

(2) Definition of Place of Residence

The recipient's place of residence is wherever he makes his home. This may be his own dwelling, an apartment, homeless shelter or a relative's home. An institution which meets the definition of a hospital or nursing facility shall not be considered as the recipient's home for the purpose of determining coverage for home health services. Under certain limited circumstances, medical services may be provided in a family care or personal care home. Additionally, services rendered in a school, day care center, or Head Start center shall not be considered valid places of service. Place of service shall not be a nursing facility for Medicare coinsurance and deductible claims.

(3) Plan of Care

Recipients are accepted for treatment on the basis of a reasonable expectation that the recipient's medical, nursing, and social needs can be met adequately by the agency in the recipient's place of residence. Services shall follow a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.

The plan of care is developed by the physician in consultation with appropriate professional agency staff. The plan of care shall contain all pertinent diagnoses including the recipient's mental status; services needed, including supplies and equipment required; frequency of visits to be made; prognosis;

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rehabilitation potential; functional limitations, activities permitted; nutritional requirements; medications and treatment; any safety measures to protect against injury; instructions for timely discharge or referral; and any other appropriate items. A dated physician's signature must be obtained within twenty one (21) days of the establishment of the plan of care. If the physician's signature is obtained after the twenty one (21) day time limit, any services and/or supplies provided prior to the date of the signature are not reimbursable by Medicaid.

Services provided before the physician signs and dates the plan of care are considered to be provided under a plan established and approved by the physician if there is a verbal order for the care received prior to providing the services and the verbal or written order is documented in the medical record. The services shall be included in a signed and dated plan of care. If the physician refers a recipient under a verbal plan of care, the agency shall forward its written record to the physician who shall sign and date it and return it to the agency. Verbal orders shall be signed and dated within twenty one (21) days in accordance with 902 KAR 20:081. If the physician refers an individual under a plan of care that cannot be completed until after an evaluation visit, the physician shall be consulted to approve additions or modification to the original plan. Any additions or modification to the original plan of care are to be indicated on a change of order form, signed and dated by the physician and included in the recertification. Orders for therapy services are to include the specific procedures and modalities to be used and the amount, frequency, and duration of the therapy service.

Drugs and treatments are administered by agency staff only as ordered by the physician. The nurse or therapist immediately records, dates and signs oral orders and obtains the physician's countersignature. Agency staff shall check all medicines a recipient may be taking to identify possible ineffective drug therapy or adverse reactions, significant side effects, drug allergies and contraindicated medication, and promptly report any problem to the physician.

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The orders on the plan of care shall indicate the type of services to be provided, nature of service, frequency of the service and expected duration. Orders for care can indicate a specific range in the frequency of visits to ensure that the most appropriate level of service is provided. When a range of visits is ordered, the upper limit of the range is to be considered the specific frequency. It is not acceptable for the orders to state 3x per week and PRN (as needed). This is not a specific order because the number of weeks is not specified; PRN is open ended; and the nature of the service is not specified. An example of an acceptable order would be 3x per week x4 weeks and PRN x2 to perform a specific service. Orders for therapy services are to include the specific procedures and modalities to be used and the amount, frequency and duration. The therapist and other agency personnel shall participate in developing the plan of care.

It is acceptable to utilize the same plan of care forms required by Medicare to another form which meets all licensure and certification requirements for a plan of care. The status of each recipient and the plan of care shall be reviewed at such intervals as the severity of the recipient's illness requires but no less frequently than every two months, with a maximum of sixty (60) [sixty-two-(62)] days, by home health agency staff and the physician. Requests for re-certifications may be submitted for review up to five (5) business days prior to the service plan's start date. If a request for re-certification is not submitted prior to the expiration of the current certification period, the re-certification shall begin on the date that a completed packet is received by the QIO. The physician shall sign, date, and recertify the plan of care no less frequently than every two months, with a maximum of sixty (60) [sixty-two-(62)] days.

**C. SPECIFIC SERVICES COVERED**

Services received by recipients of the Home Health program cannot be a duplication of any services received under any other Medicaid approved program.

The following services are included as covered services through the home health services element of Medicaid when provided to an

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eligible recipient in his place of residence and ordered by a physician in a plan of care:

(1) Nursing Services

Part-time or intermittent nursing services, as defined in the Kentucky Nursing Practice Act, are covered when provided by a registered nurse or licensed practical nurse who is under the supervision of a registered nurse, according to the direction of the recipient's physician. The services shall require the skills of a registered nurse or a licensed practical nurse, and shall be reasonable and necessary to the treatment of the patient's illness or injury. Most recipients accepted for home health care will require more than one visit; however, there may be some instances where a single visit is all that is needed.

Recipients with restrictive health conditions may be considered as eligible for laboratory screenings/venipunctures on individual case by case bases if the recipient's physician considers it unsafe for the recipient to leave their residence.

A ONE TIME VISIT FOR GENERAL LABORATORY SCREENING SERVICES, HOWEVER, IS NOT A COVERED SERVICE ( FOR EXAMPLE, SERVICES WHICH MIGHT BE PERFORMED ANNUALLY, SEMI-ANNUALLY, OR QUARTERLY [FOR PATIENTS IN PERSONAL CARE FACILITIES]).

Coverage shall not be available for full-time nursing care under the Kentucky Medicaid Home Health Program. Additionally, coverage for daily nursing visits (except for unusual and complicated situations) is limited to short periods of time. Short periods of time may be defined as up to thirty (30) days. Examples of daily nursing visits would be as follows: daily visits to change a dressing following a surgical procedure or to teach the patient or family; daily visits to give insulin injections during the period of time when the agency is training the recipient or a family member how to administer the injections or when the agency is trying to make arrangements with another person who is able and willing to administer the injections; and administration of IV antibiotic therapy.

(a) Standard: Duties of the Registered Nurse (RN)

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The registered nurse makes the initial evaluation visit, regularly re-evaluates the recipient's nursing needs, initiates the plan of care and necessary revisions, furnishes those services requiring substantial and specialized nursing skill, initiates appropriate preventive and rehabilitative nursing procedures, prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the recipient's condition and needs, counsels and educates the recipient and family in meeting nursing and related needs, assists the recipient by teaching appropriate techniques for independence and self-reliance, participates in in-service programs, supervises and teaches other nursing personnel and supervises the home health aide.

(b) Standard: Duties of the Licensed Practical Nurse (LPN)

The licensed practical nurse provides services in accordance with agency policies and the Kentucky Nursing Practice Act, prepares clinical and progress notes, assists the physician and registered nurse in performing specialized procedures, prepares equipment and materials for treatments observing aseptic technique as required, and assists the recipient in learning appropriate self-care techniques.

(c) Specific Guidelines for Nursing Service.

Nursing services shall be medically reasonable and necessary for the treatment of an illness or injury, and shall require that they be performed by or under the direct supervision of a licensed nurse. In determining whether a service requires that it be performed by a nurse, consideration shall be given to the inherent complexity of the services and the medical condition of the recipient. In many instances, the service may be classified as a nursing service on the basis of its complexity alone (i.e. intravenous or intramuscular injections, insertion of a catheter). There are other instances where the nature of the service and the condition of a recipient would affect whether the service may only be performed safely and effectively by the nurse or is able to be performed by the home health aide or a non-medical person. For example, the giving of a bath does not generally require that it be performed by the RN or LPN. Consequently, it would usually not constitute a covered skilled nursing service even though it may have been performed by a nurse, unless the recipient's condition

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was of such severity that it would not be safe for the service to be performed by anyone but a nurse.

