

SECTION 2
HOME HEALTH AGENCIES

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ATTACHMENTS:

Private Duty Nursing Acuity Grid – April 2013

1 General Policy

Medicaid covers skilled nursing, physical therapy, and home health aides for categorically and medically needy recipients; occupational therapy, speech-language/audiology, and private duty nursing services are a benefit for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) clients and pregnant women.

Home health services are a benefit of the Utah Medicaid Program as described in this section. Home health services are medically necessary, part-time, intermittent health care services provided to eligible persons in their place of residence when the home is the most appropriate and cost effective setting consistent with the client's medical need, and when the medical need can be safely met in the home through one of two nursing skill levels with support from family care givers.

Home health agencies requesting services should encourage and identify how much help is available from the family to supplement the agency assistance. There is no age limitation for home health care. Support and assistance from family members is essential in order to maintain home health service for some clients at a level that is realistically appropriate and cost effective.

Home health services must be based on a physician's order and a plan of care. The home health care provided must require the skills of technical or professional personnel such as a registered nurse (RN), licensed practical nurse (LPN), trained home health aide, physical therapist, occupational therapist, or speech pathologist. Service is limited to one visit per day.

The goals of home health care are to minimize the effects of disability or pain; promote, maintain or protect health; and prevent premature or inappropriate institutionalization while allowing the patient to live at home in personal dignity and independence. The home health agency should effectively coordinate all patient care services to meet the medical, nursing and related health needs of the patient in the home. When a skilled home health nurse is authorized to provide a service, other medically necessary services must be provided at the same time, including, but not limited to providing caregiver training, completing the nursing assessment to access for condition changes, medication box fill, and changing an IV dressing. Additional visits will not be authorized for services which could be provided during other visits.

All home health service must be supervised by a registered nurse employed by an approved, certified home health agency. Nursing service and all approved therapy services must be provided by the appropriate licensed professional.

2 Clients Enrolled in an Accountable Care Organization

A Medicaid client enrolled in an Accountable Care Organization, or Prepaid Mental Health Plan (PMHP), must receive all health care services, including medical supplies, through that plan. Refer to Utah Medicaid Provider manual, Section 1, Chapter 5, Verifying Eligibility, for information about how to verify a client's enrollment in a plan and Chapter 4, Accountable Care Organizations, for more information about accountable care plans. Each plan may offer more benefits and/or fewer restrictions than the Medicaid scope of benefits explained in this section of the provider manual. Each plan specifies services which are covered, those which require prior authorization, the process to request authorization and the conditions for authorization.

All questions concerning services covered by or payment from an accountable care organization must be directed to the appropriate accountable care organization. Medicaid does NOT process prior authorization requests for services to be provided to a Medicaid client who is enrolled in a capitated managed care plan when the services are included in the contract with the plan. Providers requesting prior authorization for services for a client enrolled in an accountable care organization will be referred to that plan.

A list of Accountable Care Organizations and PMHPs, with which Medicaid has a contract to provide health care services, is included as an attachment to the provider manual. Please note that Medicaid staff makes every effort to provide complete and accurate information on all inquiries as to a client's enrollment in an Accountable Care Organization. Because eligibility information as to what plan the patient must use is available to providers, a "fee for service" claim will not be paid even when information is given in error by Medicaid staff.

3 Clients NOT Enrolled in an Accountable Care Organization

Medicaid clients who are not enrolled in an accountable care organization (fee-for-service clients) may receive services from any provider who accepts Medicaid. This provider manual explains the conditions of coverage for Medicaid fee-for-service clients.

4 Definitions

Term	Definition
Clinical Note	Clinical note means a notation of a contact with a patient that is written and dated by a member of the health team, and that describes signs and symptoms, treatment and drugs administered and the patient's reaction, and any changes in physical, emotional condition, or other health information.
CNA	CNA stands for certified nursing assistant. (See Home Health Aide)
HHA	HHA stands for home health agency. HHA can also mean home health aide.
Home Health Agency Visit	A visit is a personal contact in the place of residence of a patient for providing a covered service.
Home Health Agency or Home Care Agency	"Home health agency" means a public agency or private organization that is licensed by the Department as a home health agency under the authority of Utah Code Title 26, Chapter 21, and in accordance with Utah Administrative Code R432-700. A home health agency is primarily engaged in providing skilled nursing service and other therapeutic services.
Home Health Aide or Certified Nursing Assistant	Home health aide / certified nursing assistant services are those provided by a person selected and trained to assist with routine care not requiring specialized nursing skill and closely supervised by a registered nurse to assure competent. The aide works under written care instructions. Home health aide services must be provided by a Medicare certified and Utah state licensed Home Health Agency through an established plan of care.

Term	Definition
Home Health Assessment Visit	A visit made by a registered nurse initially or at recertification to assess the patient's overall condition; to determine the adaptability of the patient's place of residence to the provision of health care and the capability of the patient to participate in his own care; and to identify family support systems or individuals willing to assume responsibility for care when the patient is unable to do so. The outcome of the assessment visit is a documented plan of care based on the physician's written orders and the registered nurses assessment.
Licensed Practical Nurse (LPN)	A licensed practical nurse provides care and service for patients whose care needs are stabilized. The LPN functions in accordance with agency policy and according to the Utah Nurse Practice Act.
Plan of Care	The Plan of Care is a written plan developed cooperatively by the home health agency staff and the patients attending physician. The plan is designed for the agency to adequately meet specific needs of the patient in the patient's place of residence, be based on orders written by the physician, and be signed by the physician. The approved plan must be incorporated in the agency's permanent record for the patient.
Private Duty Nursing (PDN)	Private duty nursing is an optional program which is covered within the Home Health Program for clients who meet specified criteria and require more than four continuous hours of skilled nursing care per day.
Private Duty Nursing (PDN) Acuity Grid	The PDN Acuity grid is a state form available at: http://health.utah.gov/medicaid/index.html and as an attachment to this manual.
PRN Nurse Visit	A PRN visit is an 'emergency visit' by a registered nurse to a patient receiving skilled nursing service.
Progress Note	Progress note means a written notation, dated and signed by a member of the health team, which summarizes facts about care furnished and the patient's response during a given period.
Skilled Nursing	Nursing services are specifically skilled services used in the treatment of an acute illness or injury or acerbation of a chronic illness.
Summary Report	Summary report means the compilation of the pertinent factors of a patient's clinical notes and progress notes from the previous certification period that is submitted to the patient's physician.
Supervision or Supervisory Visit	Authoritative procedural guidance by a qualified person for the accomplishment of a function or activity.
Supportive Maintenance Home Health	A level of hands-on service which requires minimal assistance, observation, teaching or follow-up essential to health care at home.

