

## **Medicaid Home Health Issues and Resolutions**

**November 2009**

### **“Handwritten signed physician’s note”**

- A handwritten note signed by a physician is **not** a requirement for prior authorization of Medicaid home health services.
- A dated verbal or written doctor’s order is required for home health services. The physician signature is required on the Plan of Care (CMS 485 form), which should incorporate the types, frequency and expected duration of services to be provided to the member.
- For obtaining prior authorizations, it is not necessary to have a date the physician signed the order; verbal order dates is sufficient.

### **Verbal vs. Written Orders**

- Home health agencies initiate services based on a dated physician’s written or verbal order. It is the home health agency’s responsibility to obtain a signed Plan of Care to confirm the verbal order as specified in the home health licensure regulation.
- The fact that the home health agency has not yet obtained the signature on the Plan of Care should not be used as a reason to deny prior authorization for home health services.

**Kentucky Medicaid Home Health Coverage for Dual Eligibles** - Medicaid is the payer of last resort—most home health services for a Kentucky Medicaid recipient who has Medicare will be covered by Medicare.

Home health agencies are required to complete, and have in the patient file, the MAP 34 form if they have determined that it is appropriate to bill Medicaid for any home health service or supply for a dual eligible member. The agency will note on the MAP 34 whether the service or supply was billed to Medicare and has been rejected, or whether the home health agency’s internal utilization review has determined that it is not a Medicare covered service or supply and needs to be billed to Medicaid. The MAP 34 form and instructions are available on the DMS Home Health web page.

Following is a listing of the most common services and supplies which are not covered by Medicare and are billed to Kentucky Medicaid by home health agencies.

**Not covered by Medicare:**

- Paper incontinence supplies (diapers, chux, pads)
- Supplemental nutrition
- Home health aide services with no skilled need
- Medication management visits (filling the patient's mediplanner and monitoring self-administration of medications) when there is no Medicare PPS episode of care or when additional visits beyond those included in the Medicare PPS episode are medically necessary
- Vitamin B12 injections when not for pernicious anemia or other diagnoses specified by Medicare, or more frequently than once a month after the initial episode.
- Flushing of mediport if not used for active administration of medications for 90 days or more
- Venipuncture when it is the only skilled need ordered by the physician

**Covered by Medicare during a Medicare PPS Episode of Care:**

- Venipuncture (This is covered if the patient has other qualifying skilled needs. Venipuncture ONLY is not a qualifying skilled need for a Medicare episode of care.)

This service may be billed to Kentucky Medicaid if the patient does not qualify for a Medicare PPS episode of care, and the service is medically necessary under Kentucky Home Health policy.

**The following services initiate a Medicare PPS Episode of Care, provided that the patient meets other Medicare home health criteria:**

- Vitamin B12 injections for a confirmed diagnosis of pernicious anemia and other diagnoses specified by Medicare
- Flushing of medi-port when medication has been actively infused within the past 90 days
- Under some circumstances, teaching a recipient to follow a new medication regimen (in which there is a significant probability of adverse drug reaction due to the nature of the drug and the patient's condition) initiates a Medicare episode of care.

### **Mediplanner Prefills for Dual Eligibles**

- Kentucky Medicaid will cover medically necessary medication management visits for dual eligibles when there is no Medicare PPS episode of care.
- During a Medicare PPS episode of care, the home health agency should make every effort to fill the mediplanner and educate the member during the Medicare visits. In cases where the Medicare visits are infrequent, Medicaid will cover additional medication management visits if medically necessary.
- Medicaid asks agencies to plan to prefill mediplanners every two weeks; however Medicaid also acknowledges that prescription refill schedules can be problematic. When requesting mediplanner visits more frequently than every two weeks, providers should be able to provide clinical explanations as to why the more frequent visits are needed.

### **Medicare and Medicaid Policy on Services in the Home**

- The attached table summarizes Medicare and Kentucky Medicaid policy related to a patient's medical condition and ability to leave his home to receive health services.
- These policies are to be utilized to determine whether a particular patient is an appropriate candidate for home health services.
- Please note that the two policies have many similarities, but also some differences. More detailed information, including patient examples, is provided in the policy manuals cited on the table.
- As indicated in Kentucky Medicaid's policy, this determination may vary depending on the particular services included in the patient's plan of care.
- According to Palmetto, use of supportive or assistive devices alone would not necessarily render a beneficiary homebound for Medicare. Many people with physical limitations requiring the use of assistive or supportive devices are able to leave home on a regular basis (and so, are not considered homebound for purposes of determining Medicare home health coverage).

### **Supplies for Dual Eligibles Receiving Home Health Services under a Medicare PPS**

**Plan of Care** – Members who are Medicare/Medicaid dual eligibles and who are receiving home health services under a Medicare plan of care should receive their disposable supplies through Medicare, unless the supplies needed are:

- Incontinence supplies not covered by DME; or
- Supplemental nutrition products.

These two types of supplies may be billed to Medicaid.

### **Supplies for Dual Eligibles Receiving Supplies Only**

- Recipients who are Medicare/Medicaid dual eligible should not receive their disposable medical supplies through the Medicaid program unless it is for incontinent supplies not covered by DME or supplemental nutrition products.
- These recipients should receive other needed disposable medical supplies through the Medicare DME program.

