



Florida Medicaid

Home Health Services Coverage and Limitations Handbook

Agency for Health Care Administration





CHARLIE CRIST
GOVERNOR

Better Health Care for all Floridians

HOLLY BENSON
SECRETARY

December 22, 2008

Dear Medicaid Provider:

Florida Medicaid has issued the revised Florida Medicaid Home Health Services Coverage and Limitations Handbook, July 2008. The revised handbook is available on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-Florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks. If you are unable to access the Internet, you may request a paper copy by calling the Provider Contact Center at 800-289-7799 and selecting Option 7.

The handbook was revised to allow independent providers to enroll to provide personal care services and to allow the provision of private duty nursing services to an eligible child by a parent or legal guardian who has a valid license as a RN or LPN in the State of Florida and who is employed by a Medicaid enrolled home health agency. It also contains updated contact information for the new Medicaid fiscal agent.

Please contact your local Medicaid area office if you have any questions. The Medicaid area offices' phone numbers and addresses are available on the Agency's website at <http://ahca.myflorida.com>. Click on Medicaid, and then on Area Offices. They are also listed in Appendix C of the Florida Medicaid Provider General Handbook. All the Medicaid handbooks are available on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-Florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

We appreciate the services that you provide to Florida's Medicaid recipients.

Sincerely,

Beth Kidder
Chief, Bureau of Medicaid Services



UPDATE LOG

HOME HEALTH SERVICES

COVERAGE AND LIMITATIONS HANDBOOK

How to Use the Update Log

Introduction

The current Medicaid provider handbooks are posted on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks. Changes to a handbook are issued as handbook updates. An update can be a change, addition, or correction to policy. An update may be issued as either replacement pages in an existing handbook or a completely revised handbook.

It is very important that the provider read the updated material. It is the provider's responsibility to follow correct policy to obtain Medicaid reimbursement.

Explanation of the Update Log

Providers can use the update log to determine if they have received all the updates to the handbook.

Update No. is the month and year that the update was issued.

Effective Date is the date that the update is effective.

Instructions

When a handbook is updated, the provider will be notified by a postcard or notice. The notification instructs the provider to obtain the updated handbook from the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

Providers who are unable to obtain an updated handbook from the Web Portal may request a paper copy from the Medicaid fiscal agent's Provider Support Contact Center at 800-289-7799.

| UPDATE NO. | EFFECTIVE DATE |
|----------------------------|----------------|
| Mar2000—Revised Handbook | March 2000 |
| Oct2003—Revised Handbook | October 2003 |
| Jul2007—Revised Handbook | July 2007 |
| July 2008—Revised Handbook | July 2008 |
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HOME HEALTH SERVICES COVERAGE AND LIMITATIONS HANDBOOK

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INTRODUCTION TO THE HANDBOOK

Overview

Introduction

This chapter introduces the format used for the Florida Medicaid handbooks and tells the reader how to use the handbooks.

Background

There are three types of Florida Medicaid handbooks:

- Provider General Handbook describes the Florida Medicaid Program.
- Coverage and Limitations Handbooks explain covered services, their limits, and who is eligible to receive them.
- Reimbursement Handbooks describe how to complete and file claims for reimbursement from Medicaid.

Exception: For Prescribed Drugs, the coverage and limitations handbook and the reimbursement handbook are combined into one.

Legal Authority

The following federal and state laws govern Florida Medicaid:

- Title XIX of the Social Security Act,
- Title 42 of the Code of Federal Regulations,
- Chapter 409, Florida Statutes, and
- Chapter 59G, Florida Administrative Code.

The specific Federal Regulations, Florida Statutes, and the Florida Administrative Code, for each Medicaid service are cited for reference in each specific coverage and limitations handbook.

In This Chapter

This chapter contains:

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Handbook Use and Format

| | |
|--|--|
| Purpose | <p>The purpose of the Medicaid handbooks is to furnish the Medicaid provider with the policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients.</p> <p>The handbooks provide descriptions and instructions on how and when to complete forms, letters or other documentation.</p> |
| Provider | <p>The term "provider" is used to describe any entity, facility, person or group who is enrolled in the Medicaid program and renders services to Medicaid recipients and bills Medicaid for services.</p> |
| Recipient | <p>The term "recipient" is used to describe an individual who is eligible for Medicaid.</p> |
| General Handbook | <p>General information for providers regarding the Florida Medicaid Program, recipient eligibility, provider enrollment, fraud and abuse policy, and important resources are included in the Florida Medicaid Provider General Handbook. This general handbook is distributed to all enrolled Medicaid providers and is updated as needed.</p> |
| Coverage and Limitations Handbook | <p>Each coverage and limitations handbook is named for the service it describes. A provider who furnishes more than one type of service will have more than one coverage and limitations handbook.</p> |
| Reimbursement Handbook | <p>Each reimbursement handbook is named for the claim form that it describes.</p> |
| Chapter Numbers | <p>The chapter number appears as the first digit before the page number at the bottom of each page.</p> |
| Page Numbers | <p>Pages are numbered consecutively throughout the handbook. Page numbers follow the chapter number at the bottom of each page.</p> |
| White Space | <p>The "white space" found throughout a handbook enhances readability and allows space for writing notes.</p> |

Characteristics of the Handbook

Format

The format styles used in the handbooks represent a concise and consistent way of displaying complex, technical material.

Information Block

Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of the subject. Blocks are separated by horizontal lines.

Each block is identified or named with a label.

Label

Labels or names are located in the left margin of each information block. They identify the content of the block in order to facilitate scanning and locating information quickly.

Note

Note is used most frequently to refer the user to pertinent material located elsewhere in the handbook.

Note also refers the user to other documents or policies contained in other handbooks.

Topic Roster

Each chapter contains a topic roster on the first page, which serves as a table of contents for the chapter, listing the subjects and the page number where the subject can be found.

Handbook Updates

Update Log

The first page of each handbook will contain the update log.

Every update will contain a new updated log page with the most recent update information added to the log. The provider can use the update log to determine if all updates to the current handbook have been received.

Each update will be designated by an "Update No." and the "Effective Date".

Handbook Updates, continued

| | |
|--|--|
| How Changes Are Updated | <p>The Medicaid handbooks will be updated as needed. Changes may consist of any one of the following:</p> <ol style="list-style-type: none">1. Pen and ink updates—Brief changes will be sent as pen and ink updates. The changes will be incorporated on replacement pages the next time replacement pages are produced.2. Replacement pages—Lengthy changes or multiple changes that occur at the same time will be sent on replacement pages. Replacement pages will contain an effective date that corresponds to the effective date of the update.3. Revised handbook—Major changes will result in the entire handbook being replaced with a new effective date throughout. |
| <hr/> | |
| Numbering Update Pages | <p>Replacement pages will have the same number as the page they are replacing. If additional pages are required, the new pages will carry the same number as the preceding replacement page with a numeric character in ascending order. (For example: page 1-3 may be followed by page 1-3.1 to avoid reprinting the entire chapter.)</p> |
| <hr/> | |
| Effective Date of New Material | <p>The month and year that the new material is effective will appear in the inner corner of each page. The provider can check this date to ensure that the material being used is the most current and up to date.</p> <p>If an information block has an effective date that is different from the effective date on the bottom of the page, the effective date will be included in the label.</p> |
| <hr/> | |
| Identifying New Information | <p>New material will be indicated by vertical lines. The following information blocks give examples of how new labels, new information blocks, and new or changed material within an information block will be indicated.</p> |
| <hr/> | |
| New Label | <p>A new label for an existing information block will be indicated by a vertical line to the left and right of the label only.</p> |
| <hr/> | |
| New Label and New Information Block | <p>A new label and a new information block will be identified by a vertical line to the left of the label and to the right of the information block.</p> |
| <hr/> | |
| New Material in an Existing Information Block | <p>New or changed material within an existing information block will be indicated by a vertical line to the left and right of the information block.</p> |
| <hr/> | |
| New or Changed Paragraph | <p>A paragraph within an information block that has new or changed material will be indicated by a vertical line to the left and right of the paragraph.</p> <p> Paragraph with new material. </p> |
| <hr/> | |

CHAPTER 1

HOME HEALTH SERVICES

PROVIDER QUALIFICATIONS AND REQUIREMENTS

Overview

Introduction

This chapter describes the Medicaid Home Health Services Program, defines the specific authority regulating home health services, defines provider qualifications, and specifies the purpose of the program and who may provide home health services.

Legal Authority

Home health services are governed by Title 42, Code of Federal Regulations (C.F.R.), Part 440.70.

The Florida Medicaid Home Health Services Program is authorized by Chapter 409, Florida Statutes (F.S.) and Chapter 59G, Florida Administrative Code (F.A.C.).

In This Chapter

This chapter contains:

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Purpose and Definitions

Medicaid Provider Handbooks

This handbook is intended for use by home health services providers that furnish services to Medicaid recipients. It must be used in conjunction with the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which contains specific procedures for submitting claims for payment, and the Florida Medicaid Provider General Handbook, which contains general information about the Medicaid program.