5 Limitations

The following limits apply to coverage of home health services.

- A. Home health service must be cost effective. It must cost less over the long-term to provide the required care and service in the patient's home than it would cost to meet the medical needs in a nursing facility or other institutional setting.
- B. Prior authorization is not required for the initial comprehensive nursing assessment or the nursing assessment required at recertification. A recertification assessment every 60 days is a federal requirement with reimbursement limited to one every 60 days. All other home health services require prior authorization.
- C. Medical supplies furnished by the home health agency are limited to those used during the initial visit to establish the plan of care.
- D. Home health care is limited to one visit per day, except in limited circumstances. A Plan of Care which exceeds established limits will not be approved.
- E. Teaching visits are limited to four per certification period in skilled nursing. Teaching visits for supportive maintenance nursing must include hands on care.
- F. An RN/LPN may bill for a brief visit to provide a skilled service the aide cannot provide, the same day as the home health aide visits. The services must be appropriately prior authorized.
- G. An aide may visit only once a day, unless billing for an extended level of service.
- H. Personal care aides and home health aides cannot be reimbursed for visits the same day.
- I. Reimbursement is subject to all other limits as indicated in the Coverage and Reimbursement Lookup Tool found on the Utah Medicaid website: <http://www.health.utah.gov/medicaid>
- J. Skilled nursing for observation, monitoring, and on-going assessments must be accompanied by hands on care.
- K. A PRN visit by an RN is limited to two in a 30-day period.
- L. An acute skilled nursing care visit by an RN is limited to twice a day for a maximum of 21 visits. It is limited to the first month of service unless the client reverts to an acute phase of a chronic condition.
- M. A prior authorization for one visit will be allowed to obtain physical, occupational, and speech therapy assessments. The assessment is used to determine whether a prior authorization will be given for home therapies, or if the patient should be able to receive the services in the outpatient setting. Therapy visits are limited to the most appropriate, cost-effective place of service. The home setting cannot be chosen for the convenience of the therapist or family if the patient is otherwise able to leave the home for other outpatient service and leaves to attend school.
- N. Medicaid restricts hemophilia blood factors to a single provider. The purpose is to provide a uniform hemophilia case management support program to the patient and patient's physician and to achieve economies in the purchase of blood factor through a sole source contract. Medicaid will reimburse only the sole source provider for hemophilia case management, blood factors VII, VIII and IX. No other provider will be paid for blood factors VII, VIII or IX supplied. Medicaid clients who choose not to participate in the Medicaid Hemophilia program must make their own arrangements for procurement and payment of the blood factor.

The contract affects only the procurement and management of the prescribed blood factor. The patient's physician continues to be responsible to develop a plan of care and to prescribe the blood factor. The contract with the sole source provider specifies the provider must work closely with the patient's Primary Care Provider physician or accountable care organization.

As of October 2000, the sole source provider is University Hospital Home Infusion Services. Please direct questions concerning hemophilia case management and blood factors VII, VIII and IX to this provider: (801) 466-7016.

Accountable care organizations which contract with Medicaid continue to be responsible for hemophilia-related services such as physical therapy, lab work, unrelated nursing care, and physician services.

- O. Drawing antibiotic levels or other blood work must be coordinated by the physician. When the patient is on an antibiotic, such as Vancomycin, the nurse is responsible for drawing the trough prior to providing the next dose of Vancomycin during a home health visit. The physician needs to coordinate the need for antibiotic levels with the home health agency so that they can be drawn during home health nursing visits. When this is not possible, the patient should go to the laboratory to have the peak Vancomycin level drawn. Exceptions must meet medical necessity for approval of an additional home health visit which should be extremely rare.
- P. Wound Management: Patients who are able to leave their home should see their physician for wound care management. During the initial nursing assessment, instructions for simple dressing changes must be provided to the patient and care giver. When the patient meets the requirements for home health nursing service and requires dressing changes for complex wounds, home health wound management requires submission of a complete wound assessment at the onset of care and weekly wound assessments throughout the certification period. Non-healing wounds require additional medical management.
- Q. Medicaid will reimburse for one IV dressing change or IV site change per 7 day period. When the client is to receive a medication such as an antibiotic for a 7-10 day period, it is expected that some type of long term IV administration line will be placed. Change of IV site dressing or IV line must have the documentation to support the medical necessity of the service.
- R. The RN assessment / reassessment must be coordinated with the Home Health Aide visits so that patients receiving periodic home health aide care are seen on a different date from the RN assessment. Only patients requiring supportive daily home health care to meet their ADL requirements may receive the RN assessment visit on the same date as the home health care aide visit.
- S. Discharge from the home health agency and readmission is only appropriate when the patient has left the home for hospitalization or a skilled nursing facility, and is returning to home health care services. There will be no carryover hours. A new nursing assessment must be completed. The prior authorization nurse will determine whether additional nursing hours are needed during the recertification.
- T. Chemotherapy by infusion technique, in home per visit, is limited to infusion of drug 5-FU when the home is the most clinically appropriate cost-effective place of service. 5-FU is the only drug considered for coverage in the home.
- U. Supportive maintenance nursing for medicine box prefills are to cover a two week period of time unless there is a documented, medically necessary reason for weekly visits.

6 Non-Covered Services

Medicaid does not cover home health services in the following situations:

- A. Home health care provided to a patient capable of self-care is not covered.

