



# **Covered Services and Limitations (Home Health)**

**Last Updated: 06/03/2022**



# Table of Contents

<b><i>Managed Care Enrolled Individuals (Home Health)</i></b> .....	4
<b><i>Home Health Services Provider Requirements</i></b> .....	8
<b><i>Services For Participants In Assisted Living Facilities (ALFs)</i></b> .....	27
<b><i>TRANSPORTATION (Home Health)</i></b> .....	30
<b><i>NON-COVERED SERVICES (Home Health)</i></b> .....	30
<b><i>Copayments For Home Health Participants</i></b> .....	32

# Covered Services and Limitations (Home Health)

Updated: 7/27/2021

## GENERAL INFORMATION AND COVERED SERVICES

### **General Information**

This chapter describes the home health services available under the Commonwealth of Virginia's *State Plan for Medical Assistance* (Medicaid). Home health services are provided in accordance with the requirements of 42 CFR §§ 440.70 and 441.15 and are available to all categorically and medically needy participants determined to be eligible for assistance. Home health services under Virginia Medicaid must not be of any less or greater duration, scope, or quality than that provided participants not receiving state and/or federal assistance for those home health services covered by Virginia Medicaid.

For the purpose of the Virginia Medical Assistance Program, a home health agency is an agency or distinct unit that is primarily engaged in providing licensed nursing services and other therapeutic services outside an institutional setting.

### **Freedom of Choice**

Medicaid eligible participants, by federal requirements must be offered 1) the choice of service provider(s) and 2) choice of where services are offered, in the home or clinic and these choices must be documented in the file of the participant.

### **Advanced Directives**

Home health providers participating in the Medicare and Medicaid Programs must provide adult participants written information upon the initial receipt of home health services of the right to make medical care decisions including the right to accept or refuse medical treatment and the right to formulate advance directives.

The term "advance directive" shall have the same meaning as provided in the Health Care Decision Act (§54.1-2981 et seq., which means (i) a witnessed written document

voluntarily executed by the declarant and in accordance with (ii) a witnessed statement, made by a declarant subsequent to the time he is diagnosed or suffering from a terminal condition. The law does not prohibit any health care provider (or any agent of such provider) from refusing, as a matter of conscience, to implement an advance directive and does not require participants to execute an advance directive.

Under the law, the home health agency must:

- Provide all adult participants with written information about their rights under State law to make health care decisions, including the right to accept or refuse treatment and the right to execute advance directives, as well as the provider's written policies respecting the implementation of such rights;
- Inform participants about the home health provider's policy on implementing advance directives;
- Document in the participant's medical record whether he/she has signed an advance directive;
- Not discriminate against an participant based on whether he/she has executed an advance directive; and
- Provide staff and community education on advance directives.

## **Managed Care Enrolled Individuals (Home Health)**

Most individuals enrolled in the Medicaid program for Medicaid and FAMIS have their services furnished through contracted Managed Care Organizations (MCOs) and their network of providers. All providers should check eligibility (Refer to Chapter 3) prior to rendering services to confirm which MCO the individual is enrolled in. The MCO may require a referral or prior authorization for the individual to receive services. All providers are responsible for adhering to this manual, their provider contract with the

MCOs, and state and federal regulations.

If the individual enrolls with an MCO, some of the services may continue to be covered by Medicaid fee-for-service. Providers must follow the fee-for-service rules in these instances where services are “carved out.” The carved out services vary by managed care program. Refer to each program’s website for detailed information and the latest updates.

There are several different managed care programs (Medallion 4.0, Commonwealth Coordinated Care Plus (CCC Plus), Program for All-Inclusive Care for the Elderly (PACE)) for Medicaid individuals. DMAS has different health plans participating in these programs. Go to the websites below to find which health plan participates in each managed care program in your area:

- Medallion 4.0:  
<https://www.dmas.virginia.gov/for-providers/managed-care/medallion-40/>
- Commonwealth Coordinated Care Plus (CCC Plus):  
[http://www.dmas.virginia.gov/Content\\_pgs/mltss-proinfo.aspx](http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx)
- Program of All-Inclusive Care for the Elderly (PACE):  
[http://www.dmas.virginia.gov/Content\\_atchs/ltc/PACE%20Sites%20in%20VA.pdf](http://www.dmas.virginia.gov/Content_atchs/ltc/PACE%20Sites%20in%20VA.pdf)

## **Medicaid Managed Care**

Most individuals enrolled in Medicaid and FAMIS receive their Medicaid services through Medicaid Managed Care Organizations (MCOs). MCOs may have different service authorization criteria and reimbursement rates, however MCO benefit service limits may not be less than fee-for-service benefit limits. Providers must participate with the member’s MCO (or negotiate as an MCO out-of-network provider) in order to be reimbursed for MCO contracted services. Home health providers must contact the member’s MCO directly for information regarding the contractual coverage, and reimbursement guidelines for services provided through the MCO.

## **Medallion 4.0**

Medallion 4.0 is a statewide mandatory Medicaid program that operates under a CMS §1915(b) waiver. The Medallion 4.0 program provides acute and primary care services with the key program focus areas of prenatal care, postpartum care, case management, care for infants and children including Early Intervention services, immunizations, screening and preventative care.

Target Population include:

1. Pregnant women,
2. Low-income families with children (LIFC),
3. Those receiving temporary assistance for needy families (TANF), and
4. Expansion adults.