(d) Observation and Evaluation

Nursing visits ordered by the physician for observation and evaluation of the recipient's condition may be covered provided: a reasonable probability exists that significant changes may occur which would require the physician or nurse's service to evaluate the need to change the plan of care; or the recipient's illness has become relatively stabilized but the physician determines a risk of future complications for the illness or injury exists which could require the skilled observation techniques of the nurse. Visits falling into this category would be infrequent; for example, monthly for a limited period of time. Frequent visits when no changes are anticipated shall not be considered medically reasonable or necessary. Recipients or family members should be taught to observe for signs and symptoms of possible complication which should be reported to the physician or the nurse. If a recipient's condition has not changed for several months, very careful consideration should be given as to the medical necessity or reasonableness of continuing service.

(e) Psychiatric Service

The following guidelines relate to the provision of psychiatric service through the Home Health Program.

It has been determined that supporting services including drawing blood for serum lithium levels, administering Prolixin injections, and monitoring medication for side effects may be covered through the Home Health Program provided that:

- (1) Recipient is not actively receiving services through a community mental health center and does not receive chemotherapy from a community mental health center;
- (2) Recipient meets the eligibility criteria for home health services;
- (3) The service has been ordered by a physician;
- (4) The service shall be medically reasonable and necessary.

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It is the responsibility of the staff of the home health agency to verify that the recipient is not receiving services from~~[being followed by]~~ the community mental health center~~[, but rather by the referring physician]~~.

Psychiatric services including counseling, psychotherapy or other mental health related services will not be reimbursed under the Home Health Program of the Department for Medicaid Services. Community mental health centers are reimbursed to provide these services ~~[either directly or through contractual agreements with the necessary follow-up required preventing possible fragmentation of services. Home visits are a covered service under the community mental health center program. To avoid possible duplication of service, the home health agency and the community mental health center would need to enter into contractual arrangements to serve identified psychiatric needs of the area. The community mental health center would continue to be the primary responsible agency and any reimbursement would be through the community mental health center element of the Department for Medicaid Services to the community mental health center]~~.

(f) Examples of Some Specific Covered Skilled Nursing Services

(1) The pre-filling of insulin syringes with monitoring of the recipient's diabetic condition may be a covered service provided there is no pharmacy or qualified person in the home to provide this service.

(2) Pre-filling medication dispensing systems when there is no one who can be taught to perform the service.

(g) Examples of Non-Covered Nursing Service

1. Nursing visits to perform glucometer testing are not covered~~[as it generally does not require the skills of a nurse to perform these tests]~~.

2. Therapy Services

As appropriate, physical, occupational, or speech therapy may be provided by the home health agency directly or under contractual arrangement by a qualified therapist or a qualified therapist assistant under the supervision of a qualified therapist in accordance with the plan of treatment. (Refer to Medicare conditions of Participation for Home Health Agencies 42 CFR Part 484.4 for qualifications of therapist and therapist assistant.) The qualified therapist assists the physician in

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evaluating the level of function, helps develop the plan of treatment (revising as necessary), prepares clinical and progress notes, advises and consults with other agency personnel and participates in in-service programs.

A recipient may qualify under Medicaid requirements if any one of the therapy service is needed, provided that the eligibility requirements for Home Health Service are met. Refer to Eligibility Services Section IV, B., pages 4.2-4.8[4.1-4.4].

(a) Physical therapy shall include:

- (1) Assisting the physician in evaluating the recipient for physical therapy through the application of muscle, nerve, joint and functional ability tests;
- (2) Therapeutic exercise program by therapist including muscle strengthening, neuromuscular facilitation, sitting and standing balance and endurance, and increased range of motion;
- (3) Gait evaluation and training;
- (4) Transfer training and instructions in care and use of wheelchairs, braces, prosthesis, etc;
- (5) Instruction in breathing exercises, percussion, postural drainage, vibration for pulmonary functioning;
- (6) Teaching compensatory technique to improve the level of independence in activities of daily living; and
- (7) Training and instructions for patient or family in setting up and following a physical therapy program.

The services shall be reasonable and necessary for the recipient's condition and of such complexity that they must be performed by the qualified therapist. A maintenance program shall be developed for the performance of simple procedures which could be safely and effectively provided by the recipient, family or home health aide.

(b) Occupational therapy shall include:

- (1) Assisting the physician in evaluating the recipient for occupational therapy services through the appropriate testing technique;
- (2) Therapeutic exercise program provided by the therapist including muscle strengthening, neuromuscular facilitation, sitting and standing balance and endurance, and increased range of motion;

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- (3) Assisting recipients to obtain better coordination, use of senses and perception
- (4) Instructing the recipient or family in setting up and following an occupational therapy program;
- (5) Teaching compensatory technique to improve the level of independence in activities of daily living; and
- (6) Designing and fitting orthotic and self-help devices (i.e., hand splints for the recipient with rheumatoid arthritis).

The services shall be reasonable and necessary for the recipient's condition and shall be of such complexity that they must be performed by the qualified therapist.

(c) Speech pathology shall include:

- (1) Assisting the physician in evaluating the recipient for speech pathology service through the appropriate testing techniques;
- (2) Determining and recommending appropriate speech, language, hearing, dysphagia and oral feeding services;
- (3) Providing necessary rehabilitative services for recipients with speech, hearing, language, dysphagia and oral feeding disabilities.
- (4) Instructing the recipients and family in setting up and following a speech pathology program.

The services shall be reasonable and necessary for the recipient's condition and of such complexity that they must be performed by the qualified therapist.

3. Home Health Aide Services

The home health aide provides services in accordance with the care plan and under the written instructions for recipient care and supervision provided by the registered nurse or therapist, as appropriate. Home health aide service may be provided directly by the home health agency or by contractual arrangements. The duties of the aide include: the performance of simple procedures as an extension of therapy services; personal care (i.e. bathing, shampoo, special foot care); range of motion exercises and ambulation; assistance with medications that are ordinarily self-administered and which have been specifically ordered by the physician; reporting changes in the recipient's condition and

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needs; and completing appropriate records. The home health aide may also perform incidental household services which are essential to the recipient's health care at home WHEN PROVIDED IN THE COURSE OF A REGULAR VISIT (i.e., straightening room, or changing linens). Domestic or housekeeping services which are unrelated to the recipient's care are not covered under the Medicaid Home Health Program.

In order for the services of the home health aide to be considered reasonable and necessary, they must be services that the recipient is either physically or mentally unable to do for himself. It shall not be considered reasonable and necessary for Medicaid to pay for services which the recipient can perform for himself but chooses not to perform.