- B. Home health care provided to a patient residing in a hospital, skilled nursing facility or intermediate care facility is not covered.
- C. Personal care services, except as determined necessary in providing skilled care, are not covered.
- D. Housekeeping or homemaking services are not covered.
- E. Supportive skilled nursing visits without hands on care are not covered.
- F. Respite care is not covered.
- G. Care for social needs is not covered.
- H. A visit to supervise a home health employee is not reimbursable as home health care. A supervision visit is considered an administrative expense for the agency.
- I. Medical supplies are not covered by the home health agency program, except as indicated in Chapter 6-7.
- J. Palliative care for speech, occupational, and physical therapy is not a covered benefit.

7 Covered Services

Home health services are covered only when provided to a patient who is under the care of a physician and has an approved plan of care. The attending physician writes the orders on which a plan of care is established, certifies the necessity for home health services, and supervises the care. Services must be based on medical necessity. After the initial visit, all home health care services require prior authorization. Home health care is physician directed and must be furnished directly by or under the supervision of a registered nurse.

Home health services are:

- Skilled services which include
 - Skilled Nursing Service (RN or LPN)
 - Speech-Language Services
 - Physical Therapy Services
 - Occupational Therapy
 - Medical supplies
 - IV therapy
 - Home health aide (see Supportive maintenance services)
- Supportive maintenance services
 - Skilled Nursing and Home health aide
- Capitated home health services
- Private Duty Nursing

Criteria for each service are described in the remainder of this chapter. Procedure codes for home health services can be found by using the Coverage & Reimbursement Look up Tool on the website:

<http://www.health.utah.gov/medicaid>

7-1 Skilled Nursing Service

Nursing services, as defined in the Utah Nurse Practice Act, are covered when provided on a part-time basis by a home health agency. Part-time or intermittent services are usually services for a few hours a day several times a week. Occasionally, more services may be provided for a limited time when recommended by a physician and included in the approved plan of care. Skilled nursing service is the expert application of nursing theory, standardized procedures and medically delegated techniques by a registered nurse (RN) to meet the needs of a patient in his or her residence, using professional judgments to independently solve patient care problems.

Highly skilled nursing levels of care occur where the severity of illness and intensity of service are such that the attendance of a family or professional care giver is necessary on a consistent basis; specialized equipment is required to support activities of daily living; and the ability to function outside of the home is severely limited by medical needs, treatment, supportive equipment and the need for physical assistance; and the skill required can only be provided by a licensed RN or LPN. Teaching is limited to four visits in the first certification period.

The registered nurse makes the initial assessment and recertification visits, regularly reevaluates the patient's nursing needs, initiates the plan of care, makes necessary revisions, provides services requiring substantial and specialized nursing skill, initiates appropriate preventive and rehabilitative nursing procedures, prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs, counsels the patient and family in meeting nursing and related needs, participates in in-service programs, and supervises and teaches other nursing personnel.

A. Assessment Visit

An in-depth physical and psychosocial assessment must be made by a registered nurse initially or at recertification to assess the patient's overall condition, needs, adaptability of the patient's place of residence to the provision of health care, capability of the patient to participate in his or her own care, identify family support systems or persons willing to assume responsibility for care when the patient is unable, and establish a plan for delivery of care.

The home health agency may conduct an initial assessment visit on the reasonable expectation that a patient's needs can be met adequately in the place of residence by the agency. The outcome of the assessment visit is a documented plan of care based on the physician's written orders and the registered nurses assessment.

B. Plan of Care

The Plan of Care is a written plan developed cooperatively by the home health agency staff and the patient's attending physician. The plan must be designed for the agency to adequately meet specific needs of the patient in the patient's place of residence, be based on orders written by the physician, and be signed by the physician. The approved plan must be incorporated in the agency's permanent record for the patient.

The plan of care developed in consultation with the agency staff must cover the following:

- Diagnoses
- Mental status
- Types of service

- Medical equipment and supplies required
- Frequency of visits
- Rehabilitation potential
- Functional limitations
- Activities permitted
- Nutritional requirements
- Medications
- Treatments and therapies
- Discharge planning or referral
- Other identified appropriate services
- Clinical documentation supporting the client needs for care, e.g., discharge summary, history and physical, operative notes, physician's written summary of need, etc.

C. Reassessment

At least every sixty (60) days, the patient must undergo reassessment. The physician must review the new plan of care and recertify the need for continuing home health care. With exception of Skilled Home Health Aide/Supportive Maintenance, once daily Home Health Aide, Medicaid must approve an updated Plan of Care at least every 60 days. A 60-day summary of care from the previous certification period must be included on every care plan after the initial authorized period.

The average home health patient is served for 60-75 days. As the 60-day time frame nears, the home health agency should determine the need for continued care and complete a new prior authorization request. Include all information and documentation as was initially required. This reassessment can take place no more than five days prior to, or two days after, the previous certification period expires.

Home health care services must be administered by agency staff only as ordered by a physician and approved in the Plan of Care. All changes shall be made in writing and signed by the physician or by a registered nurse on the staff of the agency receiving the physician's oral order. All oral orders must be subsequently documented in writing on or before the next plan review. All changes in orders for legend drugs and narcotics must be signed by the physician.

If the patient does not require home health care for the entire 60-day period, service should be discontinued as appropriate.

7-2 Speech-Language Services

Speech-Language services are covered services under Home Health when the home is the most appropriate and cost effective place for the service. Speech-Language services are a benefit for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program clients and pregnant women.

Speech-Language services must be medically necessary and essential to treat problems associated with birth defects, prematurity, illness, accidents or injury. All services must be provided under physician orders, in accordance with a Plan of Care, and provided by a licensed, qualified Speech-Language therapist employed directly by or on contract to a Home Health Agency. There must be an expectation that with treatment, the patient's medical condition will improve in a predictable period of time. Speech-language services in the home are not an option for the convenience of physician, family or therapist.