Additional information is available at <https://www.dmas.virginia.gov/#/med4>

## **Commonwealth Coordinated Care (CCC) Plus**

CCC Plus is a managed long-term services and supports (MLTSS) program. This mandatory Medicaid managed care program serves individuals with complex care needs through an integrated delivery model that includes medical services, behavioral health services and long-term services and supports.

Target Population:

5. Individuals who receive Medicare benefits and full Medicaid benefits (dual eligible),
6. Individuals who receive Medicaid LTSS in a facility or through CCC Plus Waiver. Individuals enrolled in the Community Living, the Family and Individual Support, and Building Independence waivers, known as the Developmental Disabilities (DD)



waivers, will enroll for their non-waiver services only. At this time, DD waiver services will continue to be covered through Medicaid fee-for-service.

- 7. Individuals who are eligible in the Aged, Blind, and Disabled (ABD) Medicaid coverage groups, including ABD individuals previously enrolled in the Medallion 3.0 program.

Additional information is available at: <http://www.dmas.virginia.gov/#/cccplus>.

All services furnished by a home health agency, whether provided directly by the agency's qualified staff or under contractual arrangements with others, must be furnished or under the supervision of qualified personnel as required by Part 484 of Title 42 of the *Code of Federal Regulations* and professional licensing requirements as required by the *Code of Virginia*.

DMAS requires the following for fee-for-service coverage of Home Health Services:

- The participant meets Change Healthcare criteria upon initial and recertification review. These criteria may be obtained through:

Change Healthcare

275 Grove Street

Suite 1-310

Auburndale, MA 02466-2283

Telephone: 617-273-2800

Fax: 617-273-3777

Website: [ChangeHealthcare.com](http://ChangeHealthcare.com)

## **Home Health Services Provider Requirements**

### **Face-to-Face Encounter Requirements for Fee-for-Service**

This only applies to FFS members and not those enrolled in one of DMAS' managed care plans.

Beginning July 1, 2017, no payment shall be made for initiation of home health services (as defined in [12VAC30-50-160](#)) unless a face-to-face encounter has been performed by an approved practitioner (outlined below) within 90 days prior to when the individual enrolled in Medicaid begins the services or within 30 days after the individual begins the services. The Medicaid face-to-face encounter shall be related to the primary reason the individual enrolled in Medicaid requires home health services.

The face-to-face encounter must be conducted by one of the following five (5) practitioners:

- A physician licensed to practice medicine;
- A licensed nurse practitioner or licensed clinical nurse specialist who is legally authorized to practice and act within the scope of his or her license;
- A certified nurse midwife who is legally authorized to practice and act within the scope of his or her license;
- A licensed physician assistant working under the supervision of the physician who orders the individual's services; or
- For individuals admitted to home health immediately after an acute or post-acute stay, the attending acute or post-acute physician.

The practitioner performing the face-to-face encounter must document the clinical findings in the individual's medical record and communicate the clinical findings of the encounter to the ordering practitioner. For the home health services that exceed five (5) visits and require service authorization, home health providers must, during the service authorization process, "attest" that the face-to-face encounter requirement has been met.

Face-to-face encounters may occur through telemedicine, which is defined as the two-



way, real time interactive electronic communication between the member and the Provider located at a site distant from the member. This electronic communication must include, at a minimum, the use of audio and video equipment. Telemedicine shall not include by telephone or email.

Providers **may** use the **sample form** (found in Chapter 6) to document these new requirements. If a provider does not use the DMAS sample form or the CMS-485 (with the F2F elements clearly included) to document the F2F encounter, any supporting documentation must be clearly titled and easily recognizable as documentation of the F2F encounter and include the required elements listed below.

Providers who opt to use their own forms or systems to document the face-to-face encounter must include:

1. The date of the face-to-face encounter;
2. The practitioner, including full name and credentials, who conducted the face-to-face encounter;
3. The primary reason the Medicaid individual requires home health services;
4. Any communication between the ordering practitioner and the practitioner who conducted the face-to-face encounter, if such individuals are different;
5. The date of the order and the ordering practitioner's full name and signature.

### **Practitioner Supervision and Certification**

Participants of home health services must be under the care of a practitioner, which is defined as a physician, nurse practitioner, clinical nurse specialist and physician assistant, who is legally authorized to practice and act within the scope of his or her license. The practitioner may be the participant's private physician, nurse practitioner, clinical nurse specialist or physician assistant, a practitioner on the staff of the home health agency, practitioner working under an arrangement with the assisted living facility (ALF) which is the participant's residence or, if the agency is hospital-based, a physician on the hospital staff.

A written practitioner's statement, which may be on the home health certification plan of care/treatment, in the form of practitioner orders, in the medical record, must indicate that:

- The participant needs licensed skilled nursing care, home health aide services, physical therapy, occupational therapy, or speech-language pathology services; and
- A plan for furnishing such services to the participant has been established and is periodically reviewed and signed by a physician.

The initial plan of care (certification) must be reviewed by the attending physician or practitioner. The practitioner must sign the initial certification before the home health provider may bill DMAS. A practitioner shall review and recertify the plan of care every 60 days. DMAS will not reimburse the home health agency for services provided prior to the date of the practitioner's signature.