Note: The Florida Medicaid provider handbooks are available on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks. The Florida Medicaid Provider General Handbook is incorporated by reference in 59G-5.020, F.A.C.; and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, is incorporated by reference in 59G-4.001, F.A.C.

Purpose of the Home Health Program

The purpose of the home health program is to provide medically-necessary care to an eligible Medicaid recipient whose medical condition, illness or injury requires the care to be delivered in the recipient's place of residence.

Note: See the Glossary in the Florida Medicaid Provider General Handbook for the definition of medically necessary.

Home Health Services Definition

Home health services are medically necessary services, which can be effectively and efficiently provided in the place of residence of a recipient. Services include home health visits (nurse and home health aide), private duty nursing and personal care services for children, therapy services, medical supplies, and durable medical equipment.

Home Health Visit Definition

A home health visit is a face-to-face contact between a registered nurse, licensed practical nurse, or home health aide and a recipient at his place of residence.

A home health visit is not limited to a specific length of time, but is defined as an entry into the recipient's place of residence, for the length of time needed, to provide the medically-necessary nursing or home health aide service(s).

Medicaid reimbursement for a home health visit does not include travel time to or from the recipient's place of residence. Such expenses are administrative and not reimbursable by Medicaid.

Purpose and Definitions, continued

Place of Residence Definition

Place of residence is the location where a Medicaid recipient lives and may include:

- Recipient's private home;
- Assisted Living Facility (ALF);
- Developmental services group home;
- Foster or medical foster care home; or
- Any home where unrelated individuals reside together in a group.

Note: See the topics on the specific services in Chapter 2 for information on place of residence exclusions for a specific service, i.e., Private Duty Nursing.

Attending Physician Definition

The attending physician is the doctor in charge of the recipient's medical condition that causes the recipient to need home health services.

Support Coordinator or Case Manager

A support coordinator or case manager is an enrolled Home and Community-Based Services Waiver provider who is selected by the recipient enrolled in the waiver (or his guardian or guardian advocate) to assist the recipient who receives waiver services in gaining access to needed waiver and Medicaid state plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Waiver support coordinators or case managers are responsible for ongoing monitoring of supports and services to ensure they are provided to meet the recipients' needs. They also initiate and oversee the process of assessment and reassessment of the recipients' level of care and the review of support plans.

Independent Personal Care Provider

An independent personal care provider renders personal care services directly to recipients and does not employ others for the provision of personal care services.

Independent Personal Care Group Provider

An independent personal care group provider is an unlicensed group (agency) enrolled to provide personal care services that has one or more staff employed to perform the services. All employees of the unlicensed group provider must meet the qualifications and requirements specified for the provision of personal care services and be enrolled in the Medicaid program as an individual personal care provider.

Purpose and Definitions, continued

Geographic Service Area

Geographic service area is an area, as specified by county(ies) on the license, in which the home health agency may send its personnel to provide home health services to recipients in their places of residence.

A geographic service area cannot encompass more than one AHCA-designated geographic area of the state.

Parent Office

A parent office is a home health agency responsible for the services furnished to recipients and for implementation of the plan of care. Additionally, it is responsible for the development and administrative control of subunits and branch offices. A parent office must meet the Medicare Conditions of Participation.

Branch Office

A branch office is a separately licensed location or site from which a parent home health agency provides services within a portion of its total geographic service area. A branch office is located sufficiently close to share administration, supervision and services with the parent office. It is not required to independently meet the Medicare Conditions of Participation.

Offices of a corporate home health agency located in different geographic service areas are required to enroll in Medicaid as parent offices.

Subunit

A subunit is a separately licensed, semi-autonomous organization that serves recipients in a portion of the geographic service area different from that of the parent office. A subunit must independently meet the Medicare Conditions of Participation because it is too far from the parent office to share administration, supervision, and services on a daily basis. A subunit may meet specified standards of the Medicare Conditions of Participation through its parent office.

Provider Qualifications

**Home Health
Agency Provider
Qualifications**

To enroll as a Medicaid provider, a home health agency must be licensed in accordance with Chapter 400, Part III, F.S. and Chapter 59A-8, F.A.C., or applicable laws of the state in which the services are furnished.

The home health agency must:

- Meet the Medicare Conditions of Participation as determined through a survey conducted by the Agency for Health Care Administration (AHCA), Division of Health Quality Assurance (HQA); or
- Be accredited and deemed by the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) or the Community Health Accreditation Program (CHAP) as meeting the Medicare Conditions of Participation.

Home health agencies receiving accreditation and deemed status by JCAHO or CHAP are responsible for providing accreditation documentation to HQA.

Independent personal care providers are exempt from this requirement for the provision of personal care services.

**Independent
Personal Care
Provider
Qualifications**

Medicaid reimburses independent personal care providers under their Medicaid home health provider number, for the provision of personal care services.

To enroll in the Medicaid program, independent personal care providers must:

- Be at least 18 years of age;
- Be trained in the areas of cardiopulmonary resuscitation (CPR), HIV/AIDS, and infection control;
- Have at least one year of experience working in a medical, psychiatric, nursing or child care setting or working with recipients who have a developmental disability. College, vocational or technical training in medical, psychiatric, nursing, child care, or developmental disabilities equal to 30 semester hours, 45 quarter hours, or 720 classroom hours may be substituted for the required experience.

Independent personal care providers are responsible for meeting the experience and training requirements and must maintain on file documented proof of annual or required updated training. The documentation must verify the provider's and its employees' participation in the required training session, the date and location of the training, the name and signature of the trainer, and the name and signature of person(s) in attendance.

Provider Qualifications, continued

Therapy Services

Medicaid reimburses home health agencies, under their Medicaid home health provider number, for the following therapies:

- Occupational therapy;
- Physical therapy; and
- Speech-language pathology services.

To qualify to provide these therapies, the home health agency must list each therapy service on its application for licensure and certification. HQA determines if the agency meets licensure requirements for the provision of the therapy service(s).

Note: See Chapter 2 of this handbook for service coverage and limitations.

Note: See the Florida Medicaid Therapy Services Coverage and Limitations Handbook for additional information. The handbook is available on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com> . Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

Licensed to Cover County

The parent office must be licensed to cover the county in which the branch office is located in order to receive Medicaid reimbursement for the home health services provided through the branch office.

Complaint Surveys

Complaints of alleged violations of regulations are investigated by HQA.

Provider Enrollment

General Enrollment Requirement

Home health providers must meet the general Medicaid provider enrollment requirements that are contained in the Florida Medicaid Provider General Handbook. In addition, home health providers must meet the specific enrollment requirements that are listed in this section.

Independent Personal Care Provider Enrollment

Independent personal care providers must meet the general Medicaid provider enrollment requirements that are contained in Chapter 2 of the Florida Medicaid Provider General Handbook. In addition, independent personal care providers must follow the specific enrollment requirements that are listed in this section. Proof of training is required upon enrollment as a personal care provider.

Independent Personal Care Group Provider Enrollment

An unlicensed independent agency or group provider enrolled in the Medicaid program to provide personal care services that employs one or more persons for the actual provision of services must enroll as a personal care provider group. In order to receive payment from Medicaid, each member of the group must enroll in Medicaid as an individual personal care services treating provider within the group for which he performs services. It is the responsibility of the individual treating provider to notify the Medicaid fiscal agent of all group practices with which he is affiliated. Any individual treating provider who is terminating his relationship with a group must notify the Medicaid fiscal agent in writing of this termination in order to update his provider file.

Branch Offices and Subunits

Home health agencies are required to submit a Declaration of Service Address, AHCA Form 2200-0004, for its branch offices and subunits.

Note: The Declaration of Service Address, AHCA Form 2200-0004, can be obtained from the Medicaid fiscal agent by calling 800-289-7799 and selecting Option 4 or the fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Enrollment. The form is incorporated by reference in 59G-5.020, F.A.C.

Closure of a Branch Office or Subunit

A home health agency must report any closure of a practice location and the effective date of the closure to the Medicaid fiscal agent and HQA in writing on office letterhead stationery. The letter must be sent 60 days prior to the closure.

Drop Off Site

Medicaid does not enroll drop-off sites since they are not considered to be places of service.

Provider Enrollment, continued

Surety Bond Requirements

A surety bond is required for home health agencies if there have been (within the past 5 years) or currently are sanctions or terminations (voluntary or involuntary) involved. This requirement is applicable to future terminations or sanctions of a home health agency.

Note: See Chapter 2 in the Florida Medicaid Provider General Handbook for the surety bond requirements and exemptions.

Who May Provide Home Health Services

Qualified Home Health Agency Staff

Home health services are provided by qualified health care professionals who are directly employed by or under contract with a home health agency that is enrolled in the Medicaid Home Health Services Program.

Employed or contracted means that the home health agency provides a W2 or 1099 tax form for the individual.