Outpatient service must be considered for any continuing service beyond the initial intervention when the patient participates in other activities outside the home.

Before any therapy services are provided in the home, the Home Health Agency must request prior authorization and submit an initial assessment that includes, but is not limited to:

- Plan of Care based on physician orders
- Current medical findings and diagnosis
- Identification of any previous treatment provided
- Anticipated goals and methods of treatment clearly stated
- Amount, duration and frequency of services
- Prognosis

The plan of care and progress toward goals must be reviewed by the nurse reviewer every 60 days and reviewed and recertified with physician involvement every 6 months. Requests for continued service in the home will be evaluated by consultants and nursing staff on a case-by-case basis. A new plan of care must be submitted with a prior authorization request, and must include the following information:

- A medical evaluation from the physician including any change in medical condition and prognosis
- A status/progress report from the speech-language therapist clearly stating progress made toward meeting previous goals. Continued service is questionable if there is no progress. The speech-language therapist is responsible to recommend discontinuation of treatment when continued progress is not evident
- Goals, objectives, treatment methods and frequency of continued service requested. Goals must include teaching family care givers to work with the patient on a daily basis so that improvement can be maintained.
- Medical problems the patient may have that support or justify continued service in the home
- Anticipated transition to outpatient service
- If the patient is on the Tech Dependent Waiver or Early Intervention Programs, the information must be included with each request.

Speech Language Services are non-covered for the following:

- Social, educational or developmental limitations without medical diagnosis
- Chronic conditions which cannot benefit from communication services or where there is no potential for improvement
- Non-therapeutic routine, repetitive or reinforcing procedures
- Non-pregnant adults

7-3 Physical Therapy Services

Physical Therapy services are covered services through home health when the home is the most appropriate and cost effective place for the service to be provided. Physical therapy services must be medically necessary and essential to treat problems associated with accidents, injury, illness, birth defects or prematurity. All physical therapy must be provided under physician orders, in accordance with a Plan

of Care, and provided by a licensed, qualified physical therapist employed directly by or on contract to a Home Health Agency.

There must be an expectation that with treatment, the patient's medical condition will improve in a predictable period of time. Physical therapy in the home is not an option for the convenience of physician, family, or therapist. Outpatient service must be considered for any continuing service beyond the initial intervention when the patient participates in other activities outside the home.

The purpose of physical therapy in the home is to improve the functional ability of a patient with a temporary or permanent disability.

The goal of physical therapy in the home is to improve the ability of the patient, through the rehabilitative process, to function at a maximum level.

Before any physical therapy is provided in the home, the Home Health Agency must request prior authorization and submit an initial assessment that includes, but is not limited to:

- A Plan of Care based on physician orders for medically necessary services to be provided
- Patient information, history, current medical findings, diagnosis and severity of the medically oriented disorder or disability
- A factual evaluation and statement of the function present and prognosis for reasonable and predictable improvement.
- Expected goals and objectives for the patient that may reasonably be achieved in a predictable period of time using professionally appropriate standards.
- The specific treatments or modalities to be used, frequency of treatment sessions, and anticipated duration of the physical therapy service.

The Plan of Care and progress toward goals must be reviewed by the nurse reviewer every 60 days and reviewed and recertified with physician involvement every 6 months. Requests for continued service will be evaluated by consultants and nursing staff on a case-by-case basis. A new plan of care must be submitted with a prior authorization request, and must include the following information:

- A medical evaluation from the physician including any change in medical condition and prognosis.
- A status/progress report from the physical therapist clearly stating progress made toward meeting previous goals. Continued service is questionable if there is no progress
- Physician orders, goals objectives, treatment methods and frequency of continued service requested. Goals must include teaching family care givers to work with the patient on a daily basis so that improvement can be maintained.
- Medical problems the patient may have that support or justify continued service in the home
- Anticipated transition to outpatient service
- If the patient is in the Tech Dependent Waiver or Early Intervention Programs, the information must be included with the request. Physical Therapy services are non-covered for the following:

Physical Therapy services are non-covered for the following:

- Social or educational limitations without medical diagnosis
- Conditions where there is no documented potential for improvement
- Non-therapeutic repetitive or reinforcing procedures

7-4 Occupational Therapy Services

Occupational Therapy services are covered services through home health when the home is the most appropriate and cost effective place for the service to be provided. Occupational therapy is a benefit for EPSDT clients and pregnant women.

Occupational therapy services must be medically necessary and essential to treat problems associated with accidents, injury, illness, birth defects or prematurity. All occupational therapy must be provided under physician orders, in accordance with a Plan of Care, and provided by a licensed, qualified occupational therapist employed directly by or on contract to a Home Health Agency. There must be an expectation that with treatment, the patient's medical condition will improve in a predictable period of time. Occupational therapy in the home is not an option for convenience of physician, family or therapist. Outpatient service must be considered for any continuing service beyond the initial intervention when the patient participates in other activities outside the home.

The purpose of occupational therapy is to address the developmental or functional needs of a person related to the performance of self-help skills, adaptive behavior and sensory, fine motor skills and postural development. Evaluation and treatment services are available to correct or ameliorate physical and/or emotional deficits. Typical activities related to occupational therapy are:

- Perceptual motor activities;
- Exercises to enhance functional performance; kinetic movement activities;
- Guidance in the use of adaptive equipment; and
- Other techniques related to improving fine motor development.

The goal of occupational therapy in the home is to improve the ability of the patient, through the rehabilitative process, to function at a maximum level.

Before any therapy services are provided in the home, the Home Health Agency must request prior authorization and submit an initial assessment that includes, but is not limited to:

- A Plan of Care based on physician orders for medically necessary services to be provided
- Patient information, history, current medical findings, diagnosis and severity of the medically oriented disorder or disability
- A factual evaluation and statement of the function present and prognosis for reasonable and predictable improvement.
- Expected goals and objectives for the patient that may reasonably be achieved in a predictable period of time using professionally appropriate standards.
- The specific treatments or modalities to be used, frequency of treatment sessions, and anticipated duration of the physical therapy service.

