Utilization Review (Home Health)

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INTRODUCTION

Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of the care and services by providers and participants paid through Medicaid. These reviews are mandated by Title 42 Code of Federal Regulations, Parts 455 and 456. The Department of Medical Assistance Services (DMAS) or their contractors conduct periodic utilization reviews on all programs including providers that are found to provide services in excess of established norms, or referrals and complaints from agencies or participants.

Participating Medicaid providers are responsible for ensuring that requirements for services rendered are met in order to receive payment from Medicaid. Under the Participation Agreement with DMAS, the provider also agrees to provide access to records and facilities to Virginia Medical Assistance Program representatives, the Attorney General of Virginia or his authorized representatives, and authorized federal personnel upon reasonable request.

Individuals Enrolled in Managed Care (DME)

Most individuals enrolled in the Medicaid program have their services furnished through contracted managed care organizations (MCOs) and their network of providers. Durable medical equipment (DME) providers serving individuals enrolled within an MCO shall reference their MCO provider agreement regarding Utilization Review and Control. All providers are responsible for adhering to this manual, their provider contract with the MCOs, and state and federal regulations. For those who are enrolled in Medicaid and continue to receive care under Medicaid fee-for-service, the provider is responsible for adhering to state and federal regulations, as well as this manual.

Financial Review and Verification (Podiatry)

The purpose of financial review and verification of services is to ensure that the provider bills only for those services that have been provided in accordance with DMAS policy and that are covered under the Virginia Medical Assistance programs and services. Any paid provider claim that cannot be verified at the time of review cannot be considered a

valid claim for services provided, and is subject to retraction.

Compliance Reviews (Home Health)

The Department of Medical Assistance Services routinely conducts compliance reviews to ensure that the services provided to Medicaid participants are medically necessary and appropriate and are provided by the appropriate provider. Providers and participants are identified for review by:

- Systems generated exception reporting using various sampling methodologies or by referrals and complaints from agencies or participants. Exception reports developed for providers compare an participant provider's billing activities with those of the provider peer group. An exception profile report is generated for each provider that exceeds the peer group averages by at least two standard deviations.
- Referrals and complaints from agencies or participants. Referrals and complaints of inappropriate utilization of Medicaid services are investigated to determine if a Quality Management Review is necessary. The case may be referred to the DMAS' Provider Review Unit or the Attorney General's Office for further review. Reviews are conducted by:
- The reviewer, who is either a Health Care Compliance Specialist (HCCS), trained professional employed by DMAS or a Contractor of DMAS, reviews all cases using available resources, including appropriate consultants, and make on-site reviews of medical records as necessary.

On-site review process:

- Upon arrival at the facility, the reviewer will supply the provider with a list of the records to be reviewed. The provider must supply the reviewer with the records as requested. The reviewer will begin the review at the facility.
- At completion of the on-site portion of the review, the reviewer will conduct an Exit Conference. This conference is a brief summary of the onsite findings.
- Upon return to DMAS, the reviewer will complete the review. Completion of this review includes a summary letter to the provider. This letter includes technical assistance, areas of citation and, if applicable, documentation of overpayment.
- If overpayment occurs, a copy of the letter will be forwarded to the Fiscal

Division of DMAS. The provider will receive another letter outlining the repayment requirements from this Division. Desk review process:

- The reviewer will mail, via United States Post Office certified mail, a list of the records to be reviewed. The provider must supply the reviewer with the records as requested. The records must be received by DMAS by the date instructed. Upon receipt of the documents, the reviewer will review the records received. The reviewer may contact the provider for clarification of any documents received.
- Upon completion of the review, the reviewer will send a summary letter to the provider via certified mail. This letter includes technical assistance, areas of citation and, if applicable, documentation of overpayment.
- If overpayment occurs, a copy of the letter will be forwarded to the Fiscal Division at DMAS. A letter outlining the repayment requirements will be received from this Division.

Overpayments:

- Overpayments may also be calculated based upon review of all claims submitted during a specified time period.
- Providers will be required to refund payments made by Medicaid if they are found to have billed Medicaid contrary to law or regulation, failed to maintain records or adequate documentation to support their claims, or billed for medically unnecessary services. In addition, due to the provision of poor quality services or any of the above problems, Medicaid may restrict or terminate the provider's participation in the program.

