

SECTION 2

HOME HEALTH SERVICES

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1 General Information

All underlined words contained in this document should serve as hyperlinks to the appropriate internet resource. Email dmhfmmedicalpolicy@utah.gov if any of the links do not function properly noting the specific link that is not working and the page number where the link is found.

For general information regarding Utah Medicaid, refer to [Section I: General Information](#), Chapter 1, General Information.

1-1 Home Health Services

Medicaid covers skilled nursing, physical therapy, and home health aides for categorically and medically needy members.

Occupational therapy, speech-language pathology and audiology, and private duty nursing services are covered for pregnant members and those eligible for the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program when medically necessary.

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 members in settings defined by 42 CFR Part 440.70 when they are medically necessary, cost-effective, and consistent with the member's medical need.

Home health services must be based on a physician's order and a documented 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 and certified home health aide, physical therapist, occupational therapist, or speech pathologist.

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 member to live in their place of residence with dignity and independence.

The home health agency should effectively coordinate services to meet the members medical needs in their place of residence. When a skilled home health nurse is authorized to provide a service, other medically necessary services should be provided at the same time. Additional visits will not be authorized for services which could be provided during other visits.

Home health service must be supervised by a registered nurse employed by an approved, Medicare-Certified Home Health Agency.

2 Health Plans

Information specific to ACOs can be found in [Section I: General Information](#), Chapter 2, *Health Plans*.

Refer to [Section I: General Information](#) Chapter 1-7, Fee-for-Service and Managed Care for information regarding Accountable Care Organizations (ACOs) and how to verify if a Medicaid member is enrolled in an ACO.

3 Provider Participation and Requirements

To enroll as a Medicaid Home Health Provider refer to [Section I: General Information](#) Chapter 3, *Provider Participation and Requirements*.

4 Record Keeping

Refer to [Section I: General Information](#), Chapter 4, *Record Keeping*.

5 Provider Sanctions

Refer to [Section I: General Information](#), Chapter 5, *Provider Sanctions*.

6 Member Eligibility

It is the responsibility of the provider to verify the member's eligibility prior to every rendered service. For additional information regarding member eligibility refer to [Section I: General Information](#) Chapter 6, *Member Eligibility*.

7 Member Responsibilities

For information on member responsibilities including establishing eligibility and co-payment requirements refer to [Section I: General Information](#), Chapter 7, *Member Responsibilities*.

8 Programs and Coverage

8-1 Definitions

Definitions of terms used in other Medicaid programs are available in *Section I: General Information* of the Utah Medicaid Provider Manual. Definitions specific to the content of this manual are provided below.

Clinical Note: A notation of contact with a member written and dated by a member of the health team. It describes signs and symptoms, treatment and drugs administered and the member's reaction, and any changes in physical, emotional condition, or other health information.

Home Health Agency Visit: A personal contact in the member's place of residence for providing a covered service.

Home Health Agency or Home Care Agency: A public agency or private organization 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 (HHA) or Certified Nursing Assistant (CNA): Services provided by a person selected and trained to assist with routine care not requiring specialized nursing skill and closely supervised by a registered nurse. Home health aide services must be provided by a Medicare-certified and Utah State licensed Home Health Agency through an established plan of care.

Home Health Assessment Visit: Made by a registered nurse initially or at recertification to assess the member's overall condition; to determine the adaptability of the member's place of residence to the provision of health care and the capability of the member to participate in his own care; and to identify family support systems or individuals willing to assume responsibility for care when the member 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 nurse's assessment.

Plan of Care: A written plan developed cooperatively by the home health agency staff and the member's attending physician. The plan is designed for the agency to adequately meet the specific needs of the member in the member'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 beneficiary.

Private Duty Nursing (PDN): Private duty nursing is an optional program which is covered within the Home Health Program for members who meet specified criteria and require more than four continuous hours of skilled nursing care per day.

Private Duty Nursing Acuity Grid: A form developed by the State of Utah to assist the assessing RN to determine the acuity level of the beneficiary. The form is available at [General PA Forms](#).

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 member'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 exacerbation of a chronic illness.