Medicaid home health services are designed to address the needs of eligible recipients, regardless of age. The recipient who needs services of the home health aide, with the supervision, evaluation and coordination by the RN, may be considered for coverage under the home health program. Home health recipients who have a long-term health care condition or a condition that is not expected to improve over time may be evaluated by the physician or home health agency for admission to the Home and Community Based Waiver (HCB) program. The HCB waiver is the appropriate provider of services for recipients who have long term health care needs that could result in nursing facility placement if the services were not available [~~long-term, chronically ill recipient as well as the needs of the short-term, acutely ill recipient. For example, the recipient who mainly needs services of the home health aide, with the supervision, evaluation and coordination by the registered nurse, may be considered for coverage under the home health program~~].

- (a) SUPERVISION: The RN or Licensed Physical Therapist if physical therapy services are provided, shall make a supervisory visit to the recipient's residence at least every fourteen (14) days [~~two weeks~~], either when the aide is present to observe and assist, or when the aide is absent, to assess relationships and determine whether goals are being met.

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Visits made to evaluate the aide services or to supervise or instruct the home health aide are considered (as) administrative costs and are not reimbursable.

- (b) **TRAINING OF HOME HEALTH AIDES:** The home health agency shall be responsible for assuring that the home health aide meets the training and competency evaluation or a competency evaluation requirements as outlined in Conditions of Participation for Home Health Agencies in 42 CFR Part 484.

4. **Medical Social Services**

Medical social services are a covered service when provided under the direction of the physician's plan of care by a qualified medical social worker or a qualified social work assistant under the direction of a qualified social worker, as defined by the Medicare Program: Home Health Agencies: Conditions of Participation.

Responsibilities of the social worker are to:

- (a) assist the physician and other team members in understanding the significant social and emotional factors related to the health problems;
- (b) participate in the development of the plan of care;
- (c) prepare clinical and progress notes;
- (d) assist the recipient and family to understand, accept, and follow medical recommendations;
- (e) assist recipient and family to recognize and change personal and environmental difficulties which predispose toward illness or interfere with obtaining maximum benefit from medical care;
- (f) evaluate the need for and utilize other support resources available within the community to enable the recipient to remain at home;
- (g) participate in discharge planning and in-service programs;
- (h) act as a consultant to other agency personnel.

A recipient requiring ONLY medical social services shall not meet Medicaid home health guidelines for coverage. A plan of care must include other necessary home health services in addition to the medical social services. Coverage may continue for

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completing the social work plan after the recipient's care plan had been closed to other services, provided a recertification is not due. A recipient shall not be recertified for medical social services only.

5. Disposable Medical Supplies

Disposable medical supplies are a covered home health service. Payment may be made for those medical supplies which are essential in providing the treatment which the physician has ordered for the recipient and which are in keeping with accepted medical practice. The plan of care or recertification shall support the need for the supplies. When appropriate, the specific items and directions for use must be included as part of the physician's plan of care and recertification.

~~[Supplies, such as syringes, which are relatively inexpensive and are needed frequently in the treatment of a recipient, are billed collectively by the type of supply used. If the supplies are rarely used, they should be considered part of the routine or "bag supplies" and are to be included as administrative cost. The necessity for one swab, one band-aid or one 4 X 4 bandage should not initiate a request for payment.]~~

Program funds have prohibited the indiscriminate reimbursement for supplies from which the recipient might benefit. Reimbursement shall be limited to the supplies actually used by the recipient during the course of treatment provided by the HHA, considered within the norm of accepted practice, and which have received proper PA from the QIO. For example, an apron used by the nurse, for protection of both the nurse and recipient, is not used on the recipient as a part of the treatment; therefore, it shall not be reimbursed as a covered medical supply. Gloves that are used in treatment of an open wound requiring extensive handling of dressings, which would be impractical to do with sterile forceps to prevent contamination, are considered reimbursable; however, gloves used for protection of the nurse or aide shall not be reimbursable as a covered medical supply~~[, but are an allowable administrative cost].~~

The cost of supplies for personal hygiene is considered outside the services covered under the home health program and is not reimbursable. Examples of items considered as used for personal hygiene would be; soap, shampoo, toothpaste, toothbrush, wash cloths, towels, deodorant, and shaving lotion. Physician ordered therapeutic supplies ~~[including~~

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~~lotions or powders]~~ used in providing nursing care to a bedfast recipient, may be considered as reimbursable items, if deemed medically necessary ~~[essential in providing the degree of care which the physician has ordered for the bedfast recipient]~~ and not available through the pharmacy program.

In the event a recipient is not in need of home health visits but has a condition that requires disposable paper incontinence~~[medical]~~ supplies to maintain him in the home, vendor payment may be made under the home health program. ~~[The procedures required for coverage of these supplies through the home health agency will be as follows:]~~

The physician shall certify that the disposable medical supplies are medically required. The physician is to sign and date a completed Certification for Medical Supply Form (MAP-248). There may be instances where the physician orders supplies on another type of form such as a prescription form; it shall still be necessary for the agency to have the physician sign and date the completed Certification for Medical Supply Form. A new physician's certification is to be completed and signed, every 6 months or earlier if a change occurs in supplies requested.

When the services provided are limited to disposable incontinence~~[medical]~~ supplies, it is not required that the agency open a complete recipient record. However, records shall be maintained which include the physician's certification and orders, and any other pertinent information.

~~[The UB-82 (HCFA-1450) is to be completed in the usual manner.~~

~~Examples of Covered Supplies Include But are Not Limited To:~~

- ~~-Adapters;~~
- ~~-Applicators;~~
- ~~-Drainage supplies;~~
- ~~-Dressing supplies;~~
- ~~-Catheter, ileostomy and ureostomy supplies;~~
- ~~-Colostomy supplies;~~
- ~~-Detection reagents for other than sugar or ketone;~~
- ~~-Diapers, underpads and incontinent pants (not covered before age 3);~~
- ~~-Egg crate mattress;~~

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- ~~-Enema and elimination supplies including fleets enema or dulcolax suppository;~~
- ~~-Gastrostomy supplies;~~
- ~~-Gloves (clean or sterile);~~
- ~~-Inhalation therapy supplies;~~
- ~~-Irrigation solutions;~~
- ~~-IV therapy supplies including solutions unless a drug has been added to the solution by the pharmacy in which case it should be billed by the pharmacy;~~
- ~~-Lambs wool pads or synthetic pads;~~
- ~~-Lotions – powders – cream (invalid or bedfast patient);~~
- ~~-Nipples (specially designed for cleft palate only);~~
- ~~-Inexpensive occupational therapy supplies including plastic utensil holder and long arm reacher;~~
- ~~-Suction supplies;~~
- ~~-Support supplies including antiembolism stockings, support vest, support gauntlet, or support glove;~~
- ~~-Syringes and needles (excluding insulin syringes for diabetic);~~
- ~~-Tracheostomy supplies;~~
- ~~-Tubing;~~

~~\*DRUGS — NOTE: Drugs are not included as disposable medical supplies.~~

~~Payment is made by Medicaid for covered drugs through the pharmacy program. The drugs are included on the Medicaid Drug List or approved by the special Drug Pre-authorization Project. Please refer to Appendix XII for a copy of "Drug Preauthorization Policies and Procedures" from Pharmacy Services Manual. The telephone number for Drug Preauthorization is (800) 756-7558 (in-state) and (502) 227-9073 (out of state).]~~

#### 6. Nutritional Supplements and Enteral Nutritional Products

Coverage shall be available through the Home Health Program for nutritional products. Nutritional products may be either ingested orally or delivered by tube into the gastrointestinal tract. Coverage shall be available for nutritional products which provide for supplemental nutrition of the recipient. These products shall be covered when provided as an integral part of a treatment plan which the physician has deemed medically necessary and ordered for the recipient. The recipient shall

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also be receiving covered home health visits by at least one of the following disciplines; nursing, home health aide, physical therapy, speech therapy, or occupational therapy. These visits may be covered by Medicare, Medicaid, or an insurance policy. Coverage for enteral nutritional products **shall not** be available as a “stand alone” service [as is possible for disposable medical supplies].