Fraudulent Claims (Home Health)

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Since payment of claims is made from both state and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or state court. The Program maintains records for identifying situations in which there is a question

of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

Provider Fraud

The provider is responsible for reading and adhering to applicable state and federal regulations and to the requirements set forth in this manual. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his or her signature or the signature of his or her authorized agent on each invoice that all information provided to the Department of Medical Assistance Services is true, accurate, and complete. Although claims may be prepared and submitted by an employee, providers will still be held responsible for ensuring their completeness and accuracy.

Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with appropriate supportive evidence*:*

Department of Medical Assistance Services

Division of Program Integrity

Supervisor, Provider Review Unit

600 East Broad Street

Richmond, Virginia 23219

Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from that unit for investigative purposes. Referrals are to be made to:

Office of the Attorney General

Director, Medicaid Fraud Control Unit

900 E. Main Street, 5th Floor

Richmond, Virginia 23219

Participant Fraud

Allegations concerning fraud or abuse by participants are investigated by the Division of Program Integrity of the Department of Medical Assistance Services. The Division focuses primarily on determining whether participants misrepresented material facts on the application for Medicaid benefits or failed to report changes that, if known, would have resulted in eligibility. The Division also investigates incidences of card sharing and prescription forgeries.

If it is determined that benefits to which the participant was not entitled were approved, corrective action is taken by referring participants for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the Virginia State Plan for Medical Assistance, DMAS must sanction an participant who is convicted of Medicaid fraud by a court. That participant will be eligible for Medicaid for a period of twelve months beginning with the month of fraud conviction.

Referrals should be made to:

Department of Medical Assistance Services

Division of Program Integrity

Cost Settlement and Audit

600 East Broad Street

Richmond, Virginia 23219

Referrals to the Client Medical Management Program (Hospice)

DMAS providers may refer individuals enrolled in Medicaid who are suspected of inappropriate use or abuse of Medicaid services to the Division of Program Integrity (PI) of the Department of Medical Assistance Services. Referred individuals will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or pharmacy in the Client Medical Management (CMM) Program. If CMM enrollment is not indicated, Recipient Monitoring Unit (RMU) staff may educate these individuals on the appropriate use of medical services, particularly emergency room services.

Referrals may be made by telephone, fax, or in writing. A toll-free helpline is available for callers outside the Richmond area. Voicemail receives after hours referrals. Written referrals should be mailed to:

Program Integrity Division

Department of Medical Assistance Services

600 East Broad Street

Richmond, Virginia 23219

Telephone: (804) 786-6548

CMM Helpline: 1-888-323-0589

When making a referral, provide the name and Medicaid number of the individual and a brief statement about the nature of the utilization problems. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

Home Health Program

> The home health agency and its staff must operate and furnish services in compliance with all applicable federal, State, and local laws and regulations and must comply with accepted professional standards and principles that apply to professionals furnishing services. All personnel furnishing services must

maintain liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. The clinical record or minutes of case conferences must establish that effective interchange, reporting, and coordination of patient care has occurred. A written summary report for each participant must be sent to the attending physician at least every 60 days.

Retention of Medical Records (Home Health)

A medical record containing pertinent past and current findings in accordance with accepted professional standards must be maintained for every participant receiving home health services and must contain the plan of care, appropriate identifying information; the name of the physician; drug, dietary, treatment and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and once discharged, a discharge summary.

For participants currently receiving a home health service, a copy of the plan of care, all supporting verifiable medical documentation, and all associated billing documentation must be kept on file at the location serving the participant. For participants no longer receiving a home health service, completed plans of care, all supporting verifiable medical documentation, and all associated billing documentation must be retained by the provider as stipulated by the licensing agency for at least five years. If a participant transfers to another home health agency, medical documentation shall be forwarded to the new home health provider.

Medical record information must be safeguarded against loss and unauthorized use. The home health agency must have written procedures in place that govern the use and removal of records and the conditions for the release of information. The participant's written consent is required for the release of information not otherwise authorized or required by law.

Documentation Requirements For Home Health Services

Face-to-Face Encounters 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 (see Chapter 4) 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.