The home health agency must ensure that all staff (employed or contracted) who provide home health services are qualified and licensed.

Subcontracting

A Medicaid home health services provider cannot subcontract with a non-Medicaid home health services provider for the provision or billing of Medicaid services.

Multiple Home Health Services Providers

In situations which require services from more than one home health services provider in order to provide all the care required by a recipient, Medicaid applies the following criteria for reimbursement:

- Medicaid will not reimburse duplicative nursing or home health aide services;
- Each home health services provider is responsible for coordinating its plan of care with other involved home health services providers;
- Each home health services provider is responsible for noting on its plan of care the services being provided by another home health services provider;
- Each home health services provider is accountable for the provided services and billing pursuant to its plan of care; and
- When requesting precertification or prior authorization, each home health services provider is responsible for informing the Medicaid Peer Review Organization of other home health services providers also providing services to the recipient.

A home health services provider furnishing home health services without documented knowledge of other home health services providers furnishing services to its recipient is at risk for recoupment of reimbursement.

Who May Provide Home Health Services, continued

Nurse Qualifications

Home health nursing services must be provided by a nurse licensed pursuant to Chapter 464, F.S., or applicable laws of the state in which the services are provided.

Home Health Aide Qualifications

A home health aide must have successfully completed a training program that meets minimum standards for aide training as defined in 42 C.F.R. §484.36(a)(1) and Chapter 400, F.S.

Personal Care Services

Personal care services may be provided by:

- Home health agencies, licensed in accordance with Chapter 400, part III, F.S., or
- Independent personal care providers who meet the experience and training requirements as described in this section and who are enrolled as home health providers with a specialty code of DC.

Skill Level of Staff

The home health services provider must provide staff with the skill level designated or appropriate for each service prescribed in the physician order and approved plan of care.

Staff Substitutions

Whenever staff absences occur, the home health services provider is responsible for providing and assuring that appropriate staff substitutions are made.

Staff discipline must be equivalent to or above the discipline level as specified in the plan of care. Under no circumstances can staff of a lower discipline be substituted for staff of a higher discipline level than ordered.

If a nurse is substituted for a home health aide, Medicaid will only reimburse at the home health aide rate.

Multiple Counties

A parent agency may employ staff located in other counties listed on its license to serve the recipients in those counties (a facility cannot be set up in these counties) as long as they meet the qualifications for home health staff. All recipient records and documentation must be housed and maintained at the parent office, including all required home health record documentation, daily progress notes, plans of care, etc. This documentation must be original and must be signed and dated by the individual provider of service on the day the services were rendered. Medicaid does not pay for travel to and from the parent office to transmit this documentation.

Provider Responsibilities

Health Insurance Portability and Accountability Act (HIPAA)

Florida Medicaid has implemented all of the requirements contained in the federal legislation known as the Health Insurance Portability and Accountability Act (HIPAA). As trading partners with Florida Medicaid, all Medicaid providers, including their staff, contracted staff and volunteers, must comply with HIPAA privacy requirements. Providers who meet the definition of a covered entity according to HIPAA must comply with HIPAA Electronic Data Interchange (EDI) requirements. This Coverage and Limitations Handbook contains information regarding changes in procedure codes mandated by HIPAA. The Medicaid Provider Reimbursement Handbooks contain the claims processing requirements for Florida Medicaid, including the changes necessary to comply with HIPAA.

Note: For more information regarding HIPAA privacy in Florida Medicaid see Chapter 2 in the Florida Medicaid Provider General Handbook.

Note: For more information regarding claims processing changes in Florida Medicaid because of HIPAA, see the Florida Medicaid Provider Reimbursement Handbook, CMS-1500.

Note: For more information regarding changes in EDI requirements for Florida Medicaid because of HIPAA, contact the fiscal agent EDI help desk at 866-586-0961 or 800-289-7799, select Option 3.

Record Keeping Requirements

In addition to the specific documentation that is required for the covered services listed in Chapter 2 of this handbook, home health providers must follow the record keeping requirements listed in Chapter 2 of the Florida Medicaid Provider General Handbook.

Chart Forms

The home health services provider must ensure that all staff (employed or contracted) utilize the home health services provider's chart forms for documentation of home health services.

Accountability

The home health services provider is accountable for:

- Services provided by staff (employed or contracted); and
 - Billing of the provided services.
-

CHAPTER 2

HOME HEALTH SERVICES

COVERED SERVICES, LIMITATIONS AND EXCLUSIONS

Overview

Introduction

This chapter describes the services covered under the Florida Medicaid Home Health Services Program. It also describes the requirements to receive services, service limitations and exclusions.

In This Chapter

This chapter contains:

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Requirements to Receive Services

Introduction

Medicaid reimburses home health services provided to an eligible Medicaid recipient when it is medically necessary to provide those services in his place of residence.

Home health services are not considered emergency services.

Requirements to Receive Services, continued

Medically Necessary

Medicaid reimburses services that do not duplicate another provider's service and are medically necessary for the treatment of a specific documented medical disorder, disease or impairment.

Chapter 59G-1.010 (166), Florida Administrative Code defines medically necessary as follows:

"Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:

- (a) Meet the following conditions:
1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
- (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

Home Health Service Requirements

In order to be reimbursed, home health services must also be:

- Ordered by and remain under the direction of the attending physician (a doctor of podiatric medicine may only authorize plan of care services that are consistent with the functions he is authorized to perform under state law) licensed under Chapter 461, 458 or 459 F.S. or licensed in the state in which the attending physician practices.
- An exception to the above requirement is a plan of care for personal care services, which may be written by independent providers and approved by the recipient's home and community-based waiver services support coordinator, case manager, or physician.
- Consistent with the individualized, written and approved plan of care.
- Provided by qualified staff; and
- Consistent with accepted standards of medical and nursing practice.

Requirements to Receive Services, continued

Who Can Receive In-Home Services

Medicaid reimburses home health services for Medicaid recipients who are under the care of an attending physician.

The recipient must meet the following requirements:

- Require services that, due to a medical condition, illness or injury, must be delivered at the place of residence rather than an office, clinic or other outpatient facility because:
 - Leaving home is medically contraindicated and would increase the medical risk for exacerbation or deterioration of the condition; or
 - The recipient is unable to leave home without the assistance of another person;
- Require services that are medically necessary and reasonable for the treatment of the documented illness, injury or condition;
- Require services that can be safely, effectively and efficiently provided in the home; and
- Live in a residence other than a hospital, nursing facility or intermediate care facility for the developmentally disabled (ICF/DD). (See exceptions for ICF/DDs in 42 CFR 483, Subpart I.)

Medicaid does not reimburse home health services solely due to age, environment, convenience or lack of transportation.

Requirements to Receive Services, continued

Physician Treatment Orders

A physician's order (written or verbal) from the attending physician is required to initiate or continue home health services.

At a minimum, the order must describe the:

- Recipient's acute or chronic medical condition or diagnosis that causes a recipient to need home health care;
- Documentation regarding the medical necessity for the service(s) to be provided at home;
- Home health services needed;
- Frequency and duration of the needed services; and
- Minimum skill level (nurse, home health aide) of staff who can provide the services.

The physician's order may be incorporated into the plan of care or included with the plan of care as a separate document.

Physician orders to initiate or continue home health services must be signed and dated by the attending physician before submitting a request for precertification or prior authorization.

If the home health service does not require precertification or prior authorization, physician orders to initiate or continue home health services must be signed and dated by the attending physician before a claim for payment is submitted.

Verbal orders must be put in writing and countersigned by the attending physician or validated by physician fax order before requesting precertification or prior authorization or submitting a claim for payment.

Medicaid will reimburse home health services ordered by an ARNP or physician assistant only if the order has been countersigned by the attending physician.

Dually-eligible Medicare and Medicaid Recipients

Medicaid cannot reimburse a home health agency for services that can be reimbursed by Medicare when a recipient is eligible for both Medicare and Medicaid services.

The home health agency is responsible for retaining documentation in the recipient's record that the service is not Medicare reimbursable.

Note: See Chapter 4 in the Florida Medicaid Provider General Handbook for information on Medicare crossover claims.

Requirements to Receive Services, continued

**MediPass
Recipients**

When a MediPass recipient is referred for home health visit (RN, LPN, home health aide) services, the home health agency must obtain authorization from the MediPass primary care provider.

The MediPass authorization number must be entered on the claim when billing the service.

Note: See Chapter 1 in the Florida Medicaid Provider Reimbursement Handbook, CMS 1500, for instructions on entering the MediPass authorization number on the claim.

**Children’s Medical
Services (CMS)
Network Recipients**

When a CMS Network recipient is referred for home health visit (RN, LPN, home health aide) services, the home health agency must obtain authorization from the CMS Network primary care provider (PCP).

The CMS Network PCP authorization number must be entered on the claim when billing the service.