~~[The revenue code for nutritional products is 279. For reporting purposes, these items shall report in the general disposable medical supply category.]~~

6. ~~Reimbursement and Quantity Limitation for Disposable Medical Supplies~~

~~Disposable medical supplies are limited to a total of two thousand dollars (\$2,000) monthly per recipient. If the recipient's condition requires supplies in excess of the two thousand dollars (\$2,000) monthly limit, the provider must request prior authorization of the excess supplies from the QIO before the supplies will be reimbursable by Medicaid. Billing of supplies in excess of two thousand dollars (\$2,000) monthly must be submitted on the UB-04 paper claim with supporting documentation attached.~~

~~Any item that exceeds quantity limitations established in 907 KAR 1:479 (DME covered benefits and reimbursement) or the Home Health Care supply fee schedule shall be reimbursed upon PA and determination of medical necessity by the QIO.~~

~~The UB-04 is to be completed in the usual manner for billing of supplies.~~

~~Providers shall refer to the DME fee schedule for identification and maximum pricing of supplies and/or nutritional supplements that shall be reimbursed through the home health program. If a supply item is not available on the DME fee schedule, the provider shall refer to the home health care fee schedule for HCPCS identification and pricing. If an item is not identified by a HCPCS code on the DME fee schedule or the home health supply fee schedule, it shall be reimbursed, upon PA and determination of medical necessity by the QIO. Both the DME and Home Health~~

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~~Care fee schedules are available on the Medicaid website at  
<http://www.chfs.ky.gov/dms>.]~~

**D. Exclusions for Coverage (Services and Supplies)**

The following services and supplies are excluded from coverage under the Department for Medicaid Services home health program:

- (1) Domestic or housekeeping services which are unrelated to recipient care;
- (2) Transportation services, i.e. from place of residence to a facility to receive services;
- (3) Drugs;
- (4) Newborn or post-partum service without the presence of medical complications except for the first week following a home delivery;
- (5) Disposable diapers shall not be covered before the recipient is 3 years of age regardless of medical condition. Age 3 and over disposable diapers are covered if medical condition and diagnosis indicate the need;
- (6) Services for which the recipient has no obligation to pay and for which no other person has a legal obligation to pay.

**E. Hospice Service Relation to Home Health**

Home Health services are not covered for recipients who have elected to receive Medicare or Medicaid Hospice care when the service provided IS related to the terminal condition;

When the service to be provided by the home health agency is NOT related to the terminal illness an arrangement shall be made between the hospice provider and the home health agency. In that case, the hospice provider would notify Medicaid and request approval for the home health service. A MAP-397 shall be sent to the home health agency by the hospice provider and the home health agency shall attach the MAP-397 to the home health bill for that particular approved service.

**F. End Stage Renal Disease (ESRD) Services Relation to Home Health**

Payments shall not be made through the Home Health Program for services provided in the home to end stage renal disease (ESRD)

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recipients receiving dialysis either at the dialysis clinic or at home. If the care provided to the recipient is dialysis related, that care is the responsibility of the ESRD facility. An example would be treating an infected shunt site or epogen injection. Home health services which are not ESRD related may be considered for the home health recipient who is also receiving dialysis. Examples would be treating an abandoned shunt site or decubitus wound care.



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**SECTION V – HOME VISITS AND NONDUPLICATION/INAPPROPRIATE  
PAYMENTS[REIMBURSEMENT]**

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**V.> HOME VISITS AND DUPLICATE/INAPPROPRIATE  
PAYMENTS[REIMBURSEMENT]**

**A. [REIMBURSEMENT POLICY**

**(1) ~~Service Provided – In-State or Out-of-State~~**

~~Home Health agencies shall be reimbursed on the basis of a fee-based reimbursement system subject to upper limits established by Medicaid.~~

~~When a home health agency undergoes a change of ownership, the new owner shall be recertified by the Medicaid program and issued a new vendor number.~~

~~The agency shall bill their usual and customary reasonable charge for all services, including disposable medical supplies and nutritional products. This is the agency's charge to all recipient's for the same or similar service.~~

**(2) ~~Supplemental Payments to Licensed In-State County Health Departments~~**

~~Beginning September 1, 2003, the department shall make supplemental payment to a licensed in state county health department home health agency equal to the difference between:~~

~~(a) Payments received for services on or after November 1, 2002 in accordance with the fixed upper payment limits of 907 KAR 1:031; and~~

~~(b) The estimated cost of providing services during the same time period.~~

**B.] Reimbursable Home Visits**

The following explanations are included to clarify the counting and reimbursement of home health agency visits. A visit is a personal

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**SECTION V – HOME VISITS AND NONDUPLICATION/INAPPROPRIATE**  
**PAYMENTS[REIMBURSEMENT]**

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contact by a covered staff member of the home health agency or by others under contract or arrangement with the home health agency in the recipient's place of residence, made for the purpose of providing a home health service. Covered services are defined in Section IV, Services Covered.

(1) Evaluation Visit

An initial evaluation visit shall be made by the RN or therapist if therapy is the only service ordered. The evaluation visit shall include any nursing procedures ordered by the physician as well as (but not be limited to) the following: an evaluation of the home situation; obtaining health information; performing a health assessment; a determination of the ability of the recipient to manage in meeting his needs in the absence of the home health agency staff; a determination of the availability of family members or other appropriate people to assist in the care of the recipient as indicated; a determination that appropriate physical facilities are available; and a determination that the home health care which could be provided by the home health agency would be an appropriate level of care for the recipient. The evaluation visit is a directly reimbursable visit unless it is determined that the recipient does not qualify for home health services, in which case the visit would be an administrative cost of the home health agency. Also, the evaluation visit shall not be billed to Medicaid when the home health services are to be billed to Medicare. The initial skilled nursing visit (SNV) to complete an assessment shall have the PA requirement waived. However, after the initial assessment is conducted, the assessment visit must be included in the total number of visits requested on the PA in order to receive reimbursement by Medicaid.

Most recipients accepted for home health care will require more than one visit; however, there may be

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**SECTION V – HOME VISITS AND NONDUPLICATION/INAPPROPRIATE  
PAYMENTS[REIMBURSEMENT]**

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some instances where a single visit to perform a service is all that is needed.

A one-time visit for general laboratory screening services, however, is not a covered service (for example, services which might be performed annually, semi-annually, or quarterly for patients in personal care facilities).