The Plan of Care and progress toward goals must be reviewed by the nurse reviewer every 60 days and reviewed and recertified with physician involvement every 6 months. Requests for continued service will be evaluated by consultants and nursing staff on a case-by-case basis. A new plan of care must be submitted with a prior authorization request, and must include the following information:

- A medical evaluation from the physician including any change in medical condition and prognosis
- A status/progress report from the occupational therapist clearly stating progress made toward meeting previous goals. Continued service is questionable if there is no progress
- Physician orders, goals objectives, treatment methods and frequency of continued service requested. Goals must include teaching family care givers to work with the patient on a daily basis so that improvement can be maintained.
- Medical problems the patient may have that support or justify continued service in the home
- Anticipated transition to outpatient service
- If the patient is in the Tech Dependent Waiver or Early Intervention Programs, the information must be included with the request.

Occupational Therapy services are non-covered for the following:

- Social or educational limitations without medical diagnosis
- Conditions where there is no documented potential for improvement
- Non-therapeutic repetitive or reinforcing procedures
- Non-pregnant adults

7-5 Medical Supplies

Medical supplies for home health service are limited to the following:

- Supplies used during the initial visit to establish the plan of care;
- Supplies indicated by the physician in the approved plan of care;

Medical supplies provided by the home health agency on the initial visit do not require prior authorization. After the initial visit, medical supplies needed for patient care must be included in the plan of care.

Medical supplies included in the plan of care are subject to the coverage and prior authorization requirements and limitations of the Medical Supplies Program. For additional information about this program, refer to the Utah Medicaid Provider Manual for Medical Suppliers and the Coverage and Reimbursement Look up Tool on the website: <http://www.health.utah.gov/medicaid>.

7-6 IV, Enteral, and Parenteral Therapy

Skilled nursing is appropriate for IV placement, demonstration of IV medication delivery, blood draws associated with infusion therapy, or teaching. Medical necessity and reasonableness must be established based on the appropriateness of administration in the home setting and the patient's condition and diagnosis.

The plan of care for infusion therapy must include:

- Name of the substance
- Dose (quantity)
- Frequency

- Duration

When the client is to receive a medication such as an antibiotic for a 7 to 10 day period, it is expected that some type of long term IV administration line will be placed. Pregnant women are excepted from this requirement and may have a visit every 3 days for peripheral line maintenance.

IV, enteral, and parenteral therapy are covered as a home health service either in conjunction with skilled or maintenance care or as the only service provided. Refer to the Utah Medicaid Provider Manuals for Pharmacy and Medical Supply policy for information about IV, enteral, or parenteral therapy.

7-7 Supportive Maintenance Service

- A. The supportive maintenance level of service includes skilled nursing and home health aides and is available to the patient with nursing care needs that have stabilized to the point that there are few significant changes occurring in the plan of care. The patient demonstrates limitations or significant disability which requires assistance with activities of daily living and could be totally bed bound or subject to nursing facility admission without the assistance. Care and service needs are based on physician orders and an approved plan of care, with review and recertification completed by the home health agency and the physician, every 60 days. Teaching, assessment, observation, and monitoring by a skilled nurse must be accompanied by hands on care.

Supportive maintenance levels of care occur where the patient demonstrates permanent limitations or significant disability due to illness or injury, requiring minimal assistance, use of specialized equipment, assistance with activities of daily living, observation, teaching and follow-up. Care needs are relatively stable, supportive in nature, and long term. The client is capable of leaving home to attend school, sheltered workshops, work, or receive necessary medical care after assistance from the care giver to get out of bed, bathe, dress and get into a wheelchair or other conveyance. Assistance may be needed to reverse the process at night. The typical client requiring this level of service is generally the paraplegic or quadriplegic individual. However, this level of care can also apply to clients with medical needs related to degenerative neurological diseases; newly diagnosed diabetics; acute, high risk diabetic complications; and those with multi-system problems requiring a skilled service or acute monitoring.

- B. Home health aide is a covered service. Severity of illness and intensity of service must be such that the skills of a home health aide can meet the need on a consistent basis at an appropriate skill level. Home health aide visits can occur once or twice daily. For extended service, see part E below.

One visit per day is up to two hours. If the nurse determines, after the initial 60-day certification period, that services requested are due to a chronic condition, and Medicaid determines that the condition and associated loss are expected to continue for at least one year, once daily service may be authorized for a 180-day period. If the patient's condition improves, and the patient does not require the service for the entire 180-day authorization period, it is the responsibility of the home health agency to notify Medicaid of the change of condition.

- C. Approval of the 180-day period, per federal regulations, requires a physician's order and plan of care reviewed by the agency every 60 days. Agencies will be responsible for maintaining a record of the required 60-day review within the patient's home health record and will be subject to possible post-payment review by Medicaid.

- D. When two patients in the home are receiving services, care needs will be evaluated as a total package, and service units will be adjusted and authorized as a total package. Two aides will not be approved for service except under extreme circumstances or changing care needs requiring additional service by individual care givers. Duplicate payment will not be approved under any circumstances if only one care giver goes to the home and provides the total units of care for both patients.
- E. Extended home health aide service is one hour per visit with a maximum of four visits per day. The health aide can visit the home to assist activities of daily living more than once daily. The patient must live in an independent situation without a care giver to assist. Care needs should be stabilized to the point that few significant changes are occurring in the plan of care. The patient must require assistance with activities of daily living to prevent bed confinement or nursing home admission. The plan of care needs be based on physician's orders and an approved plan of care with review and recertification every 60 days. Extended home health aide service does not qualify for the 180-day certification period.

7-8 Capitated Home Health Service

A patient may be eligible for the long term capitated home health program when documented, diagnosed medical conditions require extensive services or substantial physical assistance with activities of daily living but little skilled care.

Capitated home health care provides service for clients with paraplegia and quadriplegia who require little skilled care and need long term maintenance with activities of daily living, along with some other services, usually twice a day. Once a patient is approved for capitated home health care, the reimbursement is based on the cost of nursing facility care per day. The home health agency provides the required care to meet the patient's needs without billing for each service or visit.