Summary Report: Summary report means the compilation of the pertinent factors of a member's clinical notes and progress notes from the previous certification period that is submitted to the member'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.

8-2 General Coverage

Home health services are covered only when provided to a member who is under the care of a physician. Home health services must comply with [Utah Administrative Code R414-1-30](#). The physician writes the orders on which an assessment is based and plan of care established, certifies the medical necessity for home health services, and provides supervision of cares. Home health care is physician-directed and must be furnished by or under the supervision of a registered nurse.

Home health services require prior authorization except for the initial and 60-day recertification assessments.

Refer to the [Coverage and Reimbursement Code Lookup](#) for additional covered services.

Home health services include:

- Skilled services
 - Nursing services (RN or LPN)
 - Speech-Language
 - Physical therapy
 - Occupational therapy
 - Medical supplies
 - IV therapy
 - Home health aide (see 8-9.1 *Home Health Aides* for related policy)
- Supportive maintenance services
 - Skilled nursing
 - Home health aide
- Capitated home health services

- Private Duty Nursing

Criteria for each service are described in the remainder of this manual.

8-3 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 member in his or her residence, using professional judgments to independently solve member 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 abilities are 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 member'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 member's condition and needs, counsels the member and family in meeting nursing and related needs, participates in in-service programs, and supervises and teaches other nursing personnel.

8-3.1 Assessment Visit

An in-depth physical and psychosocial assessment must be made by a registered nurse initially or at recertification to assess the member's overall condition, needs, adaptability of the member's place of residence to the provision of health care, capability of the member to participate in his or her own care, identify family support systems or persons willing to assume responsibility for care when the member 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 member's needs can be met adequately in their place of residence. The outcome of the assessment visit is a documented plan of care based on the physician's written orders and the registered nurse's assessment.

8-3.2 Plan of Care

The plan of care is a written plan developed cooperatively by the home health agency staff and the member's attending physician. The plan must be designed for the agency to adequately meet specific needs of the member in the member'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 member.

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 member needs for care, e.g., discharge summary, history and physical, operative notes, physician's written summary of need, etc.

8-3.3 Reassessment

At least every sixty (60) days, the member must undergo reassessment. The physician must review the new plan of care and recertify the need for continuing home health care. 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. Exceptions to this requirement are located in chapter 8-8 IV, *Enteral, and Parenteral Therapy Administration*.

The average member is served by home health 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 member does not require home health care for the entire 60-day period, service should be discontinued as appropriate.

8-4 Physical Therapy Services

Physical Therapy services are covered through home health when the setting is the most appropriate and cost effective. Physical therapy services must be medically necessary and essential to improve the functional ability of a member with a temporary or permanent disability associated with accidents, injury, illness, birth defects, or prematurity. The goal of

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

Physical therapy must be provided under physician orders, in accordance with an established plan of care, and provided by a licensed, qualified physical therapist or physical therapy assistant employed directly by or under contract with a home health agency.

There must be an expectation that with treatment, the member's medical condition will improve in a predictable period of time. Physical therapy delivery by a home health agency 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.

Before physical therapy is provided by the home health agency, prior authorization must be requested with submission of 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
- Member 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 member 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 by the attending physician 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 member on a daily basis so that improvement can be maintained
- Medical problems the member may have that support or justify continued service
- Anticipated transition to outpatient service
- If the member 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:
 - Social or educational limitations without medical diagnosis
 - Conditions where there is no documented potential for improvement
- Non-therapeutic repetitive or reinforcing procedures

8-5 Occupational Therapy Services

Occupational Therapy services are covered through home health when the setting is the most appropriate and cost effective. Occupational therapy is a benefit available for pregnant members and those eligible for the EPSDT program.

Occupational therapy services must be medically necessary and essential to treat problems associated with accidents, injury, illness, birth defects or prematurity. Therapy should maximize the developmental or functional needs of member performance to include any or all of the following:

- Self-help skills
- Adaptive behavioral skills
- Sensory skills
- Fine motor skills
- Postural development

Evaluation and treatment services are available to correct or ameliorate physical and/or emotional deficits.