(2) Counting of Visits

If a visit is made by two or more disciplines from the Home Health agency for the purpose of providing separate and distinct types of services, each is counted. Multiple visits to the recipient's home on the same day should be closely evaluated by the home health agency, and, whenever possible, coordination should be worked out between agency staff so staff members will not be visiting on the same day. This would provide the recipient with more days of contact with someone from the agency. If a recipient's condition requires that a SNV be provided more than once per day, reimbursement for the SNV shall be limited to two (2) visits per day. All other services are reimbursable at one (1) visit per day.

If a visit is made simultaneously by two or more persons from the home health agency to provide a single service, for example where one person supervises or instructs the other, it is counted as one visit. If a visit is made to a residence containing two recipients this would be counted as two visits only if separate and distinct services were provided to both recipients (i.e., a medical social worker visits the home to assess the home situation and the need for support services from the community, this would be considered as a single service and should be counted as a visit for only one of the recipients).

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**SECTION V – HOME VISITS AND NONDUPLICATION/INAPPROPRIATE**  
**PAYMENTS[REIMBURSEMENT]**

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B.[C.] Duplicate or Inappropriate Payments

Any duplication or inappropriate payment by Medicaid to a provider, whether due to erroneous billing or payment system faults, shall be refunded to Medicaid. Sufficient documentation and explanation of the refund shall be attached to the refund check in order to process the refund correctly. Refund checks should be made payable to "Kentucky State Treasurer" and sent immediately to:

EDS  
P.O. Box 2100  
Frankfort, Kentucky 40602  
Attn: Cash/Finance Unit

Failure by the provider to refund a duplicate or inappropriate payment could be interpreted as fraud or abuse, and prosecuted as such.

[D. ADJUSTMENT

~~An incorrect payment of an entire claim or line item would need to be corrected through the adjustment process, and would not be refunded unless the entire amount was billed in error.~~

~~A. Kentucky Patient Access and Care System (KenPAC)~~

~~KenPAC is a statewide patient care system which, as an adjunct to the Kentucky Medicaid Program, provides certain categories of medical recipients with a primary physician or family doctor.~~

~~Home Health services are provided by a referral from the primary physician or clinic in order to be reimbursed by Medicaid.~~

~~Referrals may be made by the KenPAC primary physician to another provider for specialty care. Home health agencies will provide services on a referral basis. The home health agency may receive the home health referral directly from the primary physician or indirectly from the specialist to whom the primary physician has~~

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**SECTION V – HOME VISITS AND NONDUPLICATION/INAPPROPRIATE  
PAYMENTS[REIMBURSEMENT]**

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~~referred the recipient. No special authorization or referral form is required other than the usual referral and plan of treatment form utilized by the home health agency. However, to assure that payment will be made for the home health services, the primary physician shall provide the home health agency with his Medicaid provider number, which must be entered on the UB-04 billing form in the appropriate block to signify that the service has been authorized.~~

~~It is very important that the home health agency maintain ongoing contact with the primary physician and in those situations where a specialist has made the referral, to assure that the recipient has not changed primary care physicians and that home health services are still indicated.~~

~~Should problems arise where the recipient changes physicians in the middle of a home health recertification period and the home health agency is continuing to provide services under the first physician's two (2) months, maximum of sixty (60) days certification (recertification), EDS Member Management may be contacted at 877-298-6108 for assistance if the new physician will not honor the current certification of the earlier primary physician or specialist to whom the primary physician referred.~~

~~Ken PAC does not alter the manner in which claims are submitted to EDS. There are no new or additional forms associated with KenPAC; however, we stress the importance of obtaining the primary care physician's provider number. IT IS MANDATORY THAT THIS NUMBER BE ENTERED ON THE UB-04 FORM IN THE APPROPRIATE BLOCK. OMISSION OF THIS NUMBER SHALL RESULT IN A REJECTED CLAIM.~~

~~If you have further questions about the KenPAC Program you may contact:~~

~~\_\_\_\_\_ EDS Member Management  
656 Chamberlain Ave.  
\_\_\_\_\_ Frankfort, Kentucky 40601~~

**SECTION V – HOME VISITS AND NONDUPLICATION/INAPPROPRIATE**  
**PAYMENTS[REIMBURSEMENT]**

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~~Information and special authorization numbers may be obtained by calling toll free 1-800-635-2570 or 1-502-564-9444 (In and out-of-state).~~

~~F. — Kentucky Health Care Partnership Program (PASSPORT)~~

~~In accordance with 907 KAR 1:705, the Department implemented, within the Medicaid Program, a capitated managed care system to provide physical health services for recipients residing in the sixteen (16) PASSPORT counties (Shelby, Spencer, Trimble, Wayne, Marion, Meade, Nelson, Oldham, Hardin, Henry, Jefferson, LaRue, Breckinridge, Bullitt, Carroll and Grayson counties).~~

~~Medicaid recipients receiving waiver services, as well as nursing facility and Long Term Care Services, are exempt from participation in the PASSPORT managed care system. These recipients receive services through the traditional Medicaid program.~~

~~Home Health services provided to recipients who are members of PASSPORT must be Prior Authorized and billed through PASSPORT.~~

~~G. EMPOWER Kentucky Transportation Initiative~~

~~In accordance with 907 KAR 3:065, the Department implemented, the EMPOWER Kentucky Transportation Initiative, a capitated non-emergency medical transportation delivery system which excludes ambulatory stretcher services. The Department contracts with the Transportation Cabinet, along with three other Cabinets, to provide this program.]~~

HOME HEALTH SERVICES MANUAL

**SECTION VI – REIMBURSEMENT IN RELATION TO MEDICARE**

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VI. REIMBURSEMENT IN RELATION TO MEDICARE

A. General Information

The Medicare Program shall be billed for services which would be covered by the Medicare Program. The Medicaid program shall not be billed for services which could have been covered by the Medicare Program. It is the responsibility of the home health agency to keep abreast of current Medicare coverage guidelines and bill according to the guidelines.

~~(1) Deductible and Coinsurance~~

- ~~(a) The Medicaid Program will make payment to the home health agency for the Medicare deductible and coinsurance amount for eligible recipients.~~
- ~~(b) Services, including therapies, provided in a nursing facility are excluded from coverage. This will be edited through post-payment review.]~~

(2) Billing Instructions and the billing manual are available through the Medicaid fiscal intermediary

- (a) All necessary billing should be completed with the Medicare Intermediary before any billing is submitted to the Medicaid fiscal intermediary[EDS].
- ~~(b) Upon receipt of Medicare's Remittance Advice, the home health agency may bill EDS for the deductible and coinsurance amount due for a Medicaid eligible recipient. All Medicare deductible and coinsurance claims must be billed on a UB-82 claim form with a copy of the Medicare Remittance Advice attached.~~
- ~~(c) There may be several recipients listed on the Medicare Remittance Advice. It is necessary to make a copy of the Medicare Remittance Advice to attach to the completed UB-82 claim form submitted to EDS. The recipient information on the Medicare Remittance Advice for which the Medicare billing statement is applicable MUST be underlined in RED.~~

**SECTION VI – REIMBURSEMENT IN RELATION TO MEDICARE**

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**B. Recipients Who Are Eligible For Medicare But The Services Have Been Rejected By The Medicare Intermediary**

A MAP-34 shall be completed and kept as a part of the recipient's record whenever a recipient has been rejected by Medicare and the agency will be billing the Medicaid Program for services provided. ~~[The MAP-34 block on the UB-82 shall be marked with a "Y1" to indicate that the MAP-34 is available in the recipient's record.]~~ A new MAP-34 shall be completed whenever there is a medical status change and a modification to the plan of care~~[the reason changes]~~ or at least every twelve (12) months.