**Provider Service
Network Recipients**

Home health visit services provided to a recipient enrolled in a Provider Service Network (PSN) are authorized and claims are processed through the PSN only. Home health agencies may contact the PSN’s Provider Relations Unit for assistance as needed.

Home health claims for a PSN recipient that are submitted directly to the Medicaid fiscal agent will be denied.

**Medicaid Health
Maintenance
Organization
(HMO) Recipients**

Home health visit services provided to a recipient enrolled in a Medicaid HMO are authorized and reimbursed through the HMO only.

Home health claims for a HMO recipient submitted directly to the Medicaid fiscal agent will be denied.

Plan of Care Requirements

Description

A plan of care (POC) is an individualized written program for a recipient that is developed by health care professionals including the attending physician. The POC is designed to meet the medical, health and rehabilitative needs of the recipient. The POC must identify the medical need for home health care, appropriate nursing interventions, and expected health outcomes.

The home health agency must provide a copy of the initial and subsequent plans of care to the attending physician for the medical record.

Required Plan of Care Document

The Centers for Medicare and Medicaid Services (CMS) Form-485, (C-3)(02-94) Home Health Certification and Plan of Care, must be used for the plan of care. CMS is the federal agency formerly known as the Health Care Financing Administration (HCFA), and is transitioning form names to reflect the new name of the agency. Forms that contain the name "HCFA" will still be accepted.

Note: See Appendix B for a copy of the CMS-485 and instructions. The form is incorporated by reference in 59G-4.130, F.A.C. It is available by photocopying the form in Appendix B.

Plan of Care Components

The POC must include:

- Diagnosis(es), mental status, prognosis, rehabilitation potential, functional limitations, permitted activities, nutritional requirements, medications and treatments.
- Physician orders.
- An explanation of the medical necessity of home health services.
- Nursing services, home health aide services or therapy to be provided.
- Medical supplies, appliances or durable medical equipment to be provided.
- Start date, end date and frequency of in-home services, including the level of staff necessary to perform the services required.
- Safety measures to protect against injury.
- Discharge plan.
- Approval by the attending physician as evidenced by his signature (if a rubber stamp signature is used, it must be initialed by the physician). Personal care services may be approved by the home and community-based services waiver support coordinator, case manager, or physician, if provided by an independent personal care services provider.
- Expected health outcomes.

The physician, support coordinator, or case manager (for personal care services only) may approve a POC by faxing a signed copy to the provider; however, the physician, support coordinator, or case manager must retain the plan with the original signature in the recipient's medical record.

Plan of Care Requirements, continued

Plan of Care Certification Period

The “FROM” and “TO” dates identify the period covered by the POC.

- The FROM date is the first day of the POC.
- The TO date is the last day of the POC.
- The TO date can include up to, but never exceed, 60 days. Personal care services may be approved for up to six months if provided by an independent personal care services provider.
- On subsequent recertifications, the next sequential FROM date will be the day after the TO date on the previous POC.

Example of Valid Dates for Plan of Care Certification Period

A physician’s order specifies skilled nursing care twice per day from July 1, 2007 to August 29, 2007. The initial POC covers the period July 1, 2007 (“From” date) through August 29, 2007 (“To” date).

- The POC begins on July 1, 2007 and is effective through August 29, 2007;
- A new POC is necessary to continue skilled nursing care on August 30, 2007; and
- August 30, 2007 is day one and the “From” date on the subsequent POC.

General Plan of Care Review Requirements

All plans of care must contain current information concerning the recipient. Photocopies of previous plans of care are not acceptable and will result in denials of precertification and prior authorization requests.

Subsequent plans of care must include an assessment of all changes in the recipient’s medical conditions including activities of daily living (ADL) since the previous certification period. All applicable POC components must be included in each subsequent POC.

Note: See Precertification and Prior Authorization in this chapter for the submission requirements for the precertification and prior authorization processes.

Note: See Medical Record Requirements under Required Documentation in this chapter for additional information.

Plan of Care Requirements, continued

| | |
|---|---|
| <p>Additional Plan of Care Review Requirements for Licensed Home Health Agencies</p> | <p>For licensed home health agencies, the attending physician must review the POC at least every 60 days. The attending physician is required to indicate his approval by signing each POC. The attending physician must countersign an ARNP or physician assistant signature on a POC.</p> <p>If home health services require precertification or prior authorization, the POC must be reviewed and signed by the attending physician before submitting the precertification or prior authorization request. Payments of home health claims submitted without proper authorization are subject to recoupment.</p> <p>If home health services do not require precertification or prior authorization, the POC must be reviewed and signed by the attending physician before a claim for payment is submitted. Payments of home health claims submitted prior to the physician signing the POC are subject to recoupment.</p> <p>Each POC must incorporate or include as a separate document the physician order for home health services.</p> |
| <p>Additional Plan of Care Review Requirements for Independent Personal Care Providers</p> | <p>For personal care services, the physician, support coordinator, or case manager must review the POC at least every six months. The attending physician, support coordinator, or case manager is required to indicate approval by signing each POC.</p> <p>The POC must be reviewed and signed by the attending physician, waiver support coordinator, or case manager before submitting the prior authorization request. Payments of home health claims submitted without proper authorization are subject to recoupment.</p> |
| <p>Recipient's Copy of the Plan of Care</p> | <p>The home health services provider must provide a copy of the initial and subsequent plans of care to the recipient or legal guardian if requested.</p> |
| <p>Patient Condition Summaries</p> | <p>Home health agencies must provide the attending physician a summary of the recipient's condition at least every 60 days. This summary must include all necessary information to support the justification for:</p> <ul style="list-style-type: none"> • Continuation of the home health services; or • Termination of the home health services. |

Plan of Care Requirements, continued

Compliance Review

The Agency for Health Care Administration will periodically conduct on-site or desk reviews of home health services providers for the purpose of determining compliance with POC requirements.

Services

Medicaid does not reimburse open-ended orders. (Examples: Skilled nursing visits 1 x month and PRN x 2 months for Foley catheter change, or private duty nursing up to 24 hours a day up to 7 days a week.)

Medicaid may reimburse orders that reflect a limited range of visits or minimum and maximum number of hours to be provided. In order to be reimbursed the order must include the following:

- Description of the recipient's medical signs and symptoms that require services;
- Specific limit on the number of those visits to be made under that order; and
- Minimum and maximum number of hours per day

(Examples: Skilled nursing visits 1 x month for 2 months for Foley catheter change and PRN x 2 visits for Foley catheter obstruction or 4 hours a day, 2 days a week.)

If more services are needed, an additional physician order must be obtained and an addendum reflecting the service(s) must be added to the current POC.

Covered, Limited and Excluded Services

Covered Services For Adults

Medicaid reimburses the following services provided to eligible recipients age 21 years or older:

- Licensed nurse and home health aide visits;
- Limited durable medical equipment and supplies; and
- Limited therapy evaluations.

Covered, Limited and Excluded Services, continued

**Covered Services
For Children**

Medicaid reimburses for the following services provided to eligible recipients under age 21 years:

- Licensed nurse and home health aide visits;
 - Private duty nursing;
 - Personal care;
 - Occupational, physical and speech-language pathology evaluations and treatments; and
 - Durable medical equipment and supplies.
-

Exclusions

Medicaid does not reimburse for the following services under the home health services program:

- Audiology services;
- Housekeeping, homemaker, and chore services, including shopping;
- Meals-on-wheels;
- Mental health and psychiatric services (these services are covered under the Medicaid Community Behavioral Health Program);
- Normal newborn and postpartum services, except in the event of complications;
- Respite care;
- Services which can be effectively and efficiently obtained outside the recipient's place of residence without any medical contraindications;
- Baby-sitting;
- Services to a recipient residing in a community residential facility when those services duplicate services the facility or institution is required to provide;
- Social services;
- Transportation services;
- Escort services;
- Home health visits or personal care services furnished by household members. Household members are defined to be: parents, stepparents, spouse, siblings, sons, daughters, or any person with custodial or legal responsibility for a Medicaid recipient;
- Respiratory therapy. (See the Florida Medicaid Therapy Services Coverage and Limitations Handbook for respiratory therapy provider enrollment requirements.)

Covered, Limited and Excluded Services, continued

Exclusions,
continued

- Nursing assessments related to the plan of care.
- Attending physicians, support coordinators, or case managers for certifying the home health plan of care. (See the Florida Medicaid Physician Services Coverage and Limitations Handbook for information on reimbursement of evaluation and management services.)
- Services to a recipient enrolled in hospice when the services are related to the treatment of the terminal illness or associated condition.

Note: The Florida Medicaid provider handbooks are available on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

**Out-of-State
Services**

Medicaid reimburses out-of-state home health services that are prior authorized.

Whenever a Florida Medicaid recipient receives an out-of-state prior authorized Medicaid service, that recipient may be eligible to receive medically-necessary home health services out-of-state.