### **Supplies for Dual Eligibles Receiving Home Health Services under a Medicaid Plan of Care**

- Medicaid will cover medically necessary supplies included on the Home Health Supply List which are related to the plan of care provided to members by the home health agency which is providing home health services to the member.
- During a Medicaid episode of care, supplies will include not only the supplies the Home Health staff utilizes during the visit, but also supplies used by the member during the episode of care. Members providing self-care and family members assisting in care must have access to the proper supplies ordered by the physician; deemed necessary to meet Plan of Care objectives; and to provide essential treatment of the patient.

### **Supplies for Medicaid Members Receiving Home Health Services under a Medicaid Plan of Care**

- Medicaid will cover medically necessary supplies included on the Home Health Supply List which are related to the plan of care provided to members by the home health agency which is providing home health services to the member.
- During a Medicaid episode of care, supplies will include not only the supplies the Home Health staff utilizes during the visit, but also supplies used by the member during the episode of care. Members providing self-care and family members assisting in care must have access to the proper supplies ordered by the physician; deemed necessary to meet Plan of Care objectives; and to provide essential treatment of the patient.

## **Home Health Aide or Personal Care Services through Home Health or HCB Waiver**

- Department for Medicaid Services policy currently permits home health aide or personal care services for an HCB waiver member to be delivered through the Home Health program or the HCB waiver program.
- DMS and the Home Health TAC have discussed the following as important factors in making the decision about which program should be used to provide this service:

The member's underlying medical condition. Since R.N. supervision is provided more frequently under the Home Health program, members with complex or unstable medical conditions might be appropriate candidates for home health aide services rather than personal care through the waiver program.

The specific paraprofessional services needed by the member. The home health aide can provide supportive services and facilitate treatment as directed by the R.N. or therapist in addition to providing personal care.

How the member enters care may also have an impact on which program provides their aide or personal care services. If the member begins receiving skilled home health services, at the point that they no longer require skilled home health care and their underlying medical condition does not require a home health aide under skilled nursing supervision, then the individual may be appropriate to transition to waiver services.

Another factor which should be considered is coordination of all of the member's services. Services may be better coordinated if all the member's services are provided by one agency.

## Home Health Prior Authorizations, Special Circumstances

- Authorization in advance does not have to occur if the service or item is rendered for immediately needed care **as defined** below. However, the request for PA must be **called in** to SHPS by the next business day.

Following the notification, the provider should submit documentation of medical necessity and evidence that the care or item was immediately needed.

### Definitions:

1. “Emergency medical condition” means the sudden and, at the time, unexpected onset of an illness or medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by the prudent layperson who possess an average knowledge of health and medicine, to result in:

- A. placing the member’s physical or mental health in serious jeopardy; or
- B. serious impairment to bodily functions; or
- C. serious dysfunction of any bodily organ or part.

2. “Urgently-needed care” or “urgent care” means those health care services that are necessary to treat a condition or illness of an individual that if not treated within twenty-four (24) hours presents a serious risk of harm.

3. “Immediately needed” means that action is needed on the same day to avoid delay in discharge from the hospital, treatment in the emergency room, or hospital admission, or to allow the beneficiary to remain in a community setting.

- Unanticipated services which are needed after the Home Health Agency’s usual operating hours may also be **called in** to SHPS on the next business day.

<b>Medicare and Medicaid Home Health Homebound Requirements, October, 2009</b>	
<b>Medicare</b>	<b>Medicaid</b>
The law requires that a physician certify in all cases that the patient is confined to his/her home.	Services follow a written plan of care established and periodically reviewed by a doctor. Does not require specifically that the recipient be labeled essentially homebound in order to be eligible.
Condition of patient is such that there exists a normal inability to leave home and leaving home would require a considerable and taxing effort	Consideration shall be given to the degree of difficulty the recipient has in getting around and making trips away from his home (e.g., degree of fatigue, shortness of breath, sensory problems, and functional limitations.)
If patient does leave home, may still be considered homebound if absences from home are infrequent or for periods of relatively short duration or are to receive health care treatment, including adult day health care.	Evaluation is to be made of frequency and purpose of absences from home in light of the services required as a result of the medical condition. Absences from home to receive medical services do not necessarily preclude home health services.
Attending religious services shall be deemed an absence of infrequent or short duration	
Occasional absences from home for nonmedical purposes are allowable if infrequent or of relatively short duration and don't indicate the capacity to obtain health care outside rather than in the home.	It is not the intent that recipients never leave their home for non-medical reasons. It is recognized that people must be able to leave home on occasion even though it requires a considerable and taxing effort.
Generally speaking, patient will be considered homebound if they have a condition, due to illness or injury, that restricts their ability to leave home without aid of supportive devices such as crutches, canes, wheelchairs, and walkers; use of special transportation; or the assistance of another person; or if leaving home is medically contraindicated.	Consideration shall be given to the amount of assistance necessary to transport the recipient.
(Although the mental condition of the recipient is not specifically mentioned in the Medicare definition, the examples of homebound patients include individuals who must be accompanied when they leave home because of their mental condition.)	Consideration shall be given to the mental condition of the recipient.
	The services to be provided shall also be considered when determining if home health services are reasonable. 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 recipient is able to be away from home with difficulty, nor the purpose of his trips away from home would have a bearing on appropriateness of home health services.
	Absences from home for educational purposes would not prevent the recipient from receiving home health services if other requirements are met.
	It is the intent 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 services in an out-patient setting.
SOURCE: Medicare Benefit Policy Manual, Chapter 7 - Home Health Services, Section 30.1 - Confined to the Home, CMS Web site, downloaded 8-09.	SOURCE: Home Health Services Manual, Kentucky Medicaid Program Home Health Benefits Policies and Procedures, Department for Medicaid Services Web site, downloaded 8/09.