A practitioner recertification shall be performed within the last five days of each current 60-day certification period, i.e. between and including days 56-60. The practitioner recertification statement must indicate the continuing need for services and should estimate how long home health services will be needed. The practitioner must sign the recertification before the home health provider may bill DMAS. DMAS will not reimburse the home health agency for services provided prior to the date of the practitioner's signature.

If a participant is admitted to home health care before Medicaid eligibility is effective, the Medicaid enrollment date is considered the date of admission to services and will determine when the next certification is due.

### **Nursing Services**

Nursing services may be provided by contract with a licensed registered nurse in geographic areas where there is no licensed home health agency. Nursing services may be provided on an intermittent or PRN basis to any participant who requires home health care. Nursing care must be provided by a licensed registered nurse or practical nurse under the supervision of a licensed registered nurse who is a graduate of an approved school of professional nursing. On January 1, 2005, Virginia joined the Nurse Licensure Compact. Under the Code of Virginia, the Nurse Licensure Compact authorized licensed practical nurses and registered nurses licensed and residing in a **compact** state to practice in other **compact** states without the necessity of obtaining an additional license.

The Virginia Board of Nursing website ([www.dhp.virginia.gov](http://www.dhp.virginia.gov)) provides detailed information as to which states are considered **compact** states and an explanation of “primary state of residence.” It is the home health agency’s responsibility to insure that the nurse is licensed by the Virginia Board of Nursing and meets all requirements as mandated by the Virginia Department of Health Professions.

There are three types of nursing visits:

Initial assessment is a visit by a registered nurse, to assess all of the participant’s health care needs and to admit the participant into home health services.

- Routine follow-up are visits in which a specific treatment/procedure or participant/ caregiver education related to developed goals is performed. Some examples of routine follow-up visits are:
  - Wound care where strict aseptic or sterile technique is required;
  - Periodic Foley catheter changes;
  - Post-hospital teaching sessions where the primary focus is to assist the participant and/or caregiver in the transition of receiving extensive patient teaching to meet the participant’s medical needs in the home environment;
  - Pre-filling of insulin syringes no more than once every two weeks, unless the participant’s blood sugar instability warrants medically necessary changes in insulin dosages or the prescribed brand of insulin changes.
- A routine follow-up visit is not a visit that would be done periodically over extended periods of time for general or non-specific goals. Examples of these types of visits are, but not limited to: periodic assessment of diabetic

hypertensive or otherwise chronically ill participants whose conditions have remained stable and well-baby growth and development assessments on infants and children without current acute deficits or routine infant care teaching to parents. Visits made because of on-going social welfare limitations (e.g., protective services) do not constitute a routine, follow-up skilled nursing visit. These types of visits are not Medicaid reimbursable visits.

- The comprehensive skilled nursing visit criteria establishes a set of conditions that must be met for a visit to be billed as a comprehensive skilled nursing visit, therefore, reimbursed at the higher reimbursement rate. This set of conditions includes, but are not limited to:
- High technology and extended lengths of time for the provision of the high tech task;
- Complex AND multidimensional situations requiring skills in teaching the provision of extensive hands-on skilled care by qualified personnel. It is the responsibility of the agency to send a qualified nurse into the home. The credentials of the nurse are not the determining factor of Medicaid reimbursing at the comprehensive rate.)

“High-technology” refers to the complexity of procedures often involving the use of instruments, equipment and machines. At a minimum, supporting documentation in the form of practitioner’s orders, plans of treatment, nursing care plans, and/or visit progress notes must clearly describe the following:

- The number and type of skilled procedures to be performed by the nurse during the visit;
- The number and complexity of steps needed to complete each procedure; and

The extent to which the nurse is called upon to use nursing knowledge and expertise to make an assessment, follow-up with a practitioner, and/or adjust orders/plans of care.

**NOTE:** See Chapter VI for minimum documentation requirements for reimbursement at the comprehensive visit rate.

A registered nurse must make the start of care assessment visit to initiate home health services; regularly evaluate the participant's nursing needs; initiate the plan of care and necessary revisions; provide those services requiring substantial and specialized nursing skill; initiate appropriate preventive and rehabilitative nursing procedures; prepare clinical and progress notes; coordinate services; inform the practitioner and other personnel of changes in the participant's condition and needs; educate the participant and family in meeting nursing and related goals; and supervise and educate other personnel involved in the participant's care.

As a normal scope of practice, the licensed practical nurse furnishes services according to agency policies; prepares clinical and progress notes; assists the practitioner and registered nurse in performing specialized procedures; prepares equipment and materials for treatments involving aseptic techniques as required; and assists the participant in learning appropriate self-care techniques.

### **Home Health Aide Services**

Home health aide services are intended to assist the participant/caregiver during a period of daily living or can appropriately be utilized to assist in carrying out nursing or rehabilitative care plans. Home health aide services must be incorporated into an outcome-specific nursing care plan.

Home health aides must meet the qualifications specified by 42 CFR § 484.36. The home health agency must maintain documentation which demonstrates that the home health aides employed or contracted by the agency meet these required qualifications. Home health aide services are not intended to be utilized for any services outside the specified qualifications. Examples of services which are not considered a part of the home health aide responsibilities are preparing or administering medications, administering nasogastric or gastrostomy tube feedings and teaching or instruction to the participant or caregiver.

Home health aide services may include assisting with personal hygiene, eating, walking, meal preparation and feeding, and taking and recording blood pressure, pulse, and respiration. Written instructions for participant care must be prepared by the registered nurse or licensed therapist as appropriate.