The following requirements must be met in order for a recipient to qualify for out-of-state home health services:

- The recipient must meet all in-state home health program requirements;
- Out-of-state home health services must be prior authorized by the Florida Medicaid Transplant Coordinator or Medicaid RN Consultant for out-of-state services;
- The home health agency must be a Medicaid or Medicare provider in the relevant state; and
- The home health agency must enroll as a Florida Medicaid provider.

Out-of-state home health services must be coordinated through the authorized hospital, which must provide an anticipated plan of outpatient care that is signed and dated by the recipient's attending physician.

Covered, Limited and Excluded Services, continued

Infusion Therapy Services

An infusion therapy service includes set-up, infusion, and take down time. It also includes recipient assessment time at the beginning and end of the procedure.

For adults, each single episode of infusion therapy service is reimbursed as a skilled nursing visit regardless of the length of time required for the infusion service.

For children (birth through 20 years of age), an infusion therapy service is reimbursed as:

- A skilled nursing visit if the length of time required for the service is less than two hours; or
- A private duty nursing service if the length of time required for the service is two hours or more.

Drugs for infusion therapy services and formulae or solutions for nutrition-infusion services are reimbursed through the Medicaid Durable Medical Equipment and Medical Supply Services Program and the Medicaid Prescribed Drug Program.

Assisted Living Facility (ALF) Services

Medicaid does not reimburse services that duplicate those an ALF provides to a resident in its contract and service plan with the resident.

Home health agencies are responsible to determine that the provided home health service is not included in the ALF resident contract and service plan.

Medicaid does not reimburse home health visit services provided to recipients living in an ALF when the following apply:

- The nurse or home health aide providing the service is an employee, directly or by contract, of both the home health agency billing for the service and the ALF; and
 - The nurse or home health aide performs the home health visit service during a time period when he is also being paid or reimbursed for his services by the ALF.
-

Licensed Nurse and Home Health Aide Services

Home Health Visit Limitations

Home health visits are limited to a maximum of four intermittent visits per day. The visits may be any combination of licensed nurse and home health aide visits.

Each recipient who is receiving services on a fee-for-service basis is limited to a maximum of 60 visits in a lifetime without precertification.

Recipients requiring more than 60 visits may receive additional visits through a precertification request to the Medicaid peer review agency for the services.

Precertification of Services

It is recommended that precertification requests be submitted prior to provision of services. Precertification of services before delivery will avoid potential denial of reimbursement for provided services.

Visits must be precertified before services can be reimbursed.

Note: See Precertification in this chapter for information on requesting precertification for additional visits.

Place of Service Exclusions

Medicaid does not reimburse for home health visit services provided in the following locations:

- Hospitals.
 - Nursing facilities.
 - Intermediate care facilities for the developmentally disabled (ICF/DD). (See exceptions for ICF/DDs in 42 CFR 483, Subpart I);
 - Day care centers for children or adults.
 - Prescribed pediatric extended care centers (PPEC).
-

Home Health Nurse Visit Requirements

Home health nurse visit services must be:

- Provided through home health visits;
 - Medically necessary;
 - Furnished by a registered nurse (RN) or a licensed practical nurse (LPN); and
 - Ordered by the attending physician and specified in the physician approved plan of care.
-

Licensed Nurse and Home Health Aide Services, continued

Supervisory Requirement

RNs must supervise home health services provided by a LPN or a home health aide in accordance with the standards defined in 42 CFR 484.36(d)2 and Rule 59A-8.008, F.A.C. If the recipient requires only nursing; or nursing and physical, respiratory, occupational or speech therapy services; or nursing and dietetic and nutrition services, case management shall be provided by a licensed RN directly employed by the agency. If the recipient is receiving only physical, speech, respiratory or occupational therapy services or is receiving only one or more of these therapy services and home health aide services, case management shall be provided by the licensed therapist, who is a direct employee of the home health agency or a contractor.

The supervising RN must:

- Assign tasks to LPNs and home health aides;
- Ensure that a medical record is maintained for each recipient;
- Ensure that nursing progress notes are made in the recipient's medical record for each in-home visit; and
- Ensure that all medical records are available when required for review by Medicaid or agency designee.

Medicaid does not reimburse for required RN supervision duties or visits.

Skilled Nursing Services

The following are examples of services that require the direct care skills of a licensed nurse:

- Administration of intravenous medication;
- Administration of intramuscular injections, hypodermoclysis, and subcutaneous injections only when not able to be self administered appropriately.
- Insertion, replacement and sterile irrigation of catheters;
- Colostomy and ileostomy care; excluding care performed by recipients;
- Treatment of decubitus ulcers when:
 - deep or wide without necrotic center;
 - deep or wide with layers of necrotic tissue; or
 - infected and draining;

Licensed Nurse and Home Health Aide Visit Services, continued

Skilled Nursing Services, continued

- Treatment of widespread infected or draining skin disorders;
- Administration of prescribed heat treatment that requires observation by licensed nursing personnel to adequately evaluate the individual's progress;
- Restorative nursing procedures, including related teaching and adaptive aspects of nursing, which are a part of active treatment and require the presence of licensed nurses at the time of performance;
- Nasopharyngeal, tracheotomy aspiration, ventilator care;
- Levin tube and gastrostomy feedings, excluding feedings performed by the recipient, family or caregiver; and
- Complex wound care requiring packing, irrigation, and application of an agent prescribed by the physician.

Home Health Aide Service Requirements

Home health aide services may be reimbursed only when they are:

- Ordered by the attending physician;
- Documented as medically necessary;
- Provided by an appropriately trained aide;
- Consistent with the physician approved plan of care; and
- Delegated in writing and provided under the supervision of a registered nurse.

Home Health Aide Services

Home health aide services help maintain a recipient's health or facilitate treatment of the recipient's illness or injury. The following are examples of home health aide services reimbursed by Medicaid:

- Assisting with the change of a colostomy bag;
- Assisting with transfer or ambulation;
- Reinforcing a dressing;
- Assisting the individual with prescribed range of motion exercises that have been taught by the RN;
- Assisting with an ice cap or collar;
- Conducting urine test for sugar, acetone or albumin;
- Measuring and preparing special diets;
- Providing oral hygiene;
- Bathing and skin care; and
- Assisting with self-administered medication.

Home health aides must not perform any services that require the direct care skills of a licensed nurse.

Licensed Nurse and Home Health Aide Visit Services, continued

Types of Home Health Aide Visits

Medicaid reimburses two types of home health aide visits:

- Medicaid reimburses a home health aide visit that is associated with a skilled nursing service. The physician's order and plan of care must identify the recipient's need for both home health aide services and skilled nursing services in the home. The skilled nursing service must be provided in addition to the supervisory nursing service. This type of home health aide visit may be reimbursable by Medicare; and if so, the service must be billed to Medicare first for a dually-eligible Medicare and Medicaid recipient.
- Medicaid reimburses a home health aide visit that is unassociated with a skilled nursing service. The physician's order and plan of care must identify the recipient's need for home health aide services only. This type of home health aide visit is not reimbursable by Medicare. Providers should bill this service for a dually-eligible Medicare and Medicaid recipient directly to Medicaid, unless the recipient has other third party insurance.

Both types of visits must meet all the home health aide requirements including being provided under the supervision of a registered nurse.

Different procedure codes are used for these two types of visits, and a modifier must be added to the procedure code when billing for a dually-eligible Medicare and Medicaid recipient.

Note: See Chapter 3, for information on modifiers and Appendix A for information on procedure codes and modifiers.

Private Duty Nursing Services

Private Duty Nursing Definition

Private duty nursing services are medically-necessary skilled nursing services that may be provided in a child's home or other authorized settings to support the care required by the child's complex medical condition.

Who Can Receive Private Duty Nursing

Medicaid reimburses private duty nursing services for recipients under the age of 21 who:

- Have complex medical problems; and
- Require more individual care than can be provided through a home health nurse visit.

Note: See the Glossary in the Florida Medicaid Provider General Handbook for the definition of medically complex.

Private Duty Nursing Requirements

Private duty nursing services must be:

- Ordered by the attending physician;
 - Documented as medically necessary;
 - Provided by a registered nurse or a licensed practical nurse;
 - Consistent with the physician approved plan of care; and
 - Prior authorized before services are provided.
-

Parental Responsibility

Private duty nursing services are authorized to supplement care provided by parents and caregivers. Parents and caregivers must participate in providing care to the fullest extent possible. Training can be offered to parents and caregivers to enable them to provide care they can safely render.

Medicaid does not reimburse private duty nursing services provided solely for the convenience of the child, the parents or the caregiver.

Medicaid does not reimburse private duty nursing for respite care. Examples are parent or caregiver recreation, socialization, and volunteer activities.

Private Duty Nursing Services, continued

Private Duty Nursing Provided by a Parent or Legal Guardian

Medicaid will reimburse a home health agency for the provision of private duty nursing services to an eligible child by a parent or legal guardian who has a valid license as a RN or LPN in the State of Florida and is employed by a Medicaid enrolled home health agency.