~~C. [Reimbursement for a recipient who is eligible for Medicare when it has been determined by Utilization Review that the services would not be covered under the Medicare Program.]~~

~~A MAP-34 shall be completed and kept as a part of the recipient's record [whenever a recipient has been rejected by Utilization Review and the agency will be billing the Medicaid Program for services provided. The MAP-34 block on the UB-04 must be marked with a "Y1" to indicate that the MAP-34 is available in the recipient's record. A new MAP-34 shall be completed whenever the reason changes or at least every twelve (12) months].~~

It is emphasized again that the Medicare Program has the primary liability to cover those services which meet the Medicare Program guidelines. The Medicaid Program has the secondary liability in relation to Medicare.

HOME HEALTH SERVICES MANUAL

**SECTION VII – REIMBURSEMENT IN RELATION TO OTHER THIRD PARTY  
COVERAGE (EXCLUDING MEDICARE)**

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VII. REIMBURSEMENT IN RELATION TO OTHER THIRD PARTY  
COVERAGE (EXCLUDING MEDICARE)

A. General Information

(1) General

To expedite the Medicaid claims processing payment function, the provider of Medicaid services shall actively participate in the identification of third party resources for payment on behalf of the recipient. At the time the provider obtains Medicaid billing information from the recipient, it shall be determined if additional resources exist. Providers have an obligation to investigate and report the existence of other insurance or liability. The provider's cooperation will enable the Kentucky Medicaid program to function efficiently.

(2) Identification of Third Party Resources

Pursuant to KRS 205.662, prior to billing the Kentucky Medicaid Program, all participating providers shall submit billings for medical services to a third party when the provider has prior knowledge that a third party may be liable for payment of the services.

In order to identify those recipients who may be covered through a variety of health insurance resources, the provider should inquire if the recipient meets any of the following conditions:

- (a) If the recipient is married or working, inquire about possible health insurance through the recipient's or spouse's employer;
- (b) If the recipient is a minor, ask about insurance the MOTHER, FATHER, OR GUARDIAN may carry on the recipient;
- (c) In cases of active or retired military personnel, request information about CHAMPUS

**SECTION VII – REIMBURSEMENT IN RELATION TO OTHER THIRD PARTY  
COVERAGE (EXCLUDING MEDICARE)**

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- coverage and the social security number of the policy holder;
- (d) For people over 65 or disabled, seek a MEDICARE HIC number;
  - (e) Ask if the recipient has health insurance such as a MEDICARE SUPPLEMENT policy, CANCER, ACCIDENT, or INDEMNITY policy, GROUP health or INDIVIDUAL insurance, etc.

~~[Examine the recipient's MAID card for an insurance code. If a code indicates insurance coverage, question the recipient further regarding the insurance.]~~

~~Following is a list of the insurance codes on the MAID card:~~

- ~~A—Part A, Medicare only~~
- ~~R—Part A, Medicare Premium Paid~~
- ~~B—Part B, Medicare only~~
- ~~C—Both Parts A and B Medicare~~
- ~~S—Both Parts A and B Medicare Premium Paid~~
- ~~D—Blue Cross/Blue Shield~~
- ~~E—Blue Cross/Blue Shield/Major Medical~~
- ~~F—Private medical insurance~~
- ~~G—Champus~~
- ~~H—Health Maintenance Organization~~
- ~~J—Unknown~~
- ~~K—Other~~
- ~~L—Absent Parent's Insurance~~
- ~~M—None~~
- ~~N—United Mine Workers~~
- ~~P—Black Lung]~~

**B. Billing Instructions for Claims Involving Third Party Resources**

The Home Health agency shall complete all billing with the third party payer prior to billing EDS. After payment has been received from the third party payer, the home health agency should complete a UB-04[UB-82] claim as if they were preparing a regular home health claim. They shall enter all of the services billed to the third party payer using applicable revenue codes. Separate

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COVERAGE (EXCLUDING MEDICARE)**

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services shall be entered on separate lines of the billing form as they would be entered on the regular home health claim. The agency shall enter the total charges on the claim in ~~[Block #53]~~ (Total Claim Charge); enter the amount received from the third party payer on the claim under~~[in Block #63]~~ (Prior Payment).

NOTE: ~~[Effective with service dates on July 1, 1989, and after,]~~no payment shall be made for any deductible or coinsurance amounts due for durable medical equipment, braces, or prosthetics incurred as the result of billing an insurance company.

C. Forms of Documentation That Will Prevent A Claim From Denying for Other Insurance:

The following forms of documentation when attached to the claim will prevent the claim from denying because of other health insurance:

(1) Remittance statement from the insurance carrier that includes:

- (a) Recipient Name
- (b) Date(s) of service
- (c) Billed information that matches the billed information on the claim submitted to Medicaid.
- (d) An indication of denial or that the billed amount was applied to the deductible.

NOTE: Denials from an insurance carrier stating additional information is necessary to process the claim are not acceptable.

(2) Letter from the insurance carrier that includes:

- (a) Recipient Name
- (b) Date(s) of services
- (c) Termination or effective date of coverage
- (d) Statement of benefits available (if applicable)

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COVERAGE (EXCLUDING MEDICARE)**

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- (e) Signature of insurance representative or the letter must be on the insurance company's letterhead.
- (3) Letter from a provider that states their office contacted the insurance company by phone and provides the following information:
- (a) Recipient Name
  - (b) Date(s) of service
  - (c) Name of Insurance Carrier
  - (d) Name of the Insurance Representative contacted and their phone number (or notation indicating a voice automated response system was reached)
  - (e) Termination or effective date of coverage
  - (f) Statement of benefits available (if applicable)
- (4) A copy of a prior remittance advice from an insurance company, can be considered an acceptable form of documentation if it is:
- (a) for the same recipient
  - (b) for the same or related service being billed on the claim
  - (c) the date of service specified on the remittance advice is no more than six (6) months prior to the claim's date of service

If the remittance advice does not provide a date of service then the denial can only be acceptable by the Medicaid fiscal intermediary[~~EDS~~] if the date of the remittance advice is no more than six (6) months from the claim's date of service.

**D. How Other Health Insurance Information Documentation Sent With Claims Is Used To Update Medicaid's Recipient Eligibility Files**

When a claim is received for a recipient whose eligibility file indicates other health insurance that is active and applicable for the dates of services and types of service being billed and no

**SECTION VII – REIMBURSEMENT IN RELATION TO OTHER THIRD PARTY  
COVERAGE (EXCLUDING MEDICARE)**

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payment from other sources is entered on the Medicaid claim form, the claim is automatically denied; unless documentation is attached.

the Medicaid fiscal intermediary[EDS] will review any documentation attached to a claim to determine whether it meets the above described criteria to avoid denying a claim because of the recipient's other health insurance.