Occupational therapy must be provided under physician orders, in accordance with an established plan of care, and provided by a licensed, qualified occupational therapist or certified occupational therapy assistant employed directly by or under contract with the home health agency.

There must be an expectation that with treatment, the member's medical condition will improve in a predictable period of time. Occupational therapy delivery by a home health agency is not an option for convenience of physician, family or therapist. Outpatient service must be considered for any continuing service beyond the initial intervention.

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

Before therapy services are provided by the home health agency, prior authorization must be requested with submission of 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
- Member 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 member 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 by the attending physician 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 member on a daily basis so that improvement can be maintained
- Medical problems the member may have that support or justify continued service
- Anticipated transition to outpatient service
- If the member 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 procedure
- Non-pregnant adults

8-6 Speech-Language Pathology and Audiology Services

Speech-language services are covered under home health when the setting is the most appropriate and cost effective. Speech-language pathology and audiology services are available to eligible pregnant and EPSDT members when determined to be medically necessary.

Speech-language services must be 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 member's medical condition will improve in a predictable period of time. Speech-language services delivery by a home health agency 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.

Before services are provided, 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 by the attending physician 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 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 member on a daily basis so that improvement can be maintained
- Medical problems the member may have that support or justify continued service
- Anticipated transition to outpatient service
- If the member 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

8-7 Medical Supplies

Medical supplies for home health services are included in the coverage of the initial visit related to the start of care and are not separately reportable.

Medical supplies included in the plan of care are subject to coverage and prior authorization requirements of the Medical Supplies and Durable Medical Equipment services program. Refer to the [Medical Supplies and Durable Medical Equipment](#) Provider Manual and the [Coverage and Reimbursement Code Lookup](#) for additional information about this program.

8-8 IV, Enteral, and Parenteral Therapy Administration

The administration of enteral, parenteral, and IV therapy is covered as a home health service either in conjunction with skilled or supportive maintenance care or as the only service provided. Refer to the [Pharmacy Services](#) and [Medical Supplies and Durable Medical Equipment](#) Provider Manuals for coverage policy regarding these services.

8-8.1 IV Therapy and Parenteral Therapy

Long-term IV access, such as PICC or central line placement, is required when a member requires administration of IV antibiotics for a 7-10 day period or parental nutrition therapy. IV dressing changes are covered once every 7-day period. Members with documented risk of infection or that are pregnant are excluded from this requirement and can have a visit every three days for peripheral line maintenance when medically appropriate.

Skilled nursing is appropriate for IV placement, demonstration of IV medication delivery; blood draws associated with infusion therapy, or teaching. Medical necessity of administration in the home health setting and the member's condition and must be established based on the appropriateness diagnosis. The plan of care for infusion therapy must include:

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

8-9 Supportive Maintenance Service

The supportive maintenance level of service includes skilled nursing and home health aides. These services are available to the member with nursing care needs that have stabilized to the point that there are few significant changes occurring in the plan of care. The member demonstrates limitations or significant disability that requires assistance with activities of daily living (ADL) 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 member demonstrates chronic limitations or significant disability requiring assistance with ADLs or specialized equipment which may require ongoing observation, teaching, and hands on follow-up care. Care needs should be relatively stable, supportive in nature, and long-term. The member is typically capable of leaving their place of residence to attend school, sheltered workshops, work or to receive other medically necessary services. Assistance may be needed multiple times per day.

Examples of members with diagnosis(es) requiring this level of care include, but are not limited to:

- Paraplegia
- Quadriplegia
- Degenerative neurological diseases;
- Newly diagnosed diabetics with acute high-risk diabetic complications; and
- Those with multi-system problems requiring a skilled service or acute monitoring

8-9.1 Home Health Aides

Home health aide related services are covered when medically necessary and part of an ongoing plan of care. The members severity of illness and required intensity of service must be such that the skills of a home health aide meets their needs on a consistent basis, at an appropriate skill level.

Home health aide visits can occur daily one or more times per day with coverage determinations based on a member's medical needs.