The home health agency is required to submit an Authorization for Private Duty Nursing Provider by a Parent or Legal Guardian, AHCA-Med Serv Form 046, July 2008, for approval when private duty nursing services are provided by a parent or legal guardian. Payments of home health claims for private duty nursing services provided by a parent or legal guardian without prior approval by Medicaid are subject to recoupment.

When private duty nursing services are provided by a parent or legal guardian employed by a home health agency, the home health agency's initial assessment and all subsequent POC recertification assessments must be completed by an RN that is not a household member.

Medicaid will only reimburse a home health agency up to 40 hours per week of private duty nursing services provided by a parent or legal guardian. Any other authorized private duty nursing hours must be provided by a non-relative RN or LPN employed by the home health agency. Parents and legal guardians must participate in providing care to the fullest extent possible and are expected to continue to provide non-reimbursed care as the primary caregiver.

Medicaid will not approve additional private duty nursing hours for the child so that the child's parent or legal guardian who is providing private duty nursing for the child can also work outside the home.

Note: See Appendix C for a copy of the Authorization for Private Duty Nursing Provider by a Parent or Legal Guardian, AHCA-Med Serv Form 046. The form is available by photocopying it from Appendix C. It is incorporated by reference in 59G-4.130, F.A.C.

PPEC Services

A recipient who is medically able to attend a prescribed pediatric extended care (PPEC) center and whose needs can be met by the PPEC should have PPEC services instead of private duty nursing services. PPEC services must be approved by Medicaid or its designee. Private duty nursing may be provided as a wraparound alternative for an individual needing additional services when PPEC is not available.

Private Duty Nursing Services, continued

Limitations

Private duty nursing services are limited to a minimum of two continuous hours and a maximum of 24 continuous hours per day.

Private duty nursing service of less than two hours per day is considered a visit and must be billed as a home health nurse visit.

Note: Please see Licensed Nurse and Home Health Aide Services in this chapter for information on home health visits.

Flex Hours or Banking of Hours

Medicaid does not allow “banking of hours” or “flex hours”. Only the number of hours that are medically necessary may be approved. Home health service providers must request only the number hours that are expected to be used and must indicate the times of day and days per week that the hours are needed. If a recipient requires additional hours due to unforeseen circumstances or change in medical or social circumstances, the home health service providers should submit a modification request to the PRO for the additional hours needed.

Authorization Process

Private duty nursing services are authorized by the Medicaid peer review organization if the services are determined to be medically necessary.

Private duty nursing services will be decreased over time as parents and caregivers are taught skills to care for their child and are capable of safely providing that care or as the child’s condition improves.

Prior Authorization

All private duty nursing services must be prior authorized by the Medicaid peer review organization prior to the delivery of services.

Note: See Prior Authorization in this chapter for additional information.

Medical Foster Care

Medical foster care providers are responsible for the overall care of the children assigned to them. The use of private duty nursing services in the medical foster care home is intended to meet medical needs of the child that cannot be met by the medical foster care provider.

See the section on Alternative Caregivers in Chapter 2 of the Florida Medicaid Medical Foster Care Services Coverage and Limitations Handbook for more information and the circumstances in which private duty nursing may be reimbursed for children in medical foster care.

Note: The Florida Medicaid Medical Foster Care Services Coverage and Limitations Handbook is available on the Medicaid fiscal agent’s Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

Private Duty Nursing Services, continued

Place of Service Requirement

Private duty nursing services must be provided according to an individualized plan of care in the eligible Medicaid recipient's place of residence or, under authorized situations, outside the place of residence.

Place of Service Exclusions

Medicaid does not reimburse for private duty nursing services provided in the following locations:

- Hospital;
 - Nursing facility;
 - Intermediate care facility for the developmentally disabled (ICF/DD);
 - Physician's office;
 - Clinic; or
 - PPEC.
-

Exceptions to Place of Service Exclusions

Short-term private duty nursing services provided by a RN or LPN are allowed in an ICF/DD when the services are medically necessary to avoid transfer of the recipient to a nursing facility.

Short-term private duty nursing means services provided for a time span limited by the nursing needs surrounding a specific acute medical event.
Example: Orthopedic surgical procedure requiring more nursing intervention than is available in the ICF/DD during the initial recuperation period.

Services Outside Place of Residence

Medicaid only reimburses for private duty nursing services outside the place of residence if:

- The services are unavailable through other public or private resources; and
 - The services are medically necessary while the child is outside the home.
-

Private Duty Nursing Services, continued

School Services

Private duty nursing may be considered for the medically-complex child at school if:

- The Agency for Health Care Administration (AHCA) or the child's primary care physician considers going to school a viable option given the child's medical status; and
 - The school system is not currently providing the intensity of nursing care required by the child, and private duty nursing services would enable the child to attend school.
-

Training Exclusions

Medicaid will not reimburse for professional development training for home health private duty nursing staff or other home health personnel.

Services Overlap Days

When services begin one day and end the next day, billing should reflect the total number of care hours provided on each day.

Example:

- Services begin at 11 p.m. on January 31 and continue to 7 a.m. on February 1.
- Services begin again at 11 p.m. on February 1 and continue to 7 a.m. on February 2.

Billing would be as follows:

- January 31 = 1 hour (11 p.m. to midnight);
 - February 1 = 8 hours (midnight to 7 a.m. and 11 p.m. to midnight);
 - February 2 = 7 hours (midnight to 7 a.m.).
-

Personal Care Services

Personal Care Services Definition

Personal care services are to provide medically necessary assistance with activities of daily living that support a recipient's medical care needs.

Who Can Receive Personal Care Services

Medicaid reimburses personal care services for recipients under the age of 21 who:

- Have complex medical problems; and
 - Require more individual and continuous care than can be provided through a home health aide visit.
-

Personal Care Services Requirements

Personal care services must be:

- Documented as medically necessary;
 - Prescribed by the attending physician if provided through a home health agency;
 - Supervised by a registered nurse if provided through a home health agency;
 - Supervised by the parent or legal guardian if provided by a non-home health agency;
 - Provided by a home health aide or independent personal care provider;
 - Consistent with the physician, support coordinator, or case manager approved plan of care; and
 - Authorized prior to providing services.
-

Prior Authorization

All personal care services must be authorized by the Medicaid peer review organization prior to the provision of services.

Note: See Prior Authorization in this chapter for additional information on prior authorization.

Place of Service Requirement

Personal care services must be provided according to an individualized plan of care in the eligible Medicaid recipient's place of residence or, under authorized situations, outside the place of residence.

Personal Care Services, continued

Place of Service Exclusions

Medicaid does not reimburse for personal care services provided in the following locations:

- Hospitals;
- Nursing facilities;
- Intermediate care facilities for the developmentally disabled (ICF/DD);
- Physician's offices;
- Clinics; and
- Prescribed pediatric extended care centers.

Services Outside Place of Residence

Medicaid reimburses for personal care services outside the place of residence only if:

- The services are unavailable through other public or private resources; and
- The services are medically necessary while the child is outside the home.

Reimbursable Personal Care Services

Services may include:

- Bathing and grooming (including hair care and shaving);
- Toileting and elimination;
- Oral hygiene;
- Range of motion and positioning; and
- Oral feedings and fluid intake.

Note: See Prior Authorization in this chapter for additional information.

Limitations

Personal care services are limited to a minimum of two continuous hours.

Personal care service of less than two hours per day is considered a visit and must be billed as a home health aide visit.

Note: Please see Licensed Nurse and Home Health Aide Services in this chapter for information on home health visits.

Exception to Limitations

The Medicaid peer review organization, prior to the provision of additional services, may grant an exception to the limitation of hours of personal care services based on medical necessity.

Durable Medical Equipment and Therapy Services

Medical Supplies and Equipment

Medicaid reimburses home health agencies, under their Medicaid home health provider number, for medical supplies and durable medical equipment (DME) furnished by qualified providers in accordance with the physician approved plan of care.

Home health agencies that provide DME must comply with the policies and procedures contained in this handbook and in the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook.

Medicaid reimburses home health agencies for DME services provided only at the recipient's place of residence.

Note: See the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook for additional information on program coverage and limitations and corresponding procedure codes. The handbook is available on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

Note: See Chapter 1 in the Florida Medicaid Provider General Handbook for information on billing the recipient for supplies and equipment not covered by Medicaid.

Occupational, Physical and Speech Therapy Services

Medicaid reimburses home health agencies, under their Medicaid home health provider number, for occupational, physical and speech therapy services furnished by qualified therapy providers in accordance with a physician approved plan of care. Medicaid reimburses home health agencies only for therapies prescribed by a physician.

Home health agencies that provide these therapy services must comply with the policies and procedures contained in this handbook and in the Florida Medicaid Therapy Services Coverage and Limitations Handbook.

Medicaid reimburses home health agencies for these therapy services provided only at the recipient's place of residence.

Medicaid reimburses for medically necessary therapy services that are provided to Medicaid recipients under the age of 21.