Providers **may** use the **sample form** (found below) 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 F2F encounter must include the following required elements:

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

SAMPLE FORM: Home Health Face-To-Face Encounter Form

Individual Name:_____ **Date of Birth:**_____ **Medicaid ID:**_____

Check one of the following:

[ ] Same Practitioner: Face to Face Visit: I had a face-to-face encounter that meets the practitioner face-to-face encounter requirements with the individual. The individual is under my care. I have initiated the

establishment of the plan of care.

OR

[ ] Different Practitioner: Face to Face Visit: A face-to-face encounter was performed on this patient by (check one):

- A physician licensed to practice medicine;
- A licensed nurse practitioner or licensed clinical nurse specialist working in collaboration and with a practice agreement with the physician who orders the individual's services;
- A certified nurse midwife ;
- 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 postacute physician.

Date of Face-to-Face Encounter:_____

Based on the clinical finding of this encounter, the following services are medically necessary.

c Skilled Nursing c Therapy (type _____) c Home Health Aide

Based on clinical findings of this encounter, the services this individual needs are the following:

c Teaching/Training (Disease Management) c Observe/assess c Anticoagulation therapy

c Bladder Cath Care c Wound care care c Tracheostomy/Ventilator

c Medication/Education management c IV Care (Bowel/Bladder) c Ostomy Care

c Nutritional Status/Tube feedings c Decubitus Care c Chest Tube

c Equipment assessment/training c Oxygen therapy (new/changed)

c Other: _____

Ordering Practitioner Signature:_____Date:_____

Ordering Practitioner Printed Name:_____

Face-to-Face Practitioner Signature (if applicable):_____

Face-to-Face Practitioner Printed Name (if applicable):_____

Note to Ordering Practitioner: Please place a copy of this Face-to-Face form in the individual's medical record.

General Documentation Requirements

The documentation of home health services shall, at a minimum:

a. Describe the clinical signs and symptoms of the participant's illness;
b. Document an accurate and complete chronological picture of the participant's clinical course and treatments;
c. Document all treatment rendered to the participant in accordance with the plan with specific attention to the frequency, duration, modality, response, and identify who provided the care (include the full name, title and date);
d. Document the changes in the participant's condition;
e. Include all plans of care;
f. Document drugs and treatments as ordered by the physician;
g. Document that the home health agency staff is checking all medicines a participant is taking to identify possible ineffective drug therapy or adverse reactions, significant side effects, drug allergies and contraindicated medication and must promptly report any problems to the physician; and
h. Describe the efforts to discharge the participant from home health services
i. Documentation describing the efforts to provide the service and contacts to the physician must be maintained in the medical record.

NOTE: Home health agencies must follow all Virginia Department of Health Professions' guidelines on qualifications and supervision of staff as specified in 12 VAC5-381.

When an individual is admitted to home health services, a start of care

assessment must be completed no later than five (5) calendar days after the start of care. If services cannot be provided as ordered by the physician (e.g., in the case of the unavailability of a service, staff absences, etc.), the attending physician must be notified and the medical record must reflect the attempts made by the home health agency to provide the service and reasons why the service could not be provided as ordered. Documentation describing the efforts to provide the service and contacts to the physician must be maintained in the medical record.

If corrections are required, the error shall be crossed out, corrected, initialed and dated by the person who made the corrections.

Physician Documentation Requirements

The individual must be under the care of a physician who is legally authorized to practice and who is acting within the scope of physician's license. The physician may be the participant's private physician or a physician on the staff of the home health agency or a physician 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.

Participants are accepted for treatment on the basis of a reasonable expectation that the participant's medical and nursing needs can be met adequately by the home health agency in the participant's place of residence. Care follows a written plan of care established and reviewed by a physician as often as the participant's condition requires, but at least every 60 days. Services must be necessary to carry out the plan of care and must be related to the participant's medical condition.

The plan of care, developed in consultation with the appropriate qualified agency staff, must include the following applicable documentation:

- Diagnosis and prognosis;
- Functional limitations;
- Activities permitted;
- Mental status;

- Safety measures to protect against injury;
- Orders for medications and treatments;
- Orders for dietary or nutritional needs;
- Orders for nursing and therapeutic services;
- Orders for home health aide services;
- Orders for medical tests, including laboratory tests and x-rays;
- Measurable goals for treatment for all disciplines within established time frames;
- Frequency and duration of all services;
- Rehabilitation potential; and
- Instructions for a timely discharge or referral.