If the documentation is acceptable, copies of the documentation are made and forwarded to the third party unit at the Medicaid fiscal intermediary[EDS].

If the documentation is from the insurance company, the Medicaid fiscal intermediary[EDS] will update the recipient's eligibility file to reflect the correct dates of coverage, type of coverage, etc

When the Medicaid fiscal intermediary[EDS] receives documentation that is sufficient to process a claim, but is missing information needed to update the recipient file (example: the specific date of termination), a questionnaire is sent to the insurance carrier asking them to provide the missing information. The recipient's file will [cannot] be updated when [until] a response is received from the insurance carrier. Submission of written verification from the insurance carrier will allow the claim to be processed, and the recipient's file to be updated promptly. ~~so all claims for the recipient will continue to require that documentation be attached.~~

~~When EDS receives copies of any documentation that does not include written verification from the insurance carrier of the change, a questionnaire is sent to the insurance carrier asking them to verify the change requested in the provider's letter. The recipient's file cannot be updated until a response is received from the insurance carrier, so all claims for the recipient will continue to require that documentation be attached. This is why it is best to submit written verification from the insurance carrier so that not only can the claim be processed, but the recipient's file can be updated promptly.]~~

**SECTION VII – REIMBURSEMENT IN RELATION TO OTHER THIRD PARTY  
COVERAGE (EXCLUDING MEDICARE)**

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- E. When an Insurance Carrier is Billed and a Response is Not Received Within 120 Days.

This process shall be followed if the other health insurance has not responded to a provider's billing within 120 days from the date of filing a claim. ~~[Another situation that may occur is when the other health insurance has not responded to a provider's billing within 120 days from the date of filing a claim.]~~ This process can only be used if a provider has "no response" and should not be used if a response, but no payment, has been received.

The provider should complete a TPL Lead Form and write "No Response in 120 Days" on either the TPL Lead Form or the claim form, attach it to the claim and submit it to the Medicaid fiscal intermediary[EDS]. ~~the Medicaid fiscal intermediary[EDS]~~ will override the other health insurance edits and forward a copy of the TPL Lead Form to their Third Party Unit who will contact the insurance carrier to determine why they have not paid their portion of the liability.

- F. Accident and Work Related Claims

For claims billed to Medicaid that are related to an accident or work related incident, the provider shall pursue information relating to the accident. If an employer, individual or an insurance carrier is a liable party, but the liability has not been determined, the provider may proceed with submitting the claim to the Medicaid fiscal intermediary[EDS] and provide any information obtained (the names of attorneys, other involved parties and the recipient's employer) to:

EDS  
P. O. Box 2100 [2009]  
Frankfort, Kentucky 40602  
Attn: TPL Unit

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COVERAGE (EXCLUDING MEDICARE)**

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If you have any questions concerning how to submit claims when other insurance is involved, contact the EDS Provider Relations Unit at 1-800-635-2570 [~~1-800-756-7557~~] for assistance.

**G. Medicaid Payment for Claims Involving a Third Party**

Claims meeting the requirements for Medicaid Program payment shall be paid in the following manner if a third party payment is identified on the claim.

The amount paid by the third party shall be deducted from the Medicaid allowed amount and the difference paid to the provider. If the third party payment amount exceeds the Medicaid allowed amount, the resulting Medicaid payment will be zero. Recipients may **not** be billed for any difference between the billed amount and the Medicaid payment amount. Providers shall accept Medicaid payment as payment in full.

If the claims for a recipient are payable by a third party resource which was not pursued by the provider, the claim will be denied. The provider will receive the Medicaid Remittance Advice (RA) which will include the [~~Along with a~~]third party insurance denial explanation, the name and address of the insurance company, the name of the policy holder, and the policy number [~~will be indicated~~]. The provider shall pursue payment with this third party resource before billing Medicaid again.

If you have questions, please write to:

EDS  
P. O. Box 2100 [2009]  
Frankfort, Kentucky 40602  
Attn: Third Party Unit

Or call 1-800-635-2570 or 1-502-209-3000 [~~(800) 756-7557 (In State) or (502) 227-2525~~].



Drug Pre-authorization Policies and Procedures

Appendix XII

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INTRODUCTION

~~The purpose of the Drug Pre-authorization Procedure shall be to provide Department for Medicaid Services (DMS) recipients with access to certain legend drugs not normally covered on the DMS Outpatient Drug List, under the condition that provision of the drug(s) in question is expected to make an otherwise inevitable hospitalization or higher level of care unnecessary. The requests shall be referred to the Program by physicians, pharmacists, and social workers. Determinations shall be made based on the merits of the individual request and information received.~~

~~To assist with determining the kinds of requests which shall be considered for pre-authorization, the following outline of criteria and procedures has been developed for your convenience.~~

~~I. DRUG PRE-AUTHORIZATION CRITERIA~~

~~A. Request Criteria~~

- ~~1. The requested drugs shall be used in lieu of hospitalization to maintain the patient on an outpatient basis or prevent a higher level of care.~~
- ~~2. The requested drug shall be a legend drug. The only exception shall be non-legend nutritional supplements when: 1) general pre-authorization criteria are met; 2) the patient's nutrition shall be maintained through the use of the nutritional product; and 3) the patient would require institutional care without the nutritional supplement.~~
- ~~3. The requested drug shall be used in accordance with standards and indications, and related conditions, approved by the Food and Drug Administration (FDA).~~
- ~~4. The requested drug shall not be considered for pre-authorization if it is currently classified by FDA as "less than effective or "possibly effective" or if the labeler has not signed a rebate agreement with the Health Care Financing Administration (HCFA).~~

Drug Pre-authorization Policies and Procedures

Appendix XII

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~~5. Drugs on the formulary shall be tried, when appropriate, with documentation of ineffectiveness prior to pre-authorization.~~

~~6. The Program shall not preauthorize the trial usage of a maintenance drug except when the drug has been tried for at least two (2) weeks with successful results prior to the request. In these cases, when all criteria shall be met, retroactive pre-authorization for two (2) weeks shall be considered in addition to the usual pre-authorization period.~~

~~B. Pre-Authorization of Therapeutic Categories~~

~~Any therapeutic category may be considered for pre-authorization in accordance with the diagnosis. However, all Program criteria and guidelines shall be met.~~

~~C. Guidelines for Specific Drug Categories~~

~~1. Analgesics~~

~~Requests for analgesics shall be approved for cancer, AIDS, spinal cord injury, and rehabilitation patients up to a period of six (6) months. A seven (7) day approval may be made following out-patient surgery.~~

~~2. Antibiotics~~

~~Requests for antibiotics shall be considered ONLY if culture and sensitivity tests have identified specific sensitivity or ONLY if drugs included on the Drug List have been tried unsuccessfully. However, if a course of treatment had been started while hospitalized, consideration shall be given to the request.~~

~~3. Anti-Inflammatory Drugs (NSAID's)~~

~~Request for anti-inflammatory drugs shall not be pre-authorized unless drugs on the Drug List or NSAID certification list have been tried unsuccessfully.~~

