

Section 2
Home Health Services

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Attachment: Private Duty Nursing Acuity Grid – July 2013

1 General Information

This manual is designed for use in conjunction with other sections of the Utah Medicaid Provider Manual, such as Section I: General Information of the Utah Medicaid Provider Manual (Section I: General Information).

1-1 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) beneficiaries 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 settings defined by 42 CFR Part 440.70 when they are the most appropriate and cost effective, consistent with the client's medical need, and when the medical need can be safely met 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 beneficiaries 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 beneficiary to live at home in personal dignity and independence. The home health agency should effectively coordinate all beneficiary care services to meet the medical, nursing and related health needs of the beneficiary 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.

1-2 Fee-For-Service or Managed Care

This manual provides information regarding Medicaid policy and procedures for fee-for-service Medicaid beneficiaries. This manual is not intended to provide guidance to providers for Medicaid beneficiaries enrolled in a managed care plan (MCP). A Medicaid beneficiary enrolled in an MCP (health, behavioral health or dental plan) must receive services through that plan with some exceptions called "carve-out services," which may be billed directly to Medicaid.

Refer to the provider manual, *Section I: General Information*, for information regarding MCPs and how to verify if a Medicaid beneficiary is enrolled in an MCP. Medicaid beneficiaries enrolled in MCPs are entitled to the same Medicaid benefits as fee-for-service beneficiaries. However, plans may offer more benefits than the Medicaid scope of benefits explained in this section of the provider manual. Please contact the MCP listed on the beneficiary's medical card for further information.

Medicaid does not process prior authorization requests for services to be provided to a Medicaid beneficiary enrolled in an MCP when the services are the responsibility of the plan. Providers requesting prior authorization for services for a beneficiary enrolled in an MCP will be referred to that plan.

Medicaid makes every effort to provide complete and accurate information regarding a beneficiary's enrollment in a managed care plan. However, it is the provider's responsibility to verify eligibility and plan enrollment for a beneficiary before providing services. Eligibility and plan enrollment information for each beneficiary is available to providers from several sources. *Therefore, if a Medicaid beneficiary is enrolled in a plan, a fee-for-service claim will not be paid unless the claim is for a "carve-out service."*

1-3 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 a contact with a beneficiary written and dated by a member of the health team. It describes signs and symptoms, treatment and drugs administered and the beneficiary's reaction, and any changes in physical, emotional condition, or other health information.

Home Health Agency Visit: A personal contact in the beneficiary'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 beneficiary's overall condition; to determine the adaptability of the beneficiary's place of residence to the provision of health care and the capability of the beneficiary to participate in his own care; and to identify family support systems or individuals willing to assume responsibility for care when the beneficiary 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.

Plan of Care: A written plan developed cooperatively by the home health agency staff and the beneficiary's attending physician. The plan is designed for the agency to adequately meet specific needs of the beneficiary in the beneficiary'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 beneficiaries 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: <https://medicaid.utah.gov>.

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 beneficiary'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 beneficiary's clinical notes and progress notes from the previous certification period that is submitted to the beneficiary'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.

1-4 Procedure Codes

Effective January 1, 2013, procedure codes with accompanying criteria and limitations are no longer in the provider manual, they are found on the Medicaid website Coverage and Reimbursement Lookup Tool at: <https://medicaid.utah.gov>.

2 Provider Participation Requirements

2-1 Provider Enrollment

Refer to provider manual, *Section I: General Information* for provider enrollment information.

3 Member Eligibility

A Medicaid beneficiary is required to present the Medicaid Member Card before each service, and every provider must verify each beneficiary's eligibility each time and before services are rendered. For more information regarding verifying eligibility refer to provider manual, *Section I: General Information, Chapter 5, Verifying Medicaid Eligibility*.

4 Program Coverage

4-1 Covered Services

Refer to the Coverage and Reimbursement Lookup Tool on the Medicaid website at: <https://medicaid.utah.gov> for additional covered services.