Note: See the Florida Medicaid Therapy Services Coverage and Limitations Handbook for additional information on program coverage and limitations and corresponding procedure codes. The handbook is available on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

Required Documentation

Nursing Interventions and Outcomes

Each clinical record must contain documentation of appropriate nursing interventions and expected health outcomes.

Required Reports and Records

The home health services providers must maintain reports and medical records that accurately document the services provided to the recipient.

The medical record must indicate that services were provided in accordance with physician orders and the approved plan of care. All care provided to the recipient must be documented in the medical record and signed and dated by the practitioner who furnishes the care. These records will be used to evaluate any changes made to the plan of care.

Medical Record Release

Upon request by AHCA or its designee, the home health services provider must furnish all medical and Medicaid related records requested and determined to be relevant to the services or goods billed to the Medicaid program.

Medical Record Requirements

The home health agency must maintain the following documentation in the recipient's current medical record:

- Nursing notes of the initial assessment visit and subsequent visits by RNs;
- Most current plan of care;
- Most current physician's orders (signature and date are required);
- Progress notes;
- Tasks and duties assigned to LPNs and home health aides;
- Dates and signatures of practitioners who render care;
- Legal documents;
- Consent forms; and
- Recipient and caregiver verification of services received.

The independent personal care provider must maintain the following documentation in the recipient's current medical record:

- Copy of services logs, which must include documentation of the recipient's name, recipient's Medicaid ID number, the description of the service, activities, supplies or equipment provided, and corresponding procedure code, times and dates service was rendered, amount billed for each service, provider's name and provider Medicaid ID number, and person rendering the service along with signature; and
- Most current plan of care.

Note: See Chapter 2 in the Florida Medicaid Provider General Handbook for additional record keeping requirements.

Precertification for Home Health Visit Services

Introduction

Home health agencies must obtain precertification prior to reimbursement for home health visits that exceed 60 visits per recipient, per lifetime.

General Requirements

The following general requirements apply to precertifications for home health visit services for children and adults.

- The request must be submitted to the Medicaid peer review organization via its web-based Internet system.
 - It is recommended that the home health agency submit the request at least ten working days prior to the 61st visit or prior to a new certification period.
 - It is recommended that precertification be obtained before services are rendered to avoid potential denial of reimbursement for provided services.
-

Required Documentation

Precertification requests must include:

- Recipient's name and Medicaid ID number;
- Home health agency's Medicaid provider number, name and address;
- Procedure code(s), with modifier(s) if applicable, matching the services reflected in the plan of care;
- Nursing assessment with all initial requests; and thereafter, on an annual basis for recipients continuing to receive home health services for more than 12 consecutive months;
- The date that the plan of care was signed by the attending physician; or if not dated, the date the agency received the plan of care per the instructions for the plan of care in Appendix B;
- Patient condition summaries; and
- Summary of documentation that substantiates medical necessity and the need for requested visits, such as a hospital discharge summary, physician or nurse progress notes, history and physical.

Note: See Plan of Care Requirements in this chapter.

Precertification for Home Health Visit Services, continued

Approval Process

Medicaid peer review organization will review each precertification request and approve, deny or request additional information to support the request.

The Medicaid peer review organization will post the status of the request on its Internet system. Providers must check the Internet system for the status of submitted prior authorization requests.

Approved Request

When the request is approved, the approval will contain a precertification number for billing and reference.

An approved request is not a guarantee that Medicaid will reimburse the service. The provider and recipient must be eligible on the date of service, and the service must not have exceeded any applicable service limits.

Content and Limitations on Approved Requests

The approval of services is accessed via the Internet system and specifies:

- Procedure code;
- Units of service authorized;
- Dates of service;
- The discipline authorized to provide the service; and
- The number of days for which the precertification is valid.

Changes to Approved Requests (Modifications)

For any requested change, the provider must submit via the Internet additional new information, not previously submitted, documenting the need for the additional visits.

When requesting additional visits within a certification period, the provider should indicate that the request:

- Is for additional visits or a change to an already requested certification period; and
- Includes the attending physician approved POC, new orders, and a reason for the adjustment.

Medicaid Peer Review Organization Decision Process

If a physician denial or modified approval is proposed, the Medicaid peer review organization informs the provider via the Internet. (In a modified approval, a portion of the requested visits may be denied due to lack of medical necessity.)

The Medicaid peer review organization will post the notice of denial or modified approval on its Internet system.

Precertification for Home Health Visit Services, continued

**Submission of a
Precertification
Claim for Payment**

Providers should submit a claim for payment for a precertified procedure after the service has been approved and provided.

In order to receive reimbursement for the service, the provider must enter the precertification number on the claim form.

Note: For additional information on completing the claim form see Chapter 1 in the Florida Medicaid Provider Reimbursement Handbook, CMS 1500.

**Reconsideration
Review**

A provider who receives a denial may request a reconsideration. The provider must submit additional information if reconsideration is requested.

A reconsideration review of the denial decision must be requested via the Medicaid peer review organization's Internet system within ten business days of the date of the final denial or modified approval determination.

**Precertification
Number**

When the request is approved, the approval will contain a precertification number for billing and reference. Only one precertification number will be issued per 60-day certification period.

For Medicaid to reimburse the service:

- The precertification number must be entered in field 23 on the claim form;
 - The certification period, corresponding to the precertification number entered in field 23, must match the dates of service shown on the claim; and
 - The Medicaid provider number and Medicaid recipient identification number on the claim form and the plan of care must match.
 - The Medicaid provider must not submit a claim prior to providing the services.
-

Precertification For Medically-Needy Recipients

Medically-Needy Eligibility

A Medically-Needy recipient is an individual who would qualify for Medicaid except that the individual's income or resources exceed Medicaid's income or resource limits.

On a month-by-month basis, the individual's medical expenses are subtracted from his income. If the remainder falls below Medicaid's income limits, the individual may qualify for Medicaid for the month or for part of the month, depending on the date the medical expenses were incurred.

Note: See Chapter 3 in the Florida Medicaid Provider General Handbook for additional information on Medically-Needy eligibility. See Chapter 2 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for billing information on Medically-Needy recipients.

Medically-Needy Precertification

The Medicaid peer review organization cannot obtain a precertification number from the Medicaid fiscal agent for a Medically-Needy individual who is in a period of ineligibility. If the individual becomes eligible for the dates that the services were rendered, the provider must notify the peer review organization via the Internet that the recipient is a Medically-Needy individual and state the recipient's dates of eligibility for each month precertification is being requested.

Prior Authorization for Private Duty Nursing or Personal Care

Description Prior authorization is the approval process required prior to providing certain services to recipients under 21 years of age. Medicaid will not reimburse for these services without prior authorization when it is required.

Services Requiring Prior Authorization The following home health services require prior authorization for reimbursement:

- Private duty nursing; and
 - Personal care.
-

Requesting Prior Authorization All requests for prior authorization must be submitted to the Medicaid peer review organization via its web-based Internet system.

At a minimum, the prior authorization request must include:

- Recipient's name, date of birth and Medicaid ID number;
 - Recipient's current health status, including diagnoses codes; brief medical history by the physician; and the medical necessity of the service;
 - Type of service needed described by procedure code;
 - Planned dates and times of service;
 - Units of service requested;
 - Treating provider's Medicaid provider number, name and address;
 - Attending physician's, support coordinator's, or case manager's authorized plan of care;
 - Other documentation requested by Medicaid such as the caregiver's availability and ability to provide care.
-

Approval Process The Medicaid peer review organization will review each request and approve, deny or request additional information to support the request.

The Medicaid peer review organization will post the status of the request on its Internet system. Providers must check the Internet system for the status of submitted prior authorization requests.

Prior Authorization for Private Duty Nursing or Personal Care, continued

Content and Limitations on Approved Requests

The approval of services is accessed via the Internet system and specifies:

- Procedure code;
 - Units of service authorized;
 - Dates of service;
 - The discipline authorized to provide the service; and
 - The number of days for which the prior authorization is valid.
-

Approved Requests

When the request is approved, the approval will contain a prior authorization number for billing and reference.

An approved authorization is not a guarantee that Medicaid will reimburse the service. The provider and recipient must be eligible on the date of service, and the service must not have exceeded any applicable service limits.

Submission of a Prior Authorization Claim for Payment

Providers should submit a claim for payment for a prior authorized procedure after the service has been approved and provided.

In order to receive reimbursement for the service, the provider must enter the prior authorization number on the claim form.

Note: For additional information on completing the claim form see Chapter 1 in the Florida Medicaid Provider Reimbursement Handbook, CMS 1500.

Changes to Approved Requests (Modifications)

For any requested change, the provider must submit via the Internet additional new information, not previously submitted, documenting the need for the additional hours.