Drug Pre-authorization Policies and Procedures

Appendix XII

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4. ~~Antitussives, "Cough Mixtures," Expectorants, Antihistamines~~

~~Requests for "cough mixture" preparations such as expectorants and anti-tussives shall not be pre-authorized. Only specified antihistamines may be preauthorized if all other criteria have been met.~~

5. ~~Chemotherapeutic Agents~~

~~Requests for anti-neoplastic agents shall be considered for approved FDA indications.~~

6. ~~Hypnotics and Sedatives~~

~~Requests for sedatives and hypnotics shall be considered only after covered antidepressant or antipsychotic drugs have been tried unsuccessfully and if hospitalization would be prevented. Also these requests shall be accompanied by an appropriate psychiatric diagnosis. Hypnotics and sedatives shall not be approved for more than two (2) weeks, unless there is a diagnosis of terminal cancer.~~

7. ~~Maintenance Type Drugs~~

~~Requests for maintenance type drugs shall be considered only if the drugs have been tried for at least two (2) weeks with successful results prior to the request and related drugs on the formulary have been unsuccessful.~~

8. ~~Non-Legend Drugs~~

~~Non-legend (over-the-counter) drugs shall be excluded from coverage under drug pre-authorization.~~

~~The only exceptions shall be non-legend nutritional supplements as noted in A.2. above and nicotinic acid.~~

9. ~~Ophthalmics and Topical Preparations~~

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~~Requests for ophthalmics or topical preparations shall not be preauthorized unless related preparations included on the Drug List have been tried unsuccessfully, and a higher level of care would ensue without further medication.~~

~~10. Tranquilizers, Minor~~

~~Requests for minor tranquilizers shall be considered only for acute anxiety, alcohol or drug withdrawal (with a one (1) month limitation), cancer, seizure disorders, and quadriplegia/paraplegia.~~

~~11. Ulcer Treatment Drugs, Legend~~

~~On the basis of ulcer symptoms, legend ulcer treatment drugs may be preauthorized if other applicable pre-authorization criteria are met.~~

~~12. Total Parenteral Nutrition~~

~~May be pre-authorized if the need exists.~~

~~13. Transdermal Antihypertensive Medication~~

~~Transdermal antihypertensive medication may be pre-authorized without first prescribing oral forms when the prescriber certifies that the medication is certified for an elderly patient who is unable to follow directions in using oral forms of the medication.~~

~~D. Pharmacy Lock-IN~~

~~The pharmacy originally selected by the recipient shall remain the provider during the period of the pre-authorization unless a valid reason for change exists.~~

~~E. Pre-Authorization Period~~

~~The maximum period for which any drug shall be pre-authorized shall be six (6) months. A request for renewal shall be considered if the need for the drug continues to exist. Extensions may be backdated if~~

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~~the dates do not interfere with already existing segments on the drug file.~~

~~F. Minimum Cost Requirement~~

~~Only those requests for oral, non-liquid drugs which cost \$5.00 or more to the pharmacy for a month's supply or a course of treatment shall be considered for pre-authorization.~~

~~G. Routine Immunizations~~

~~Immunizations requested for routine health care shall not be approved. An underlying medical condition which would make the patient more susceptible to the disease must be present.~~

~~H. Exceptions to Existing Policy~~

~~The Commissioner for the Department for Medicaid Services, or his designate, may grant an exception to existing policy when sufficient documentation exists to override this policy. The request should be written, or followed up in writing, if necessary.~~

~~II. THE REQUEST PROCEDURE~~

~~A. Initiating a Request~~

~~1. Requests for pre-authorization may be initiated by the prescribing physician or office personnel under his direct supervision. Requests from pharmacists and social workers who are working directly with the recipient's physician shall also be accepted.~~

~~2. The primary concern is that the caller have available the information necessary for staff to make an accurate determination.~~

~~B. Contact Information~~

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Website: <http://Kentucky.fhsc.com/pharmacy/default.asp>

Technical Call Center: 1-800-432-7005 (24 hours per day/7 days per week)

Managed Access Program/Prior Authorization: 1-800-477-3071 (24 hours per day/7 days per week)

Prior Authorization FAX Lines:

Non-Urgent: 1-800-365-8835  
Urgent: 1-800-421-9064  
Long Term Care: 1-800-453-2273  
Mental health Drugs: 1-800-453-2273

III. INFORMATION REQUIRED FOR A DETERMINATION

Persons requesting a pre-authorization of medications shall provide information, line for line from the Pre-authorization Request Form. Special attention should be given to giving a specific statement, indicating the need for the requested drug as well as previous medications tried unsuccessfully.

IV. DISPOSITION OF REQUEST

A. Nurses shall review each request and make determinations on the basis of established Program criteria. Extenuating circumstances shall be directed to the medical consultant.

B. If the appropriate information is received and the medication Meets the Program criteria, an approval shall be made. However, if the request does not meet the basic criteria or if insufficient or contradictory information is provided, the request shall be disapproved. Drug Pre-authorization staff will NOT assume responsibility for calling physicians for more information.

C. Unusual or unique situations shall be reviewed by consultant pharmacists, physicians, and recognized University staff.

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~~D. When the medication is not on the DMS Drug List and is disapproved for pre-authorization, the recipient shall assume responsibility for the cost or obtain an alternative source of payment.~~

~~E. Determinations shall be made daily Monday through Friday, except on holidays.~~

~~V. NOTIFICATION OF DISPOSITION~~

~~A. Notification regarding the disposition (approval or disapproval) of each pre-authorized request shall be made as follows:~~

~~1. DISAPPROVALS: When disapproved, the prescribing physician shall be notified by mail. The request and reason for disapproval shall be provided.~~

~~2. APPROVALS: When approved, notification shall be made by phone to the selected pharmacy. The pharmacist shall provide the pre-authorization staff with the NDC number and provider number.~~

~~NOTE: Pre-authorization shall not be guaranteed for any request until reviewed and approved by pre-authorization staff members. If any change should occur, i.e. NDC #, KYHealth Choices card #, quantity, etc., please notify pre-authorization staff immediately to assure Program payment.~~

~~B. Period of Coverage~~

~~The effective date for Program coverage of pre-authorized drugs shall begin on the date the request is postmarked or date received by phone. The pre-authorization shall remain in effect for the specified time on the "Authorization to Bill" or until the recipient becomes ineligible, whichever comes first.~~

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~~CAUTION: Pre-authorization does not guarantee payment.  
Recipient shall be eligible on date of service.~~

~~PHARMACY INFORMATION~~

~~A. Reimbursement for Pre-authorized Drugs~~

- ~~1. Selected pharmacies shall be reimbursed at the lower of the MAC, if applicable, or Average Wholesale Price (AWP) minus ten (10) percent plus dispensing fee, or usual and customary charge to the general public.~~
- ~~2. Private insurance companies and Medicare, if applicable **SHALL BE BILLED PRIOR** to submitting claims for payment.~~

~~B. Pharmacy Billing for Pre-authorized Drugs~~

~~Pre-authorized drugs shall be billed in the same manner as drugs on the Kentucky Medicaid outpatient Drug List — utilizing regular pharmacy billing statements notating the pre-authorization number in the appropriate field.~~