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 R414-1-30. The physician writes the orders on which an assessment is based and plan of care established, certifies the necessity for home health services, and supervises the care. Services must be based on medical necessity. Home health care is physician directed and must be furnished directly by or under the supervision of a registered nurse. All home health services require prior authorization except for initial and 60-day recertification assessments.

Home health services include:

A. Skilled services

- 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)

- B. Supportive maintenance services
- Skilled Nursing and Home health aide

- C. Capitated home health services

- D. Private Duty Nursing

Criteria for each service are described in the remainder of this chapter. Procedure codes and additional criteria for home health services are found in the Coverage and Reimbursement Lookup Tool on the website:

<https://medicaid.utah.gov>.

4-1.1 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 beneficiary in his or her residence, using professional judgments to independently solve beneficiary 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 beneficiary'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 beneficiary's condition and needs, counsels the beneficiary 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 beneficiary's overall condition, needs, adaptability of the beneficiary's place of residence to the provision of health care, capability of the beneficiary to participate in his or her own care, identify family support systems or persons willing to assume responsibility for care when the beneficiary 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 beneficiary'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 beneficiary's attending physician. The plan must be designed for the agency to adequately meet specific needs of the beneficiary in the beneficiary'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.

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

4-1.2 Speech-Language Services

Speech-language services are covered services under home health when the setting is the most appropriate and cost effective. Speech-language services are a benefit for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program beneficiaries 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 beneficiary'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 any therapy 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 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 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 beneficiary on a daily basis so that improvement can be maintained.
- Medical problems the beneficiary may have that support or justify continued service.
- Anticipated transition to outpatient service.
- If the beneficiary 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

4-1.3 Physical Therapy Services

Physical Therapy services are covered services through home health when the setting is the most appropriate and cost effective. 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 or physical therapy assistant employed directly by or on contract to a home health agency.

There must be an expectation that with treatment, the beneficiary'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.

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

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.

Before any 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
- Beneficiary 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 beneficiary 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 beneficiary on a daily basis so that improvement can be maintained.
- Medical problems the beneficiary may have that support or justify continued service
- Anticipated transition to outpatient service
- If the beneficiary 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

4-1.4 Occupational Therapy Services

Occupational Therapy services are covered services through home health when the setting is the most appropriate and cost effective. Occupational therapy is a benefit for EPSDT beneficiaries 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 or certified occupational therapy assistant employed directly by or on contract to a home health agency.

There must be an expectation that with treatment, the beneficiary'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.

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 beneficiary, through the rehabilitative process, to function at a maximum level.

Before any 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
- Beneficiary 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 beneficiary 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 beneficiary on a daily basis so that improvement can be maintained.
- Medical problems the beneficiary may have that support or justify continued service
- Anticipated transition to outpatient service
- If the beneficiary 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

4-1.5 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 beneficiary 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: <https://medicaid.utah.gov>.

4-1.6 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 health setting and the beneficiary'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 and other individuals, if medically indicated, who have well documented risk of infection, are excluded 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.

4-1.7 Supportive Maintenance Service

The supportive maintenance level of service includes skilled nursing and home health aides and is available to the beneficiary with nursing care needs that have stabilized to the point that there are few significant changes occurring in the plan of care. The beneficiary 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 beneficiary 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 beneficiaries 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.

- 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 beneficiary's condition improves, and the beneficiary 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.
- 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 beneficiary's home health record and will be subject to possible post-payment review by Medicaid.
- When two beneficiaries 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 beneficiaries.
- 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 beneficiary 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 beneficiary 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.

4-1.8 Capitated Home Health Service

A beneficiary 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 beneficiaries 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 beneficiary 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 beneficiary's needs without billing for each service or visit.

Criteria considered by Medicaid Prior Authorization staff include (post payment review):

- 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 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 beneficiary'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 beneficiary'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 beneficiary'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.

4-1.9 Private Duty Nursing (PDN)

Private duty nursing (PDN) service is an optional program for the purpose of preventing prolonged institutionalization of qualifying members. 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.