- Home health aide visits that are required once per day allow for up to two hours of related services and are reported using HCPCS code T1021 - Home health aide or certified nurse assistant, per visit
 - 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 is expected to continue for a period of at least one year, once daily service may be authorized for a 180-day period
 - If the member's condition improves, and the member does not require the service for the entire 180-day authorization period, it is the responsibility of the

- home health agency to notify the Medicaid Prior Authorization unit of the change in condition
- Approval of the 180-day period requires a physician's order and documented plan of care reviewed by the home health agency every 60 days in accordance with [42 CFR 440.70](#). Home health agencies are responsible for maintaining a record of the required 60-day review within the member's medical record and is subject to post-payment review by Medicaid
- Extended home health aide services may be medically necessary in situations when a member requires home health aide services multiple times per day. When medically indicated, each visit may be for one hour with a maximum of four visits per day, based on the member's medical need. These services do not qualify for the 180-day certification period. Report services using HCPCS code S9122 - Home health aide or certified nurse assistant, providing care in the home; per hour. These services require:
 - The member needs assistance with ADLs more than once daily
 - Assistance with ADLs are needed to prevent bed confinement or nursing home admission
 - The members medical care needs should be stabilized to the point that significant changes to the plan of care are not required.
 - The plan of care needs are based on a physician's orders and an approved plan of care with review and recertification every 60 days in accordance with [42 CFR 440.70](#)
- When two members 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 members

8-10 Capitated Home Health Service

A member 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 members with paraplegia and quadriplegia who require little skilled care and need long term maintenance with activities of daily living, along with other services, usually twice a day. Once a member 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 member'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 period
- Medical condition and intensity of service must be judged to be at the level that can be provided safely in the home health 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 member'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 member'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 member'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 member is receiving service under the capitated program.

8-11 Private Duty Nursing (PDN)

PDN service is an optional program for the purpose of preventing prolonged institutionalization of a member. As an optional program, PDN is a non-covered program for Medicaid members except EPSDT eligible members.

In certain cases, if agency staff determine that the proposed PDN services are both medically appropriate and more cost effective than alternative services, the agency may exceed the limitation of PDN coverage beyond EPSDT eligible members.

8-11.1 Eligibility, Coverage, and Limitations

PDN services are covered when criteria are met and determined to be medically necessary. PDN is only available if a parent, guardian, or primary care giver is able to perform the medical skills necessary to ensure quality of care and a safe environment for the periods of time when PDN service is not provided.

PDN services are for medically necessary skilled nursing needs of the member that meet the following criteria:

- The member is the only intended recipient of the PDN service
- Skilled management by a licensed nurse is required

PDN is not covered for:

- Custodial or sitter care to ensure compliance with treatment
- The care is not intended for other members of the household
- The care is a duplication of care covered under another service or funding source
- Respite care to allow the caregiver to go to work or sleep
- Behavioral or eating disorders
- Observation or monitoring for medical conditions not requiring skilled nursing

8-11.2 Requirements

Coverage of PDN requires:

- Prior authorization
- Member requires greater than 4 hours of skilled nursing care per day while in transition from the hospital to the home health setting
 - In these cases, the period of PDN coverage is provided to allow sufficient

- training of the caregiver
- Member requires greater than 4 hours of skilled nursing care per day as part of their ongoing care needs
 - In these cases, the period of PDN coverage is provided, based on quality and cost effectiveness of care, as means to minimize the need for prolonged institutionalization
- Member is dependent on mechanical ventilation
 - For these members, PDN may be provided during active weaning, or when weaning is not appropriate, as an ongoing service based on quality and cost effectiveness of care in order to minimize the need for prolonged institutionalization

8-11.3 Requested Documentation

The following documentation must be submitted for consideration or reconsideration for PDN services. All requested forms and documentation must be submitted together.