A written physician's statement, which may be in the form of the physician's orders on the home health certification plan of care, located in the medical record must certify that:

- The participant needs nursing care on an intermittent basis; the participant needs physical or occupational therapy or speech-language pathology services; and

- A plan for furnishing such services to the participant has been established and is periodically reviewed by a physician.

The physician is responsible for signing (name and title) and dating (month, day, and year) this required documentation. Any dictated typed reports must be signed and dated by the physician. A required physician signature for Medicaid purposes may include signatures, written initials, computer entry, or rubber stamp initialed by the physician. However, these methods do not preclude other signature requirements that are not for Medicaid purposes. If the physician chooses to use a rubber stamp on documentation requiring his or her signature, the physician whose signature the stamp represents must provide the home health agency administration with a signed statement to the effect that he or she is the only person who has the stamp and is the only one who will use it. The physician must initial and completely date all rubber-stamped signatures.

The initial plan of care (certification) must be reviewed by the attending physician or physician designee. The physician must sign the initial certification before the home health provider may bill DMAS. A physician 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 physician's signature.

A physician 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 physician recertification statement must indicate the continuing need for services and should estimate how long home health services will be needed. The physician 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 physician's signature.

The recertification plan of care must include any orders obtained as a result of modifications to the previous plan of care, which remain in effect, and include updated goals and time frames for goal achievement for all services ordered. The physician must approve, in writing, modifications to the plan of care. DMAS will not reimburse the home health agency for services prior to the date of the physician's signature.

A verbal order that necessitates a change in the current plan of care must be signed and dated by the physician. The verbal order must be received by a registered nurse or qualified therapist. If rehabilitative therapies are the only services ordered by the physician, a qualified licensed therapist may receive the verbal order.

Nursing Documentation Requirements

The following components are required for nursing documentation:

Nursing Assessment - A start of care assessment must be made by a registered nurse at the time of admission to home health nursing services. This initial evaluation must be maintained in the participant record throughout the duration of treatment and must contain a history of the medical conditions; a review of the physical systems and the identification of the physical problems and disabilities; and a psycho-social assessment

which must include the identification of support persons, environmental issues, needs and the reason for admission to home health services.

Nursing Care Plan - Nursing care plans based on an admission assessment are required for all participants and must indicate the actual or potential participant/family needs, measurable goals and objectives, specifically state the method by which they are to be accomplished, and include time frames for goal achievement. Nursing care plans must be updated as the participant's nursing care needs change. If home health aides are needed to provide services, the nursing care plan should reflect their duties and frequency. If the nursing care plan is a part of the home health certification plan of care, all of the above documentation must be identified.

Nursing Visit Notes - Visit notes are required at the time of each visit and must describe the treatment and/or instruction provided. In addition, the notes must address the medical status, treatment and/or instructions given for any special nursing procedures and identification and resolution of acute episodes. Treatment and care must be in accordance with the provisions of the plan of care.

Comprehensive Nursing Visit Documentation Requirements

Reimbursement at the comprehensive rate is based on the complexity of the skilled nursing procedures ordered and performed during each visit and not on the complexity of the overall case. A visit to determine if the patient and/or caregiver performed a procedure as previously taught would not be considered reimbursable at the comprehensive visit rate. An example of this type of visit would be the assessment by the nurse that the patient or caregiver had already performed a procedure correctly, prior to the nurse's visit, and no further complex teaching/treatment was required or medically necessary by the nurse.

The following examples identify some situations and describe the minimum documentation requirements necessary to support the appropriateness of billing at the comprehensive visit rate. These examples and participant cases must be within the context of the definition of comprehensive visits. Many participants and caregivers learn from short, focused teaching sessions. These short, focused sessions do not qualify for reimbursement at the comprehensive rate.

Diabetic Instruction

- Documentation must show that the assessment, direct care, or teaching requires an extensive length of time and that the participant and/or caregiver are able to comprehend in-depth instruction. Arrival and departure times must support the extended duration of the visit for the purpose of teaching the participant or caregiver and the complexity of the skilled procedures performed.

- The teaching plan must be clearly outlined.