When it is identified that a participant has an ongoing need for services similar to those provided by the home health aide, the home health agency must provide information to the participant and/or caregiver about other services (e.g., personal care, companion aide, etc.) that may be more appropriate in meeting their needs. The home health agency is expected to make the necessary referrals for these services prior to utilization of the participant's 32 allowable home health aide visits. Once other services similar to those provided by the home health aide begin, the home health aide services are terminated.

### **Supervisory Visits for Home Health Aide Services**

As stated in the VAC 30-50-160, home health aide services must be provided under the supervision of a registered nurse or licensed therapist. When only home health aide services are being furnished, a registered nurse must make a supervisory visit to the participant's residence at least once every 60 days when the aide is furnishing care. The supervisory visit is not reimbursable by the Medicaid program.

When skilled nursing care or physical therapy, occupational therapy, or speech-language pathology services are also being furnished to the patient, a registered nurse must make a supervisory visit to the patient's residence at least every two weeks (either when the aide is present or when the aide is absent). When only a rehabilitative therapy is furnished in addition to the home health aide services, a skilled therapist may make the supervisory visit in place of a registered nurse. The supervisory visit is not reimbursable by Medicaid.

When supervisory visits are not provided in accordance with DMAS policy, DMAS will not provide reimbursement for the home health aide visits.

### **Rehabilitation Services: Physical Therapy, Occupational Therapy, and Speech Language Pathology Services**

## **Physical Therapy**

Physical Therapy services are those services provided to a participant in his/her place of residence that meets all of the following conditions:

- The services must be directly and specifically related to an active written plan of care/treatment plan designed by a practitioner after any needed consultation with a physical therapist (PT) licensed by the Virginia Board of Physical Therapy. The *Code of Federal Regulations* (42 CFR § 440.110) require that the therapist meet licensure requirements within the scope of the practice under State law;
- The services must be of a level of complexity and sophistication or the condition of the participant must be of a nature that the services can only be performed by a physical therapist licensed by the Virginia Board of Physical Therapy or a physical therapist assistant (LPTA), who is licensed by the Virginia Board of Physical Therapy, under the direct supervision of a qualified licensed physical therapist, as defined above;
- The services must be provided with the expectation, based on the assessment made by the practitioner of the participant's rehabilitation potential, that the condition of the participant will improve in a reasonable and generally predictable period of time, or the services must be necessary to establish a safe and effective maintenance program required in connection with a specific diagnosis; and
- The services must be specific and provide effective treatment for the participant's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of services be reasonable.

Only a licensed PT has the knowledge, training, and experience required to evaluate and, as necessary, reevaluate a participant's level of function, determine whether a physical therapy program could reasonably be expected to improve, restore, or compensate for lost function; and where appropriate, recommend to the practitioner a plan of

care/treatment plan. However, while the skills of a licensed physical therapist (PT) are required to evaluate the participant's level of function and develop a plan of care/treatment plan, the implementation of the plan may be carried out by a licensed physical therapist assistant. Direct supervision by a qualified therapist includes initial direction and periodic observation of the actual performance of the therapeutic activity. The plan of care/treatment plan must be developed and signed by the licensed physical therapist. When services are provided by an LPTA, the PT must conduct a supervisory visit at least every 30 days while therapy is being conducted and documented accordingly. When supervisory visits are not conducted in accordance with DMAS policy, physical therapy visits will not be reimbursed by Medicaid.

If an adequate number of qualified personnel are not available to carry out the practitioner order, the therapist must inform the practitioner of this and record the response of the practitioner in the participant's medical record. The plan of care/treatment plan must be revised according to the practitioner's written approval. This revision may be obtained in the form of a practitioner signed and dated (verbal order is acceptable) to amend the home health certification plan of care/treatment or therapy plan of care.

Physical Therapy services may include the following:

#### Gait Training

Gait evaluation and training, provided to a participant whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality, require the skills of a licensed physical therapist and constitute physical therapy, provided that it can reasonably be expected to significantly improve the participant's ability to walk.

Examples of services that do not constitute rehabilitation physical therapy are:

- Activities appropriately provided by supportive personnel (e.g., aides or nursing staff); and



- Activities that do not require the skills of a licensed physical therapist or licensed physical therapy assistant.

### Range of Motion

Range of motion exercises constitute physical therapy only when they are part of the active treatment of a specific diagnosis that has resulted in a loss or restriction of mobility as evidenced by physical therapy notes showing the degree of motion lost and the degree to be restored. Only a licensed physical therapist may perform range of motion tests, and, therefore, such tests constitute physical therapy. Range of motion exercises, whether because of their nature or the condition of the participant, which may be performed safely and effectively only by a licensed physical therapist or licensed physical therapy assistant under the direct supervision of a therapist, will be considered rehabilitation physical therapy that is reimbursed by Medicaid.

Range of motion exercises not related to the restoration of a specific loss of function can ordinarily be provided safely by supportive personnel (such as physical therapy aides, nursing staff, volunteers, etc.) and do not require the skills of a licensed physical therapist or licensed physical therapy assistant. Passive exercises to maintain range of motion in paralyzed extremities can be carried out by physical therapy aides, home health aides, nursing staff or supportive caregivers and will not be considered rehabilitation therapy and, therefore, are not reimbursable visits by Medicaid.