- A written physician order that establishes the need for PDN service.
- A completed prior authorization request form with supporting medical documentation that demonstrates the need for the service.
 - The authorization request is included in the attachments section of this manual and on the Medicaid Website [Forms](#) section
- A plan of care consistent with the member's diagnosis, severity of illness, and intensity of service. In addition, a 60-day summary of care from the previous certification period must be included with very care plan after the initial authorized period
- Verification that the caregiver receives the specialized training necessary to provide hands on care
- A completed PDN acuity grid, with adequate supporting documentation to justify the member's score

8-11.4 PDN Acuity Grid

The PDN Acuity Grid is used to determine medical necessity and to qualify and quantify the number of PDN hours that a member may receive.

The PDN Acuity Grid:

- The PDN Acuity Grid is included in the attachments section of this manual and on the Utah Medicaid website [Forms](#) section.
- Must reflect the average daily care given by the nurse during the previous certification period (or for the initial authorization period, estimated needs based on care required during the final days of hospitalization).
 - After the initial authorization period, 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
- All submitted documents are compared for consistency. The PDN Acuity Grid must be substantiated by the medical documentation submitted.

8-11.5 Scoring the PDN Acuity Grid

If a member 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. After the initial care period, ongoing care needs are determined by documentation from the previous 60 days of care.

If during a recertification period or after transition from hospital to the home health setting, continued PDN care is not substantiated, it is expected that the member will be given time to seek alternative care from community resources.

8-11.6 PDN Acuity Grid Score and PDN Hours

Score	Maximum allowable covered hours per day
21-35	12
36-45	14
46-51	16
56 ⁺	18

If 20 points or less:

- And the member is being transitioned off 9 hours, then 832 units will be approved to the home health agency for the certification period. During this time, it is expected that discharge planning occurs
- When a member’s tracheostomy is decannulated, up to 5 hours of daily nursing care may be approved during the first 24-72 hours after decannulation

8-11.7 Guidelines for decrease in quantity of PDN services over time

Active weaning occurs as follows, when indicated by PDN grid scores:

- Physician ordered
- The member’s family, caregiver, or similar education related to weaning
- The PDN nurse shall attempt to wean the member from a device or service and will identify and document any new issues that arise during the process
- The active weaning process is to be followed after the member is initially discharged from the hospital, as caregivers gain sufficient expertise to assure safe ongoing care
- The number of nursing hours approved will be decreased, as care needs decrease. Maximum hours will be reduced every certification period as the home health setting is established and organized
- The goal of active weaning is to have the member to 8 hours of PDN a day within a four-month period
- PDN service ends once the caregivers are given sufficient training to meet the member’s needs and fewer than four hours of skilled nursing are needed
- Standard home health services (visits) may be accessed for members who require fewer than four hours of home health skilled nursing service

8-11.8 Guidelines for increase in quantity of PDN services over time

An increased number of hours of PDN services may be authorized when acute exacerbations of illness require a temporary increase in skilled care. Additional documentation may be requested to support the request for increased hours. The member may receive up to 20-24 hours of PDN care daily, if authorized, only under the following circumstances:

- After initial hospital discharge, for up to 14 days to enable the care giver(s) to become

- trained on procedures
- After a subsequent hospitalization, for up to 14 days to allow care giver(s) training in any new procedures or changes in care
- An increased number of hours may also be requested if the primary care giver is unable to provide care due to caregiver illness or temporary incapacity, as documented by that caregiver's medical provider. Examples of temporary incapacitation may include severe illness, hospitalization, or injury that prevents normal physical functioning. In such cases, increased PDN coverage will be limited to a period not to exceed 30 days and is intended to provide care while alternative caregivers can be identified and trained.

8-11.9 Prior Authorized Hours May Not Be Banked

The banking, saving, or accumulation of unused, authorized hours to be used later for the convenience of the family or agency is not permitted.

Home health agencies may adjust or combine PDN hours within a 7-day period based on the needs of the family. Combing PDN hours should not be a common practice and it is not permissible to combine PDN hours because the agency could not staff a shift.