Criteria considered by Medicaid Prior Authorization staff include:

- Orders must be established by the physician and outlined in an approved plan of care.
- Service needs are greater than six months.
- Service needs require at least 120 aide visits in a consecutive 90 day periods.
- Medical condition and intensity of service must be judged to be at the level that can be provided safely in the home setting.
- Nursing intervention is required at least every two months to provide a skilled service.
- Prior authorization is required for the capitated home health care program regardless of when the previous prior authorization was given. Medicaid may authorize services under this program for up to six months, or until there is a change in the patient's condition.
- Approval of the 180-day period, per federal regulations, requires a physician's order and plan of care reviewed by the agency every 60 days. Agencies will be responsible for maintaining a record of the required 60-day review within the patient's home health record and will be subject to possible post-payment review by Medicaid.
- The home health agency must submit a new recertification request every 180 days.

Note: As with any other Plan of Care, any change in the patient's condition or care needs requires immediate evaluation and reconsideration of the service authorization.

The capitated service represents a daily rate. No other home health services can be provided or billed when the client is receiving service under the capitated program.

7-9 Private Duty Nursing (PDN)

Private duty nursing service is an optional program and is indicated to prevent prolonged institutionalization in medically categorically and needy, eligible, EPSDT clients.

A. Eligibility, Coverage, and Limitations

Medicaid may cover PDN service if the quality and cost effectiveness justify it over other alternatives of care. Private duty nursing is only available if a parent, guardian, or primary care giver is committed to and capable of performing the medical skills necessary to ensure quality of care and a safe environment for the periods of time when private duty nursing service is not provided. As an optional benefit, continuation of PDN is subject to legislative funding.

Private duty nursing is for the medically necessary skilled nursing needs of the patient.

- The client is the only intended recipient of the PDN service. The care is not intended for other members of the household.
- Services will not be authorized if the care is a duplication of care reimbursed under another benefit or funding source.
- Medically appropriate skilled nursing care may be covered where it has been determined that skilled management by a licensed nurse (registered nurse or licensed practical nurse) is required.
- Private duty nursing is not covered for
 - Custodial or sitter care to ensure compliance with treatment,
 - Respite care to allow the caregiver to go to work or sleep,
 - Behavioral or eating disorders, or
 - Observation or monitoring for medical conditions not requiring skilled nursing.

B. Requirements

- Each case is reviewed by the Utilization Review Department or the Utilization Review Committee to determine if they meet the criteria for skilled nursing.
- The home health agency must verify in the submitted documentation that the caregiver receives the specialized training necessary to provide hands on care in the home.
- Medicaid covers PDN for a period to patients in transition from the hospital to allow sufficient training of the caregiver.
- Request for service(s) is submitted through the Medicaid Prior Authorization Unit.
- The patient must require more than four continuous skilled nursing hours of care per day.
- The PDN Acuity Grid is used to determine medical necessity, to qualify and quantify the number of PDN hours that a patient may receive in the home.

The number of private duty nursing hours a patient receives is based on the total score of the PDN Acuity Grid.

- Needed for consideration or reconsideration for PDN:
 - The patient must have a written physician order establishing the need for private duty nursing service.

- The PDN provider must submit a completed prior authorization request form with medical documentation, which demonstrates the need for the service.
- The PDN provider must develop a plan of care consistent with the patient diagnosis, severity of illness, and intensity of service. A 60-day summary of care from the previous certification period must be included on every care plan after the initial authorized period.
- The PDN provider must provide adequate supporting documentation to justify the patient’s score. Two weeks of documentation must be submitted and is to include nursing progress notes, flow sheets for skills, medications, etc., physician/agency communications, other types of agency created forms used to document patient care, and a PDN Acuity Grid
- All submitted documents are compared for consistency. The PDN Acuity Grid must substantiate the medical documents submitted.
- The authorization request and the PDN Acuity Grid are included in the attachments section of this manual and at <http://health.utah.gov/medicaid/provhtml/forms.htm>.
- The request and all documents must be submitted together.
- Scoring of the PDN Acuity Grid

The PDN acuity grid must reflect the average daily care given by the nurse during the previous certification period.

- 20 points or less – If the individual is being transitioned off 8 hours, then 832 units will be approved to the home health agency for the certification period.
- Otherwise, no private duty nursing hours will be allowed.
- During this time, it is expected that the PDN provider provide discharge planning services and make referrals to appropriate community support services.
- When the patient is decannulated, up to 4 hours of nursing daily may be expected during the first 24-72 hours for the weaning process.

Points	Hours of care per day of shift care (up to)
21-35	8
36-45	10
46-51	12
56 and over	14

- If a patient is discharged from the hospital, the PDN Acuity Grid is submitted based on an estimate of the care needed, the discharge orders, or other documents from the hospital.
- Ongoing care for new clients is determined by documentation from the first 60 days of care.
- If during a recertification period or after transition from hospital to home, the care is not substantiated, it is expected that the client will be given time to seek alternative care from community resources.
- Decrease in quantity of PDN services over time.
 - Active weaning occurs as follows:

- The recipient's family, caregiver, or similar representatives are informed by the PDN provider that weaning is an expectation.
- The weaning is in coordination and consultation with the physician.
- The PDN nurse shall attempt to wean the patient from a device or service and identify new problems.
- The active weaning process is to be followed after the patient is initially discharged from the hospital.
- The number of nursing hours approved will be decreased, as care needs decrease. Maximum hours will be reduced every certification period as the home setting is established and organized.
- The goal is to have the patient to 8 hours a day within a four-month period.
- Once the caregivers are given sufficient training to meet the patient's needs, and the service requires four hours or less of skilled nursing, private duty nursing service ends.
- Standard home health services (visits) may be accessed for the child requiring less than four hours of home health skilled nursing service.
- Maximum or an increased number of hours are to be used only when acute exacerbations of the illness occur which require a short term, temporary increase in skilled needs. The patient may receive up to 20-24 hours of private duty nursing care only under the following circumstances:
 - After initial hospital discharge, for up to 2-3 days to enable the care giver(s) to become trained in the home on procedures.
 - After a subsequent hospitalization, for up to 2-3 days to allow care giver(s) training in any new procedures or changes in care.
 - If the primary care giver is unable to provide home care due to caregiver illness or temporary incapacity, up to 2-3 days of private duty-nursing service may be authorized.
 - When a patient is decannulated, the weaning process will allow up to 4 hours of nursing visits for the first 24-72 hours.
 - When the condition of the child has stabilized and acute care is no longer required, the caregivers must be trained and prepared to provide skilled services such as periodic suctioning.
- Prior authorized hours may not be banked.