- Visit notes must outline all instructions given and the ability of the participant or caregiver to demonstrate and/or verbalize comprehension in carrying out the care plan.

Wound Care

- The participant must have multiple or extensive wounds.

- Treatment orders must include multi-step procedures requiring longer periods of time than routine wound care.

- All documentation as to the size, depth, appearance, color, odor, drainage, and treatment provided must be included in each visit note.

- Arrival and departure times must support the extended duration of the visit for the purpose of teaching the participant or caregiver and the complexity of the skilled procedures performed.

- Visit notes must outline all instructions given and the ability of the participant or caregiver to demonstrate and/or verbalize comprehension in carrying out the care plan.

Intravenous (I.V.) Infusion

- Documentation must include arrival and departure times, supporting an extended duration of the visit for the purpose of teaching a participant or caregiver to administer I.V. fluids or medications and the complexity of the procedures performed.

- Visit notes must outline all instructions given and the ability of the participant or caregiver to demonstrate and/or verbalize comprehension in carrying out the care plan.

- If the nurse is required to stay with the participant throughout the administration of an I.V. medication, the physician orders and visit notes must identify the participant-specific risk factors requiring the continuous monitoring by the nurse. Additionally, the specific requirements for monitoring, reporting, and skilled interventions must be detailed in the physician's orders and documented in each visit note.

NOTE: Routine I.V. administration of fluids for hydration or medication which have no identified significant risk factors requiring nurse monitoring are not considered high-tech even if the task takes eight hours. DMAS does not consider a charge for a second skilled visit the same day as reasonable and necessary when the visit is for the sole purpose of discontinuing an I.V. when there is no other skilled intervention required.

Instruction to Non-English Speaking Participants or Caregivers

- Circumstances must be documented regarding the fact that the only acceptable communication is in the participant's birth language (no interpreter, no staff member who speaks the language of the participant

or caregiver, no English speaking family members, friend, or other support); and

- Documentation must include to the duration of the visit (arrival and departure times) and the type of service rendered to support the complexity of the procedures performed and/or the instructions given to the participant and/or caregiver.

NOTE: These situations should be very rare. Once a means of communication has been established, reimbursement at the comprehensive visit rate will no longer be considered necessary.

Extended Time Due to the Age/Condition of the Participant

- Documentation must describe the condition, the skilled procedure performed, and the difficulty resulting from the particular set of problems in situations (i.e. attempting to start peripheral I.V.s on a child with spasticity or an adult with fragile veins.

- Visit notes must identify arrival and departure times and include a clear description of the efforts to complete the physician ordered skilled procedure and why these efforts were unsuccessful.

- Visit notes must also document what steps the nurse took to either obtain additional orders or have another skilled professional attempt the procedure.

NOTE: If another nurse were successful in the performance of the skilled procedure, this visit would not be considered reimbursable at the comprehensive visit rate by Medicaid.

Visits that require additional nursing time because of social issues do not constitute reimbursement at the comprehensive nursing visit rate. Examples may include, but are not limited to:

- The participant has no community support for meals, transportation, etc.;
- The participant lives alone and has no family support; or
- The housing conditions are inappropriate or unsafe.

All nursing documentation must be fully signed with full name, title and dated completely with month, day and year.

Rehabilitative Therapies Documentation Requirements

If physical therapy, occupational therapy, or speech-language pathology services are ordered by the physician and rendered to a home health participant, there must be an initial assessment conducted by a qualified therapist. The initial assessment must include current functional deficits, clinical status, symptoms of the participant's condition, including the diagnosis, and identification of needs indicating rationale for therapeutic interventions, prior to the delivery of home health therapy services. The initial assessment must also document an accurate and complete chronological picture of any clinical course of other therapy treatments, including any prior home health or rehabilitation treatments. A plan of care specifically designed for the participant must be established and must include measurable short and long-term goals which describe the anticipated level of functional improvement and include time frames for improvement and/or goal achievement. This plan must be reviewed and updated as needed, but at least every 60 days. This includes updating goals and achievement dates that are identified on the care plan. When all the established long-term goals have been met based on the achievement dates and there are no other established long-term goals identified on the plan of care, the therapist must reevaluate the plan of care to determine if it is appropriate for services to continue. If there are no other long-term goals to be established, the participant should be discharged from services.