- Any adjustment or combining of PDN hours must meet the physician's orders and those orders take precedence in determining the daily care
- This policy change does not allow an HHA provider to omit a required daily service on one day only to combine it with another day's services
- PDN hours cannot be combined, adjusted, or accumulated for periods of time that the member is hospitalized or otherwise under the care of another provider who meets the PDN service requirements
- In the event of unexpected illness or injury, requiring additional PDN services, submit an additional PA requesting approval to exceed the previously approved units or hours

8-11.10 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 rendered service are reported with TE modifier. Service performed by and LPN reimburse at 78% of the fee schedule.
- When two members 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.
 - A differential payment will be provided to the private duty-nursing service when the total units of care apply to more than one beneficiary. For differential reimbursement, submit the appropriate modifier (UN) on the claim to indicate care provided for more than one beneficiary.

9 Non-Covered Services and Limitations

9-1 Non-Covered Services

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

- Home health care provided to a member capable of self-care.

- Home health care provided to a member residing in a hospital, skilled nursing facility or intermediate care facility.
- Personal care services, except as determined necessary in providing skilled care.
- Housekeeping or homemaking services.
- Skilled nursing or supportive maintenance service visits without hands-on-care.
- Respite care.
- Care for social needs.
- A visit to supervise a home health employee. (A supervision visit is considered an administrative expense for the home health agency.)
- Medical supplies, except where indicated.
- Palliative care for speech, occupational, and physical therapy.

9-2 Limitations

The following limitations apply to home health services:

- Home health care is limited to one visit per day, except in limited circumstances.
- RN assessment/reassessment is limited to one every 60 days. This limitation is subject to post payment review for appropriate use.
- The RN assessment / reassessment must be coordinated with the home health aide visits so that members receiving periodic home health aide care are seen on a different date from the RN assessment. Only members 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.
- If providing a skilled service an aide cannot provide, an RN/LPN may bill for a brief visit that takes place on the same day as home health aide visits. The services must be prior authorized.
- Visits on the same day by a personal care aide and a home health aide are not covered.
- Skilled nursing for observation, monitoring, and on-going assessments must be accompanied by hands-on-care.
- PRN visits by an RN are limited to two in a 30-day period.
- 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 member reverts to an acute phase of a chronic condition.
- Teaching visits are limited to four per certification period in skilled nursing. Teaching visits for supportive maintenance nursing must include hands-on-care.
- Supportive maintenance nursing for medicine box refills are to cover a two-week period of time unless there is a documented, medically necessary reason for weekly visits.
- A plan of care exceeding established limits will not be approved.
- Home health service must be cost effective. It must cost less over the long-term to provide the required care and service in the member's home than it would cost to meet the medical needs in a nursing facility or other institutional setting.
- Wound Management: During the initial nursing assessment, instructions for simple dressing changes must be provided to the member and care giver. When the member 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.
- Discharge from the home health agency and readmission is only appropriate when the member 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.

10 Prior Authorization

Prior authorization (PA) may be required for certain services. Failure to obtain prior authorization may result in payment denial by Medicaid. Providers must determine if prior authorization is necessary and obtain authorization *before* providing services. Exceptions may be made, with appropriate documentation, if the service provided is emergent or the member is retro-eligible for the dates of service requested.

Further prior authorization information is provided in the provider manual, *Section I: General Information*. Code specific coverage and prior authorization requirements are provided on the [Coverage and Reimbursement Code Lookup](#).

To request prior authorization the home health agency must submit the physician's written order requesting care, the plan of care resulting from those orders, and a *Request for Prior Authorization* 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.

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. Recertification requests must be submitted every 60 days. The member cannot be discharged if the deadline for re-certification has been missed. Certification periods must be consecutive.

Prior authorization is required for a physical, occupational, or speech therapy assessment. The assessment determines if the member is able to receive necessary services in the outpatient setting. Therapy visits are limited to the most appropriate, cost-effective place of service. The home health setting cannot be chosen for the convenience of the therapist or family.

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 beneficiary, that agency must apply for and receive a separate prior authorization.

The location of the member must be documented in the request for home health services (i.e. own home, group home, assisted living center).

Retro authorization must be requested with a PA request form, physician order for care, and nursing documentation of visit for all PRN nursing visits.