The banking, saving, or accumulation of unused prior authorized hours to be used later for the convenience of the family or agency is not covered. The home health agency may adjust or group hours to meet staffing availability of the agency within the 24-hour clock day.

C. Billing PDN:

The following provides billing information for PDN services:

- Private duty/independent nursing service(s), licensed, up to 15 minutes is billable with the correct code.

LPN Service use TE modifier. TE to pay at 78% of the fee schedule.

- When two patients in the home are receiving services, care needs will be evaluated as a total package based on physician orders and time study.
 - Service units will be adjusted and authorized as a total package.
 - Two nurses will not be approved for service except under extreme circumstances and new critical care needs requiring additional service by individual caregivers.
 - Duplicate payment will not be approved under any circumstances if only one caregiver goes to the home and provides the total units of care for both patients.
 - Effective April 1, 2006, a differential payment will be provided to the private duty-nursing service when the total units of care apply to more than one patient.
 - For differential reimbursement, submit the appropriate modifier (UN) on the claim to indicate care provided for more than one patient.
 - Refer to Billing, Chapter 10 of this manual for additional information on service for two or more patients in the home.

8 Rural Area Home Health Travel Enhancement

A. Rural Counties

Medicaid provides enhancements to the home health reimbursement rate when travel distances to provide service are extensive.

- The enhancement is available only in rural counties where round-trip travel distances from the care giver’s base of operations are in excess of 50 miles. Rural counties are defined as counties other than Weber, Davis, Salt Lake, and Utah.
- The client must reside in the same or an adjacent rural county as the provider.

To receive the rural home health travel enhancement, file the claim using an applicable, approved service code with a modifier “TN”.

Modifier TN is used for counties other than San Juan and Grand County recipients.

B. San Juan or Grand County Exception

An enhancement factor is applied to home health services rendered for residents living in San Juan or Grand County. This enhancement is irrespective of the distances traveled and is in lieu of the rural area exceptions provided for other rural counties.

C. Billing

To receive the rural home health travel enhancement file the claim using an applicable approved service code with the appropriate modifier.

Modifier	Recipients	Zone
UA	<ul style="list-style-type: none"> • Aneth and Hatch Trading Posts • Mexican Hat 	1

	<ul style="list-style-type: none"> • Montezuma Creek 	
UB	Monument Valley	2
TN	<ul style="list-style-type: none"> • Rural counties (Counties other than Weber, Davis, Salt Lake, and Utah) 	NA

9 Telehealth Skilled Nurse Pilot Project for Patients in Rural Areas *(Updated Interim December 2013)*

Medicaid implemented a Telehealth home care project effective January 1, 2000. The project is an additional, complimentary method to provide patient medical monitoring and education and to increase medical care compliance of home health care patients in rural areas. The project allows delivery of a percentage of home health care visits through Telehealth to patients who meet selection criteria. Criteria are: Patient lives in identified rural areas; meets diabetes eligibility requirements; requires two or more home care nursing visits per week; and agrees to participate in Telehealth home care services. Refer to Selection Criteria below for details.

After one year, a cost benefit analysis will be completed to determine whether the project should continue. Any change to the program will be announced in a Medicaid Information Bulletin.

Definition of Telehealth

Telehealth or Telemedicine is a technological method of providing auditory and visual connection between the skilled home health care nurse at a Telehealth site and the patient living in a rural Utah area.

Authorized providers

All interested home health care agencies serving rural areas may participate in the pilot project. Home health care visits are authorized through utilization management; typically 10-12 visits are authorized. A percentage (20-30%) of skilled nurse home health care visits may be authorized for provision through Telehealth.

Selection Criteria

Telehealth services delivered through a home health agency are medically necessary, part-time, intermittent health care services provided to eligible persons in their place of residence when the home is the most appropriate and cost-effective setting. Telehealth is a benefit for EPSDT clients and pregnant women.

Diabetes patient eligible for participation in Telehealth must be able **to physically use** Telemedicine equipment including: ability to follow directions, push two colored buttons, hear and see, apply the blood pressure cuff or stethoscope appropriately, and **want to participate** in the Telehealth project. When the patient is unable to use Telemedicine equipment, the patient may be included in the pilot project if there is a full time care giver consistently available who wishes to assist the patient with Telehealth.

Diabetes patient condition indicates to prior authorization staff that hands on assessment is probably not required, and/or the home health care nurse determines that the patient does not meet severity of illness

or have complicating conditions which might limit patient inclusion in the study. The appropriateness of delivering adequate education and/or monitoring will depend on the equipment available. The **skilled nurse must determine if patient care needs and quality of care delivery** will be met through the use of the Telehealth mode of delivery.

Covered Services

After Utilization Management preauthorization, the following services are covered for Telehealth home care patients:

- Monitoring for compliance in taking medications, foot condition/assessment of wounds or inflamed areas, blood glucose monitoring
- Education which may include a review in knowledge of the disease process, diet or nutritional counseling,
- Exercise and activity, diet /activity adjustment in illness/stress, medication, and glucometer use evaluation.

Home health care has a four-hour limit for all education purposes, which may include some diabetes training.