Progress notes must be written in the participant's medical record at the time of each visit to a home health participant and must include the type and duration of the treatment given, the participant's response to the treatment, and progress or lack of progress toward established goals. All entries to the medical record must be signed and fully dated by the provider of treatment, including full name and title. Treatment and care must be provided in accordance with the plan of care. The progress note must also indicate any education conducted, the participant/caregiver's ability to carry out the instructions given and any home program established. None of the above services are reimbursed by DMAS without a current physician's order which specifies the service treatment plan, the frequency and duration of the provision of the service.

If the participant is receiving therapy services from more than one provider (e.g., home health and outpatient or school rehabilitation), the participant's medical record must show documentation of coordination of these services, including goals, time frames for goal accomplishment and progress or lack of progress towards the established goals coordination efforts.

Home Health Aide Documentation Requirements

Written instructions for home health aide services must be documented in the medical record prior to the provision of services. These instructions must clearly identify all the services the aide is expected to perform for the participant in the place of residence. These instructions must be completely signed and dated by the registered nurse or licensed qualified therapist.

Home health aide visits must be documented in the participant's medical record for each visit to the participant in his/her place of residence must include identification of the services provided by the home health aide and must be signed and fully dated with the month, day and year, by the aide who performs the services. Documentation must also reflect that the services are being provided in accordance with the home health plan of care. Home health aide documentation should also include any information that identifies why the participant or home health aide is unable to participate in meeting the goals of home health aide services.

Supervision of Home Health Aide Services

Based on the Virginia Administrative Code, home health aide services must be provided under the general supervision of a registered nurse.. This documentation may be in the form of a visit note, by the registered nurse for the purpose of the supervisory visit of the home health aide only and must be signed

and fully dated with the month, day and year. The results of the supervisory visit must be documented (e.g., if the home health aide is performing services in accordance with the plan of care and the response of the participant and/or caregiver). If the supervisory visit is conducted in conjunction with the skilled visit, the documentation must reflect that the supervisory task was performed and the results (i.e., if the home health aide is performing services in accordance with the plan of care and the response of the participant and/or caregiver.)

When only home health aide services are provided, a registered nurse must make a supervisory visit to the participant's residence at least once every 60 days. Supervisory visits should occur while the aide is providing care.. The supervisory visit is not reimbursable Medicaid.

When skilled nursing services, in addition to home health aide services, a registered nurse must make a supervisory visit to the participant's place of residence at least every two weeks (either when the aide is present or absent). Supervisory visits should not be made when the aid is absent. This supervisory only visit is not reimbursable Medicaid. When rehabilitative therapy (physical, occupational and/or speech-language pathology therapies, in addition to the home health aide) are the only services provided, a licensed qualified therapist may make the supervisory visit instead of the registered nurse.

Discharge Planning

Discharge planning must be an integral part of the overall treatment plan which is developed at the time of admission to home health services. Discharge planning documentation for all disciplines providing services to the participant must include any or all of the following:

- Anticipated improvements in limitations or health care needs;
- Time frames necessary to meet the goals;
- Feasibility of alternative care, including options for other Medicaid covered services;
- Documentation that the participant and/or caregiver participated in the discharge planning process; and
- Discharge planning activities were explored at least every 60 days, or as

often as changes occur.

When goals have been accomplished and/or the participant no longer requires skilled services, each discipline must promptly prepare a discharge summary to be sent to the physician within 30 days. The summary should document the participant's progress or lack of progress and identify the treatment goals that were met or not met. Recommendations for follow-up care should be included.

Utilization Review Responsibilities of The Home Health Agency

The agency must maintain records on each participant in accordance with accepted professional standards and practices. Participant records must be complete, accurately documented, readily accessible, and systematically organized. All entries in the participant records must be signed with the first initial, last name, and professional title of the author and completely dated with the month, day, and year. Home health agencies must have current physician orders for services rendered, including orders to discontinue services if participants are discharged prior to the end of the current certification period.

Services must be provided within the requested time frames.

The home health agency must have written policies requiring an overall evaluation of the agency's total program at least once a year by a group of professional personnel (or a committee of this group), home health agency staff, and consumers, or by professional people outside the agency working in conjunction with consumers. The evaluation must consist of an overall policy and administrative review and a clinical record review. The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective, and efficient. Results of the evaluation are reported to and acted upon by those responsible for the operation of the agency and are maintained separately as administrative records.