When the nursing assessment indicates a Medicaid member may qualify for home health services, fax the Request for Prior Authorization form and all required documentation within 10 calendar days of the nursing assessment. Documentation must be submitted at the time of the request, or the request will be returned. Prior authorization forms can be found on the Utah

Medicaid website [Forms](#) section.

11 Billing Medicaid

For general information related to billing Medicaid refer to chapter 11 *Billing Medicaid* of the [Section I: General Information](#) provider manual for additional billing instructions.

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 member must reside in the same or an adjacent rural county as the provider.

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.

See chapter 12 *Coding* for guidance related to claims submitted for these services.

11-1 Calculating the Number of Units Billed to Each Beneficiary

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

Number of members served	Applied Modifier
2	UN
3	UP
4	UQ
5	UR
6 ⁺	US

11-2 Calculation

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

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

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

$$11/4 = 2.75$$

$$\text{Member 1} = 3$$

$$\text{Member 2} = 3$$

$$\text{Member 3} = 3$$

$$\text{Member 4} = 2$$

11-3 Electronic Visit Verification Requirement

This policy is effective as of January 1, 2023.

In accordance with Utah Administrative Code R414-522 and section 12006 of the 21st Century CURES Act, providers of Home Health must comply with Electronic Visit Verification (EVV) requirements. Providers may select the system of their choosing, provided it captures the following data elements and is compliant with the standards set in the Health Insurance Portability Accountability Act (Utah Medicaid Provider Manual Home Health Services, Updated October 2019, Page 20 of 21, Section 2).

EVV systems must collect the minimum information:

1. type of service performed;
2. individual receiving the service;
3. date of the service;
4. location of service delivery;
5. individual providing the service;
6. time the service begins and ends; and
7. the date of creation of the electronic record.

Additional information, including technical specifications for file creation/submission can be found at <https://medicaid.utah.gov/evv>.

12 Coding

12-1 Rural Counties

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 rural counties other than San Juan and Grand County members.

See chapter 11 *Billing Medicaid* for guidance related to the conditions required for enhancements to the home health reimbursement rate

12-1.1 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.

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 • Montezuma Creek 	1
UB	<ul style="list-style-type: none"> • Monument Valley 	2
TN	<ul style="list-style-type: none"> • Rural counties (Counties other than Weber, Davis, Salt Lake, and Utah) 	NA

The following table is designed to provide hyperlinks to relevant documents, forms, and information to be used in conjunction with this provider manual.

For information regarding:	
Administrative Rules	Utah Administrative Code Table of Contents Utah Administrative Code, <u>Title R414-1, Utah Medicaid Program</u> Utah Administrative Code, Title <u>R414-14, Home Health Services</u> Utah Administrative Code, Title <u>R414-40, Private Duty Nursing Service</u>
General information including: Billing Fee for Service and Managed Care Member Eligibility Prior Authorization Provider Participation	Section I: General Information Claims Managed Care: Accountable Care Organizations Utah Medicaid Prior Authorization Administrative Rules Eligibility Requirements. R414-302. Medicaid General Provisions. R414-301. Program Benefits and Date of Eligibility. R414-306. Utah Medicaid Program. R414-1.
Information including policy and rule updates: Medicaid Information Bulletins (Issued Quarterly in January, April, July, and October) Medicaid Provider Manuals Utah State Bulletin (Issued on the 1 st and 15 th of each month)	Utah Medicaid Official Publications Utah State Bulletin
Medicaid forms including: PA Request Private Duty Nursing	Utah Medicaid Forms
Medical Supplies and DME	Medical Supplies And Durable Medical Equipment Provider Manual Medical Supplies, Durable Medical Equipment, and Prosthetic Devices. R414-70.
Modifiers	Section I: General Information
Patient (Member) Eligibility Lookup Tool	Eligibility Lookup Tool
Prior Authorization	Prior Authorization Form Utah Medicaid Prior Authorization
Provider Portal Access	Provider Portal Access
Provider Training	Utah Medicaid Provider Training
References including: Social Security Act Code of Federal Regulations Utah Code	42 CFR 440.70 Social Security Act 1905(a) Social Security Act 1861 (r) Utah Annotated Code Title 58