A. Eligibility, Coverage, and Limitations

Medicaid may cover PDN service if 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 PDN service is not provided. As an optional benefit, continuation of the PDN program is subject to legislative funding.

PDN services are for the medically necessary skilled nursing needs of the member.

- The member 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
 - Observation or monitoring for medical conditions not requiring skilled nursing

B. Requirements

- Request for service(s) is submitted through the Medicaid Prior Authorization Unit. Each case is reviewed by the Utilization Review Department or the Utilization Review Committee to confirm that medical eligibility criteria for PDN services are met.
- Medicaid covers PDN for eligible members who require 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.
- Medicaid may cover PDN for eligible members who require 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.
- Medicaid may cover PDN for eligible members who are 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.

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 (<https://medicaid.utah.gov>). From the top menu bar, select “Health Care Providers” → “Administrative Information” → “Forms” → “Provider Form Directory” → “PA (Prior Authorization) Request”.
- 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 on every 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.
 - The PDN Acuity Grid is included in the attachments section of this manual and on the Utah Medicaid website. From the top menu bar, select “Health Care Providers” → “Administrative Information” → “Forms” → “Provider Form Directory” → “Private Duty Nursing Acuity Grid.”
 - The PDN acuity grid 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 substantiate the medical documents submitted.

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.

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.

PDN Acuity Grid Score and PDN Hours

| Score | Hours of care per day of shift care (up to) |
|-------|---------------------------------------------|
| 21-35 | 8 |
| 36-45 | 10 |
| 46-51 | 12 |

| | |
|-------------|----|
| 56 and over | 14 |
|-------------|----|

If 20 points or less:

- And the member is being transitioned off 8 hours, then 832 units will be approved to the home health agency for the certification period.
- Otherwise, no PDN units 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 a member's tracheostomy is decannulated, up to 4 hours of daily nursing care may be approved during the first 24-72 hours after decannulation.

Guidelines for decrease in quantity of PDN services over time

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

- Active weaning is approved by and in coordination and consultation with the physician.
- The member's family, caregiver, or similar representatives are informed by the PDN provider that weaning is an expectation.
- 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.
-

Guidelines for increase in quantity of PDN services over time

Maximum or an increased number of hours may be authorized when acute exacerbations of the illness require a short term, temporary increase in skilled needs. 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 2-3 days to enable the care giver(s) to become trained 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.
- 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.

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.

Home health agencies (HHAs) may adjust or combine private duty nursing (PDN) hours within a 7-day period based on the needs of the family. Combining 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 patient 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.

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 beneficiaries 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.

4-1.10 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 caregiver'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 • 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 |

4-1.10 Telehealth Skilled Nurse Pilot Project for Beneficiaries in Rural Areas

Medicaid implemented a Telehealth home care project effective January 1, 2000. The project is an additional, complimentary method to provide beneficiary medical monitoring and education and to increase medical care compliance of home health care beneficiaries in rural areas. The project allows delivery of a percentage of home health care visits through Telehealth to beneficiaries who meet selection criteria. Criteria are: beneficiary 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 beneficiary 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

Beneficiaries diagnosed with diabetes are eligible for participation in Telehealth and 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 beneficiary is unable to use Telemedicine equipment, the beneficiary may be included in the pilot project if there is a full time care giver consistently available who wishes to assist the beneficiary with Telehealth.

If the condition of the beneficiary diagnosed with diabetes indicates to prior authorization staff that hands on assessment is probably not required, and/or the home health care nurse determines that the beneficiary does not meet severity of illness or have complicating conditions which might limit beneficiary 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 beneficiary 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 beneficiaries:

- 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 beneficiary initiated anxiety call to the home health agency. Spot checks related to beneficiary anxiety calls are not considered a home health care visit by Utah Medicaid.
- 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 beneficiaries 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 beneficiary training in Telehealth equipment use.
- The home health care nurse and the participating home health agency will address staff and beneficiary concerns about privacy and confidentiality.
- The state requires the beneficiary have a desire to participate in the home health care project. The home health agency must not discriminate against beneficiaries 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 Modifiers

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.