As a part of the evaluation process, the policies and administrative practices of the agency are reviewed to determine the extent to which they promote participant care that is appropriate, adequate, effective, and efficient. Mechanisms must be established in writing for the collection of pertinent data to assist in the evaluation.

At least quarterly, the appropriate health professionals, representing at least the

scope of the program, must review a sample of both active and closed medical records to determine whether established policies are followed in furnishing services directly or under contract. There must be a continuing review of the medical records for each 60day period that a participant receives home health services to determine the adequacy of the plan of care and the appropriateness of the continuation of care.

Utilization Review Responsibilities Of DMAS

Under federal regulations, DMAS must provide for the continuing review and evaluation of the care and services covered by DMAS. This includes a review of the utilization of the services rendered by providers to participants. Desk and on-site reviews of each Medicaid participating home health provider will be made periodically, and may be unannounced. The utilization review will include a professional review of the services provided by the home health provider with respect to:

- The care being provided to the participants;
- The adequacy of the services available to meet current health needs and to provide the maximum physical and emotional well-being of each participant;
- The necessity and desirability of the continued participation in home health services by the participant;
- The feasibility of meeting the participant's health needs in alternate care arrangements; and
- The verification of the existence of all documentation required by Medicaid to indicate that reimbursement coincides with services provided.

Other visits may be made to follow-up on deficiencies or problems, to investigate complaints, and to provide technical assistance. A plan of correction may be requested based on the findings of the visit. All utilization reviews will be followed-up with a written report to the home health agency outlining any areas out of compliance with DMAS regulations and policies. Services not found to be appropriate or not specifically documented in the participant's medical record as having been rendered will be deemed not to have been rendered, and no reimbursement will be provided. In addition, no reimbursement will be allowed if documentation does not reflect that services provided met program criteria.

Use of Electronic Signatures (Home Health)

Use of electronic signatures for clinical documentation purposes, shall be deemed to constitute a signature and will have the same effect as a written signature on a document. Failure to properly maintain or authenticate medical records(sign and date the entry) may result in the retraction of Medicaid payments. An electronic signature that meets the following criteria is acceptable for clinical documentation:

- Identifies the participant signing the document by name and title;
- Assures that the documentation cannot be altered after the signature has been affixed by limiting access to the code or key sequence; and
- Provides for nonrepudiation; that is, strong and substantial evidence that will make it difficult for the signer to claim that the electronic representation is not valid.

Providers must have written policies and procedures in effect regarding use of electronic signatures. In addition to complying with security policies and procedures, providers who use computer keys or electronic signatures, must sign a statement assuring that they alone will have access to and use the key or computer password. The policies and procedures and statements of exclusive use must be maintained and available at the provider's location.

Additionally, the use of electronic signatures must be consistent with the applicable accrediting and licensing authorities and the provider's own internal policies. These requirements for clinical documentation apply only to Medicaid claims, and do not preclude other state or federal requirements.

An original written signature is still required on provider enrollment forms and for medical consents. This clarification does not apply to electronic claims submission or the electronic sharing or transmission of clinical records. For guidance on billing, please refer to Chapter V of this manual.

Participant Rights (Home Health)

The participant has the right to confidentiality of the clinical records maintained by the home health agency. The agency must advise the participant of the agency's policies and procedures regarding the disclosure of clinical records.

Before the care is initiated, the home health agency must inform the participant, orally and in writing, of the extent to which payment may be expected from Medicare, Medicaid, or any other federally funded or aided program known to the home health agency; the charges for services that will not be covered by Medicare; and the charges that the participant may have to pay.

The participant has the right to be advised orally and in writing of any changes in the information regarding participant's rights as they occur. The home health agency must advise the participant of these changes as soon as possible, but no later than 30 working days from the date that the agency becomes aware of a change. The participant has the right to be advised of the availability of the toll-free complaint line established by the Department of Health, Division of Licensure and Certification. The telephone number is 1-800-955-1819. When the agency accepts the participant for treatment or care, the agency must advise the participant in writing of the telephone number and that the purpose of the hotline is to receive complaints or questions about local home health agencies.