### Therapeutic Exercises

Therapeutic exercises (e.g., strengthening, stretching, tilt table activities, etc.), performed by or under the direct supervision of a licensed physical therapist, due to either the type of exercise employed or the condition of the participant, constitute covered physical therapy and can be reimbursed by Medicaid.

## **Occupational Therapy**

Occupational Therapy services are those services provided to a participant in his/her place of residence that meets all of the following conditions:

- The services must be directly and specifically related to an active written plan of care/treatment plan designed by the practitioner after any needed consultation with an occupational therapist registered and licensed (OTR) by the National Board for Certification in Occupational Therapy and licensed by the Virginia Board of Medicine. The *Code of Federal Regulations* (42 CFR § 440.110) requires that the therapist meet licensure requirements within the scope of practice under state law;
- The services must be provided with the expectation, based on the assessment made by the practitioner of the participant's rehabilitation potential, that the condition of the participant will improve in a reasonably and generally predictable period of time, or the services must be necessary to establish a safe and effective maintenance program required in connection with a specific diagnosis; and
- The services must be specific and provide effective treatment for the participant's condition in accordance with accepted standards of medical practices; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

Only a registered and licensed occupational therapist has the knowledge, training and

experience required to evaluate and, as necessary, reevaluate a participant's level of function; determine whether an occupational therapy program could reasonably be expected to improve, restore or compensate for lost of function; and, where appropriate, recommend to the practitioner a plan of care/treatment plan. While the skills of a registered and licensed occupational therapist are required to evaluate the participant's level of function and develop a plan of care/treatment plan, the implementation of the plan may be carried out by a certified occupational therapy assistant (COTA) functioning under the direct supervision of a registered and licensed occupational therapist. Direct supervision by a qualified therapist includes initial direction and periodic observation of the actual performance of the therapeutic activity. The plan of care/treatment plan must

be developed and signed by the registered and licensed occupational therapist (not the COTA). When services are provided by a COTA, the OTR must conduct a supervisory visit at least every 30 days and document accordingly. When supervisory visits are not conducted in accordance with DMAS policy, occupational therapy visits will not be reimbursed by Medicaid.

If an adequate number of qualified personnel are not available to carry out the practitioner order, the therapist must inform the practitioner of this fact and record the response of the practitioner in the medical record. The plan of care/treatment plan must be revised accordingly with the practitioner's written approval. This revision may be in the form of a practitioner signed and dated (verbal order is acceptable) to amend the home health certification plan of care or therapy plan of care.

Occupational therapy may involve some or all of the following:

- The evaluation and re-evaluation, as required to assess a participant's level of function by administering diagnostic and prognostic tests that can be completed in a participant's place of residence;
- The selection and teaching of task-oriented, therapeutic activities designed to restore physical function (e.g., use of woodworking activities to restore shoulder, elbow and wrist range of motion lost as a result of burns or other injury);
- The planning, implementing and supervising of an participantized therapeutic activity program as part of an overall active treatment program (e.g., the use of computer activities that require following multi-level directions, assist with memory loss and reality orientation in a neurologically impaired participant);
- The planning and implementing of therapeutic tasks and activities to restore sensory integrative function (e.g., providing motor and tactile activities to increase sensory input and improve response for a stroke participant with functional loss resulting in a distorted body image); and

- The teaching of compensatory techniques to improve the level of independence in the activities of daily living (e.g., teaching a participant who has lost the use of an arm dressing and cooking skills with one hand, teaching an upper extremity amputee how to functionally utilize a prosthesis, or teaching a spinal cord injured participant new techniques to enable him or her to perform feeding, toileting, and other activities as independently as possible). Rehabilitation services shall be specific and provide effective treatment for the participant's condition in accordance with accepted standards of medical practice. The amount, frequency, and duration of the services must be reasonable.

### **Speech-Language Pathology**

Speech-language pathology services are those services provided to a participant in his/her place of residence that meet the following conditions:

The services must be directly and specifically related to an active written plan of care/treatment plan designed by a practitioner after needed consultation with a speech language pathologist licensed by the Virginia Department of Health Professions and the Virginia Board of Audiology and Speech-Language Pathology. The *Code of Federal Regulations* (42 CFR § 440.110) requires that the therapist meet licensure requirements within the scope of the practice under state law.

The services must be of a level of complexity and sophistication or the condition of the participant must be of a nature that the services can only be performed by any one of the following:

- A Master's level prepared speech-language pathologist (SLP) licensed by the Virginia Department of Health Professions and the Virginia Board of Audiology and Speech-Language Pathology; or
- A participant licensed by the Virginia Board of Audiology and Speech-Language Pathology who meets one of the following:

- a. Has a Certificate of Clinical Competence (CCC) from the American Speech and Hearing Association (ASHA); or
  
- b. Has completed the Master's level academic program and is acquiring supervised work experience to qualify for the ASHA certification.

This participant is in the Clinical Fellowship Year (CFY). This participant must be under the direct supervision of a licensed CCC/SLP or SLP. Direct supervision by a qualified therapist includes initial direction and periodic observation of the actual performance of the therapeutic activity. When services are provided by a CFY/SLP, a licensed CCC/SLP or SLP must make a supervisory visit at least every 30 days while therapy is being conducted and document the visit in the participant's record accordingly.