Additional Telemedicine Covered Services

Additional Telemedicine services are available; refer to Section I: General Information, Telemedicine, at the Utah Medicaid website at: <https://medicaid.utah.gov>.

5 Non-Covered Services and Limitations

5-1 Non-Covered Services

Refer to the Coverage and Reimbursement Lookup Tool on the Medicaid website at: <https://medicaid.utah.gov> for additional non-covered services.

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

- Home health care provided to a beneficiary capable of self-care.
- Home health care provided to a beneficiary 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.
- Supportive skilled nursing 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 agency.)
- Medical supplies, except where indicated.
- Palliative care for speech, occupational, and physical therapy.

5-2 Limitations

- 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 beneficiaries receiving periodic home health aide care are seen on a different date from the RN assessment. Only beneficiaries 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.
- An aide may visit only once per day, unless the service is for an extended level of service.
- 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 cannot be reimbursed.
- 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 client 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 prefills 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.
- Medical supplies furnished by the home health agency are limited to those used during the initial visit to establish the plan of care.
- Home health service must be cost effective. It must cost less over the long-term to provide the required care and service in the beneficiary's home than it would cost to meet the medical needs in a nursing facility or other institutional setting.

- Drawing antibiotic levels or other blood work must be coordinated by the physician. When the beneficiary 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 beneficiary 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.
- Wound Management: During the initial nursing assessment, instructions for simple dressing changes must be provided to the beneficiary and care giver. When the beneficiary 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.
- Medicaid reimburses 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.
- Discharge from the home health agency and readmission is only appropriate when the beneficiary 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.
- 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.
- Medicaid restricts hemophilia blood factors to a single provider; the University Hospital Home Infusion Services. The purpose of this restriction is to provide a uniform hemophilia case management support program to the beneficiary and beneficiary's physician and to achieve economies in the purchase of blood factor through a sole source contract. Only the sole source provider for hemophilia case management, blood factors VII, VIII and IX are reimbursed. No other provider will be paid for blood factors VII, VIII or IX supplied. Medicaid beneficiaries 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 beneficiary's physician is 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 beneficiary's Primary Care Provider physician or accountable care organization.
Direct questions concerning hemophilia case management and blood factors VII, VIII and IX to the University Hospital Home Infusion Services.
Accountable care organizations which contract with Medicaid are responsible for hemophilia-related services such as physical therapy, lab work, unrelated nursing care, and physician services.

6 Billing

Home health services may be billed either electronically or on paper, according to CMS standards. Refer to the provider manual, *Section I: General Information*, for additional billing instructions.

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 Beneficiaries Served | Use Modifier |
|--------------------------------|--------------|
| 2 | UN |
| 3 | UP |
| 4 | UQ |
| 5 | UR |
| 6 (or more) | US |

Calculation

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

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

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

$$11/4 = 2.75$$

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

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

$$\text{Beneficiary 3} = 3$$

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

6-1 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 beneficiary 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 Medicaid website, Coverage and Reimbursement Lookup Tool at: <https://medicaid.utah.gov>.

To request 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 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 beneficiary 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 beneficiary 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.
- Home health is not a covered service in a skilled nursing facility. The location of the beneficiary 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.

The process to obtain prior authorization is described below:

1. When the nursing assessment indicates a Medicaid recipient 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. The Request for Prior Authorization form is found at the Medicaid website: <https://medicaid.utah.gov>. The fax number for the home health program is on the third page of the Prior Authorization Request Form.

Note: Because of the volume for home health and private duty nursing requests, all requests for prior authorization must be faxed or mailed. Requests for authorizations cannot be approved by telephone. 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.

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.

2. Medicaid will review the prior authorization request and 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.

Mail written requests to:
Medicaid Prior Authorization
BOX 143111
Salt Lake City, UT 84114-3111

7 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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