Limitations

- Centers for Medicaid and Medicare Service (CMS) rules for Medicaid/Medicare do not allow reimbursement for Telemedicine equipment or Telemedicine transmission costs.
- The State would not anticipate a bill nor approve payment for a patient initiated anxiety call to the home health agency. Spot checks related to patient anxiety calls are not considered a home health care visit by Utah Medicaid.
- Telehealth home care visits are limited to patients living in rural areas of Utah. Patients residing on the Wasatch Front are not eligible for inclusion in the study. Wasatch front patients have access to home health care through their accountable care organization provider.
- The State would not expect Telehealth home care to become the exclusive means of delivering home health care; it is viewed as an enhancement to traditional home health care for rural or remote areas of Utah.
- RN visits are covered for Telehealth home care reimbursement.
- The home health agency will provide home health agency staff with extensive training and practice in how to use Telehealth technology. The Telehealth participating patients will receive an explanation of the purpose of Telehealth home care, adequate training in the use of Telehealth equipment and will sign a consent to participate in Telehealth. Medicaid will not reimburse for home health agency staff or patient training in Telehealth equipment use.
- The home health care nurse and the participating home health agency will address staff and patient concerns about privacy and confidentiality.
- The state requires the patient have a desire to participate in the home health care project. The home health agency must not discriminate against patients who do not wish to participate in Telehealth home care.

Billing and Payment

Bill on claim form CMS-1500 (08/05). No payments will be made for Telehealth transmission expense or facility charge. Reimbursement for Telehealth home care visits will be discounted from the charge for the home health visit delivered by traditional methods.

Modifiers

Covered

GT - Each skilled nurse Telehealth home care visit must indicate the service was provided through Telehealth by adding the GT modifier. This modifier is required to monitor and evaluate the financial impact of this project.

Non-Covered

GQ – telehealth data via asynchronous telecommunications systems is the code used for transmission of telehealth data such as radiology or electrocardiogram. This is not a covered service for the Medicaid Telehealth home health care project.

10 Prior Authorization

The home health agency must submit the physician's original written order requesting care, the plan of care resulting from those orders, and a prior authorization request form for all home health services beyond the initial visit, including therapies. Approval must be received before additional services are given. The level of service, skilled, supportive, or maintenance, is established and approved based on the prior authorization request.

- Recertification requests must be submitted every 60 days. The patient cannot be discharged if the deadline for re-certification has been missed. Certification periods must be consecutive.
- Prior authorizations for home health services are provider specific. This means that only the agency that applied for and received the prior authorization may use the authorization number. If another agency assumes responsibility for serving the patient, that agency must apply for and receive a separate prior authorization.
- Home health is not a covered service in a skilled nursing facility. The location of the patient must be documented in the request for home health services (i.e. own home, group home, assisted living center).
- Therapy requests (i.e. PT, OT, or speech) must be accompanied by an updated evaluation and signed physician order.
- PRN nursing visits are unplanned, unscheduled emergencies. Retro authorization must be requested with a PA request form, physician order for care, and nursing documentation of visit.

The process to obtain prior authorization is described below.

- A. When the nursing assessment indicates a Medicaid recipient may qualify for home health services, submit the request for prior authorization within 10 calendar days of the nursing assessment. Any services provided before the request is submitted must meet criteria or they will be denied. Services not requested in a timely manner will be denied.

Because of the volume for home health and private duty nursing requests, all requests for prior authorization must be faxed. Requests for authorizations cannot be approved by telephone. The fax number for the home health program is found on the third page of the Prior Authorization Request Form found on the website: <http://www.health.utah.gov/medicaid>

Telephone contact for Prior Authorization staff:

In the Salt Lake City area, call **801-538-6155**

Call toll-free in Utah, Arizona, New Mexico, Nevada, Idaho, Wyoming and Colorado **1-800-662-9651**

The telephone prompts to reach the Prior Authorization staff for home health services are 3, 3, 8.

- B.** Medicaid will review the prior authorization request and documentation. All required documentation must be submitted at the time of the request, or the request will be returned for insufficient documentation. Initial approval may be given for up to 60 days, unless the Plan of Care indicates a shorter time is required for home health care.

For complete information about the prior authorization process, refer to Utah Medicaid Provider manual, Section 1, Chapter 9, Prior Authorization Process. (<http://health.utah.gov/medicaid>)

Send written requests to:

Medicaid Prior Authorization
BOX 143111
Salt Lake City, UT 84114-3111

11 Billing (Updated 1/1/14)

Home health services may be billed electronically or on paper using the UB-04 or CMS-1500 (08/05) claim format. Billing methods are covered in the Utah Medicaid Provider manual, Section 1, Chapter 11, Billing Claims. Medicaid encourages electronic billing. Mistakes can be corrected immediately, and your claim is processed without delays. Electronic claims may be submitted until 5:00 PM on Thursday for processing that week.

Home health services requiring minimal time and being performed for multiple persons in the same location shall be billed with the appropriate modifier.

Modifiers

Modifier to Use	Number of Patients Served
UN	2
UP	3
UQ	4
UR	5
US	6 (or more patients)

Calculate the number of units billed to each patient:

Divide the total number of units by the total number of patients served.

The resulting number of units is billed to each patient along with the appropriate modifier to indicate the service was shared. If the units do not divide among the patients served into whole numbers, then allocate and bill the remainder units among the patients until used.

Example: 4 patients received a total of 11 units is calculated and billed as follows:

11/4 = 2.75

Patient 1 = 3

Patient 2 = 3

Patient 3 = 3

Patient 4 = 2

12 Home Health Procedure Codes

All code tables have been removed from the manual. Refer to the Coverage & Reimbursement Lookup Tool located on the Medicaid website for proper coding (<http://www.health.utah.gov/medicaid>).

Requests received with improper coding are returned for correction.

13 References

- State Plan Amendment, Attachment 3.1-A, Amount, Duration, and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy
- Utah Administrative Code, Title R414-1, Utah Medicaid Program
- Utah Administrative Code, Title R414-14, Home Health Services
- Utah Administrative Code, Title R414-40, Private Duty Nursing Service

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