- c. Effective January 1, 2001, DMAS will reimburse for the provision of speech language services when provided by a participant identified as a speech language assistant, e.g., Bachelor's level, a Master's level without licensure by the Board of Audiology and Speech Language Pathology, or a Master's level with licensure only by the Department of Education. The identity of the unlicensed assistant (and the fact he/she does not meet qualification requirements to bill Medicaid) shall be disclosed to the participant, parent, or legal guardian prior to treatment, and this disclosure shall be documented and made a part of the participant's record. These speech-language assistants must be under the direct supervision of a licensed CCC/SLP or SLP that meets provider licensure requirements.

Direct supervision by a qualified therapist includes initial direction and periodic observation of the actual performance of the therapeutic activity. When services are provided by a CFY/SLP or a speech-language assistant, a licensed CCC/SLP or SLP must make a supervisory on-site visit at least every 30 days while therapy is being conducted. The supervisory therapist is not required to co-sign the speech-language assistant's progress visit notes; however, he or she is required to review the notes. If the supervisory therapist co-signs the assistant's progress visit notes, this does not constitute a 30-day supervisory

visit note. Evidence of the supervisory therapist's on-site visit must be documented every 30 days in the participant's record.

- The services must be provided with the expectation, based on the assessment made by the practitioner of the participant's rehabilitation potential, that the condition of the participant will improve significantly in a reasonable and generally predictable period of time, or the services must be necessary to establish a safe and effective maintenance program required in connection with a specific diagnosis; and
- The services must be specific and provide effective treatment for the participant's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

Only a licensed speech-language pathologist has the knowledge, training and experience required to evaluate and, as necessary, reevaluate a participant's level of function; determine whether a speech therapy program could reasonably be expected to improve, restore or compensate for lost function, and, where appropriate, recommend to the practitioner a plan of care/treatment plan. However, while the skills of a licensed speech language pathologist are required to evaluate the participant's level of function and develop a plan of care/treatment plan, the implementation of the plan of may be carried out by one of the following: SLP, CCC/SLP, and CFY/SLP, and speech-language assistants as identified above. The plan of care/treatment care plan must be developed and signed only by the licensed speech language pathologist.

If an adequate number of qualified personnel are not available to carry out the practitioner's order, particularly related to the frequency of service, the therapist will inform the practitioner of this fact and record the response of the practitioner in the medical record. The plan of care will be revised accordingly with the practitioner's written approval. This amendment to the home health plan of care may be obtained in the form of a written, verbal order including duration and frequency, as appropriate, that is signed and dated by the practitioner.

Speech-language pathology services include the following procedures:

- Assistance to the practitioner in evaluating participants to determine the type of speech or language disorder and the appropriate corrective therapy, such as an assessment by a speech-language pathologist of a participant with aphasia following a recent stroke to determine the need for speech-language pathology services;
- Providing rehabilitative services for speech and language disorders;
- Providing rehabilitative services for swallowing disorders, cognitive problems, etc.

### **Guidelines for Initiating and Continuing Therapy**

The following are guidelines designed to assist with the determination of appropriate services:

- DMAS will only reimburse for the specific therapy evaluation. A nursing evaluation is not required by DMAS and will not be reimbursed.
- **Maintenance Therapy** - Maintenance therapy is defined as the point where the participant demonstrates no further significant improvement or the skills of a qualified rehabilitative therapist are not required to carry out an activity or home program to maintain function at the level to which it has been restored. Services in this category are not covered.
- **Improvement of Function** - Rehabilitation services designed to improve function must be based on an expectation that the therapy will result in a significant, practical improvement in a participant's level of functioning within a reasonable period of time. Where a valid expectation of improvement exists at the time the rehabilitative therapy program is instituted, the services would be recognized even though the expectation may not be realized. However, this would apply only up to the time at which it would have been reasonable to conclude that the participant is not going to improve or has reached his/her maximum rehabilitation potential. A

home exercise program should be reviewed with the participant and/or caregiver to maintain skills taught by the qualified therapist. At this point, home health therapy services should be terminated.

### **Discharge/Termination from Services**

Rehabilitation services must be considered for termination regardless of the preauthorized length of services when any one of the following conditions is met:

- No further potential for improvement is demonstrated. The specialized knowledge and skills of a licensed/registered therapist are no longer required for safe and effective provision of such rehabilitation services. The participant has reached his or her maximum progress, and a safe and effective maintenance program has been developed;
- There is limited motivation on the part of the participant or caregiver;
- The participant has an unstable condition that affects his or her ability to participate in a rehabilitative plan of care/treatment plan;
- Progress toward an established goal or goals cannot be achieved within a reasonable period of time;
- The established goals serve no purpose to increase functional or cognitive capabilities; and

The service can be provided by someone other than a licensed or registered/certified rehabilitation professional.

### **Definition of a Visit**

A visit is defined as the duration of time that a home health nurse, home health aide or rehabilitation therapist is with a participant to provide covered practitioner-ordered



services in the participant's place of residence. Visits are not defined in measurements or increments of time. The furnishing of any services by a particular qualified nurse, therapist or home health aide on a particular day or particular time of day constitutes a visit. For example, if both a physical therapist and/or an occupational therapist furnish services on the same day, this constitutes two visits. However, if a therapist, nurse or home health aide furnishes several services during a visit, this constitutes only one visit for each discipline that furnishes services. If a therapist, nurse or home health aide provides two distinctly separate therapy sessions/services in the same day (e.g. morning session and an afternoon session), this would constitute two visits.

Combined visits by more than one therapist, nurse or home health aide cannot be billed as separate visits if the goals are the same for that visit by a particular discipline (e.g. two therapists, nurses or home health aides are required to perform a single procedure or are working collaboratively toward the same goal). The overall goal(s) of the session determines how the visit can be billed.

### **Covered Maintenance Services**

Home health services are services provided by a certified home health agency on a part time or intermittent basis to a participant in his/her place of residence. For Medicaid, the participant does not have to be home bound, but the services must be provided in the participant's home. Home health services are intended to provide skilled intervention with an emphasis on participant or caregiver teaching. For all maintenance services, the emphasis will be on keeping the participant at home rather than requiring the participant to go to the practitioner's office, unless practitioner visits are scheduled and would coincide with the needed home health visits. Below are some common maintenance issues and related procedures that the DMAS pre-authorization contractor, will follow when prior authorization is required.

The general questions that will be asked for these procedures are:

- Can the participant perform the procedure?
- If the participant cannot perform the procedure, is there a caregiver who is willing and able to perform the procedure? The "willing and able"

reason cannot be based solely on the provider's policy.

- If the provider states that there is no one willing or able to perform the service, this will be further explored. If the caregiver is able to learn, but is not willing, the contractor will ask for the reason(s). For example, if the caregiver has a fear of administering injections, the contractor will authorize extra teaching visits and request documentation of the teaching efforts.

In addition to the questions above, the following specific procedures require additional information:

- **B-12 injections and insulin injections:** If the practitioner certifies that there is a need for this procedure to be performed as a home health visit AND no one else is willing and able to perform this procedure AND if appropriate documentation is provided supporting the medical necessity of these home health visits, it will be approved.
- **Central venous access devices (dressing changes, etc.):** The contractor will ask the provider if the participant is currently getting medication through the line, how frequently is it being accessed, and whether it is a PICC, Groshog, Hickman, Porta Cath, etc. If the practitioner certifies that there is a need for this procedure to be performed as a home health visit and no one else is willing and able to perform this procedure and appropriate documentation is provided supporting the medical necessity of these home health visits, it will be approved.

### **Other Services**

- **Changing of indwelling catheters:** Authorization will be based on the merits of each participant case. If the service is needed no more than once a month, no discharge plan is required. If the service is needed more than once a month, will request the provider to supply documentation supporting the medical necessity of these home health visits. Approval will be based on the documentation of medical necessity provided.

- **Blood draws:** Authorization will be based on the merits of each participant case. The contractor will ask if the home health visits are medically necessary to address a specific medical condition (i.e. participant is medically unstable or is morbidly obese and requires transportation by an ambulance). The contractor will ask if the medical condition is chronic and requires routine visits. If appropriate documentation is provided supporting the visits as medically necessary, contractor will approve the visits.

## **Services For Participants In Assisted Living Facilities (ALFs)**

Limited home health coverage is available for participants in an assisted living facility (ALF). ALFs must provide for certain services as mandated by the Department of Social Services (DSS) licensing standards for ALFs. When the ALF must provide home health nursing or aide services as a component of these covered services, DMAS shall not reimburse a home health agency to provide such services to residents of ALFs. The ALF must provide the services as specified below, and the home health agency cannot bill DMAS for any of the specified non-reimbursable services. These services are:

- Home health aide services;
- Medication administration including, but not limited to:
  - By-mouth (oral) administration
  - Insulin injections
  - Eye drops
  - Rectal administration
  - Topical application
  - Inhalers, and
  - Nasal administration;
  - Medication monitoring; and
  - Superficial wound care for pressure ulcers up to stages I to II or care to skin tears, minor cuts, or abrasions.

When injections other than insulin are necessary and ordered by the practitioner, the ALF must either administer the injection by appropriately licensed staff or assist the resident by securing the injection services through a home health agency, through an outpatient clinic visit, or through emergency services as most appropriate for the medical circumstance and reimbursement guidelines.

If a home health provider bills for or has billed for any of these services for a resident of an ALF, DMAS will deny or retract reimbursement for the inappropriate payments for such services.

Medicaid may cover skilled nursing services provided by a home health agency. These cases only include services the ALF is not required to provide. Personal care/ADL services provided by a home health agency will not be reimbursed. If skilled nursing services have been utilized for over 30 days, a change in the resident's cognitive or functional ability may have occurred. The ALF should notify DMAS within two weeks of the resident's receiving 30 days of skilled nursing services. The resident's change in cognitive or functional ability may warrant an assessment as to whether the resident is receiving the appropriate level of care. The *Virginia Administrative Code* (22 VAC 4071-150) prohibits ALFs from admitting or retaining participants with any of the following conditions:

1. Ventilator dependency;
2. Dermal ulcers III and IV, except those stage III ulcers which are determined by an independent practitioner to be healing;
3. Intravenous therapy or injections directly into the vein except for intermittent therapy managed by a health care professional licensed in Virginia when it is on a time limited basis under a practitioner's treatment plan;\*
4. Airborne infectious disease in a communicable state, including diseases such as tuberculosis and excluding infections such as the common cold;
5. Psychotropic medications without appropriate diagnosis and treatment plans;

6. Nasogastric tubes;
7. Gastric tubes except when the participant is capable of independently feeding himself or herself and caring for the tube; \*
8. Participants presenting an imminent physical threat or danger to self or others;
9. Participants requiring continuous, licensed nursing care;
10. Participants for whom his or her practitioner certifies that ALF placement is no longer appropriate;
11. Unless the participant's independent practitioner determines otherwise, participants who require maximum physical assistance as documented by the Uniform Assessment Instrument (UAI) and meet Medicaid nursing facility level of care criteria as defined by the *State Plan for Medical Assistance*. Maximum physical assistance means a participant has a rating of total dependence in four or more of the seven activities of daily living as documented on the UAI; and
12. Participants whose health care needs cannot be met in the specific ALF as determined by the residence.

For those participants who do not receive the auxiliary grant payment, at the request of the resident, and pursuant to regulations of the Department of Social Services, care for the conditions or care needs defined in Sections 3 and 7 above may be provided to a resident in an ALF by a licensed practitioner, a licensed nurse under a practitioner's treatment plan, or by a home care organization licensed in Virginia when the resident's independent practitioner determines that such care is appropriate for the resident.

## **DURABLE MEDICAL EQUIPMENT AND SUPPLIES**

Supplies and equipment (e.g., gauze, cotton, adhesive bandage, sphygmomanometer, scales, etc.), which are used during the course of the home visit by personnel of the home health agency, are included in the visit fee paid to the agency. The only supplies for which the provider of supplies may receive separate reimbursement are those supplies that remain in the home beyond the time of the visit to allow the participant to continue treatment.

### **Intravenous Therapy Supplies**

Nursing visits for Intravenous (I.V.) Therapy are reimbursed under home health services.

To receive reimbursement for I.V. Therapy Nursing Services, the provider must be a Medicaid home health provider with a valid home health Medicaid provider number. The home health visit reimbursement for all nursing services includes, but is not limited to; travel time, participant education, and I.V. administration. A home health nurse must be present delivering a service that is deemed medically necessary in order to receive reimbursement. Supplies used by the nurse during the course of the home health visit for I.V. therapy, such as I.V. start kits, angiocaths, midline catheters, etc., will be reimbursed under the durable medical equipment (DME) service day rate allowance to whichever DME provider furnishes the supplies.

## **TRANSPORTATION (Home Health)**

Extraordinary transportation costs to and from the participant's home may be recovered by the home health agency if the participant resides outside of a 15-mile radius of the home health agency. An add-on fee will be paid for miles traveled per day per independent staff member in excess of a 15-mile radius from the home health agency. Mileage will be calculated from the radius to the farthest point of travel per day and return to the point of radius. Payment will be set at a rate per mile as established by the General Services Administration in the "Federal Travel Regulations," which is published in the *Federal Register*, times the excess mileage over the 15-mile radius.

If a visit is within the 15-mile radius, the transportation cost is included in the visit rate; therefore, no additional reimbursement for transportation will be made, regardless of the number of miles driven by the staff member. Mileage charges should be added to the invoice of the participant who lives the farthest point of travel for the day. The home health agency must keep daily mileage records of staff and have available a map that identifies a 15-mile radius. For a home health agency to receive reimbursement for transportation, the participant must be receiving Medicaid home health services.

## **NON-COVERED SERVICES (Home Health)**

The following services are not covered:

- Medical social services;
- Services or items which would not be paid for if provided to an inpatient of a hospital or nursing facility, or intermediate care facility for individuals with intellectual disabilities (ICF/IID), such as private-duty nursing service, or items of comfort which have no medical necessity, such as a television;
- Meals on Wheels or similar food service arrangements;
- Domestic or housekeeping services which are unrelated to participant care and which materially increase the time spent on a visit;
- Custodial care which is participant care that primarily requires protective services rather than definitive medical and skilled nursing care;
- Skilled home health nursing and home health aide services when the participant is enrolled for comparable services available under one of the home and community-based waivers;
- Home health nursing or aide services for residents of ALFs if the residence is responsible for providing the services as a component of the covered services governed by the Department of Social Services licensing standards for ALFs;
- Multiple visits when there is no break in services on a given day or multiple disciplines providing a single procedure or working collaboratively toward the same goal;

- Services which fall under the category of psychotherapy;
- Maintenance therapy;
- Services which fall under the category of private duty nursing; and
- Services related to cosmetic surgery.

## **Copayments For Home Health Participants**

The copayment for home health participants is limited to one \$3.00 charge per day. It is important that providers use care in billing for overlapping dates of service. A copayment is applicable for each date of service; however, as the invoice does not show the specific dates of service when a range of days is billed, claims processing applies certain assumptions in calculating copayments. The primary assumption is that a copayment is taken based on the lesser of the number of days indicated by the from/through days or the number of visits for a single procedure code on the claim. Providers should use care to accurately reflect the number of days (encounters) of direct patient care. Only one copayment is applicable for each day (encounter) per provider type for a participant regardless of the number of services being provided.

DMAS will calculate the copayment by multiplying the copayment amount (\$3.00) by the number of days listed in Locator 7, which is a required field on the invoice. Home health claims will be rejected if (a) Locator 7 is blank; (b) the total days exceed the number of days between the from and through dates; or (c) the total days exceed the number of services. The amount of the copay will be deducted from the provider's reimbursement. See Chapter V for detailed billing instructions.

Individuals enrolled in the Medallion 4 and CCC Plus managed care program do not have copayments for services.