When requesting additional hours within a certification period, the provider should indicate that the request:

- Is for additional hours or a change to an already requested certification period; and
 - Includes the attending physician, support coordinator, or case manager approved POC, new orders (if a home health agency), and a reason for the adjustment.
-

Prior Authorization Private Duty Nursing or Personal Care, continued

**Medicaid Peer
Review
Organization
Decision Process**

If a physician denial or modified approval is proposed, the Medicaid peer review organization informs the provider via the Internet. (In a modified approval, a portion of the requested hours may be denied due to lack of medical necessity.)

The Medicaid peer review organization will post the notice of denial or modified approval on its Internet system.

**Reconsideration
Review**

A provider who receives a denial may request a reconsideration. The provider must submit additional information if reconsideration is requested.

A reconsideration review of the denial decision must be requested via the Medicaid peer review organization's Internet system within ten business days of the date of the final denial or modified approval determination.

CHAPTER 3

HOME HEALTH SERVICES PROCEDURE CODES AND FEES

Overview

Introduction

This chapter provides and describes the procedure codes, fees and copayment requirements for recipients receiving home health services.

In This Chapter

This chapter contains:

| TOPIC | PAGE |
|---------------------------|------|
| Reimbursement Information | 3-1 |
| Procedure Code Modifiers | 3-4 |

Reimbursement Information

Who Can Be Reimbursed

Medicaid will only reimburse a home health agency for home health visit services. Medicaid will reimburse a home health agency or an independent personal care services provider for personal care services

Procedure Codes

The new procedure codes listed in this handbook are Level II Healthcare Common Procedure Coding System (HCPCS) codes. The codes are part of the national standard code set described in the HCPCS Level II Expert code book. Please refer to the HCPCS Level II Expert code book for complete descriptions of the standard codes. The HCPCS Level II Expert code book is copyright 2008 by Ingenix, Inc. All rights reserved. Level II codes are usually used to describe medical services and supplies. These codes begin with a single letter (A through V) followed by four numeric digits.

Diagnosis Code

When submitting claims for payment, providers must select the diagnosis codes that most accurately reflect the Medicaid recipient's medical need for nursing or home health aide services. To be reimbursable, a diagnosis code specific to the fourth or fifth digit as identified in the latest ICD-9-CM codes is required on each claim line.

The use of general or generic diagnosis codes such as "general debility" as the only primary diagnosis code is inappropriate and will result in further review by the Medicaid peer review organization.

Reimbursement Information, continued

Reimbursement for Home Health Services

Medicaid reimbursement for home health services is the lesser of:

- The amount billed;
- The maximum fee listed on the Home Health Services Fee Schedule; or
- The provider's usual and customary charge.

Copayment

Medicaid recipients, unless exempt, are responsible to pay a copayment of \$2.00 per home health provider, per day.

Note: See Chapter 1 in the Florida Medicaid Provider General Handbook for additional information about copayment requirements and categories of recipients who are exempt from copayment. The handbook is available on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Handbooks.

Visit Reimbursement

Medicaid reimburses per home health visit. The staffing resources needed to provide a service are included in the visit reimbursement.

Medicaid does not reimburse per individual staff person(s) providing a home health visit.

Home Health Visits for Multiple Recipients at One Location

Home health visit services provided to two or more recipients with individual residences at a single location are reimbursed as one visit for each individual receiving a home health service at that location (for example, visits at an assisted living facility).

Home health visit services provided to two or more recipients sharing a residence at a single location (for example, visits at a group home) are reimbursed as follows:

- For the first recipient, Medicaid reimburses the service at the established Medicaid visit rate;
- For the second recipient, Medicaid reimburses the service at 50 percent of the established Medicaid visit rate; and
- For any additional recipients, Medicaid reimburses the services at 50 percent of the established Medicaid visit rate.

Note: Please call your area Medicaid office for billing instructions. The area offices' telephone numbers are listed in Appendix C of the Florida Medicaid Provider General Handbook and on the AHCA Website at <http://ahca.myflorida.com>. Click on Medicaid, and then on Area Offices.

Reimbursement Information, continued

Private Duty Nursing and Personal Care Services for Multiple Recipients at One Location

Private duty nursing (PDN) and personal care (PC) furnished by one nurse, home health aide or independent personal care provider to two or more recipients at a single place of residence is reimbursed as follows:

- For the first recipient, Medicaid reimburses the services at the established Medicaid rate;
- For the second recipient, Medicaid reimburses the services at 50 percent of the established Medicaid rate; and
- For additional recipients, Medicaid reimburses services at 25 percent of the established Medicaid rate.

A modifier must be added to the home health PDN or PC visit procedure code to identify a home health PDN or PC service provided to more than one recipient in the same setting.

Note: Please refer to Procedure Code Modifiers in this chapter and Appendix A for the valid procedure codes and modifiers.

Dually-Eligible Recipients

A dually-eligible recipient is one who is enrolled in both Medicare and Medicaid.

A modifier must be added to the home health visit procedure code to identify a home health visit service provided to a dually-eligible recipient. If a claim is submitted for a dually-eligible recipient and the modifier is not added to the procedure code, the claim will deny.

Precertification requests submitted to the Medicaid peer review organization must include the modifier if the recipient is dually eligible.

The home health services provider is responsible for retaining documentation in the recipient's record that the service is not Medicare reimbursable. (Medicaid is a secondary payer to Medicare.)

Note: Please refer to Procedure Code Modifiers in this chapter and Appendix A for the valid procedure codes and modifiers.

Home Health Aide Visit Associated with Skilled Nursing Services

A home health aide visit associated with a skilled nursing service may be reimbursable by Medicare; and if so, the service must be billed to Medicare first for a dually-eligible Medicare and Medicaid recipient.

A modifier must be added to the home health aide visit procedure code to identify that the home health aide visit service is associated with a skilled nursing service.

Note: Please refer to Procedure Code Modifiers in this chapter and Appendix A for the valid procedure codes and modifiers.

Reimbursement Information, continued

Procedure Codes and Fees

Each procedure code found in Appendix A, Home Health Services Fee Schedule, corresponds to a service described in Chapter 2 of this handbook.

The fee schedule gives:

- The codes associated with the type of service;
 - The modifier if the procedure code requires one;
 - A brief description of the service; and
 - The maximum fee that Medicaid will reimburse for the procedure.
-

Procedure Code Modifiers

Definition of Modifier

For certain types of services, a two-digit modifier must be entered on the CMS-1500 claim form. Modifiers more fully describe the procedure performed so that accurate payment may be determined.

The modifier is entered in the field next to the procedure code field in item 24D, under Modifier.

Home health services providers must use the modifiers with the procedure codes listed on Appendix A, Home Health Services Fee Schedule, when billing for the specific services in the procedure code descriptions. The modifiers listed in Appendix A can only be used with the procedure codes listed. Use of modifiers with any other procedure codes will cause the claim to deny or pay incorrectly.

Note: See Chapter 1 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for additional information on entering modifiers on the claim form.

APPENDIX A
HOME HEALTH SERVICES FEE SCHEDULE
HOME HEALTH VISITS

| CODE | MOD 1 | MOD 2 | DESCRIPTION OF SERVICE | MAXIMUM FEE |
|-------|-------|-------|--|-------------------|
| T1030 | | | Registered Nurse (RN) Visit | \$31.04/per visit |
| T1030 | GY | | Registered Nurse (RN) Visit to Dually-Eligible Recipient | \$31.04/per visit |
| T1031 | | | Licensed Practical Nurse (LPN) Visit | \$26.19/per visit |
| T1031 | GY | | Licensed Practical Nurse (LPN) Visit to Dually-Eligible Recipient | \$26.19/per visit |
| T1021 | TD | | Home Health Aide (HHA) Visit—associated with skilled nursing services | \$17.46/per visit |
| T1021 | TD | GY | Home Health Aide (HHA) Visit—associated with skilled nursing services to Dually-Eligible Recipient | \$17.46/per visit |
| T1021 | | | Home Health Aide (HHA) Visit—unassociated with skilled nursing services | \$17.46/per visit |
| T1021 | GY | | Home Health Aide (HHA) Visit—unassociated with skilled nursing services to a Dually-Eligible Recipient | \$17.46/per visit |

PRIVATE DUTY NURSING

| CODE | MODIFIER | DESCRIPTION OF SERVICE | MAXIMUM FEE |
|-------|----------|--|-------------|
| S9123 | | Private duty nursing rendered by a RN (2 to 24 hours per day)* | \$29.10/hr |
| S9123 | TT | Private duty nursing rendered by a RN (2 to 24 hours per day)* provided to more than one recipient in the same setting. | \$29.10/hr |
| S9124 | | Private duty nursing rendered by a LPN (2 to 24 hours per day)* | \$23.28/hr |
| S9124 | TT | Private duty nursing rendered by a LPN (2 to 24 hours per day)* provided to more than one recipient in the same setting. | \$23.28/hr |

*Any portion of the hour that exceeds 30 minutes may be rounded up to the next hour, but the total may not exceed the daily authorized number of hours.

Appendix A, Home Health Services Fee Schedule, continued

PERSONAL CARE SERVICES

| CODE | MODIFIER | DESCRIPTION OF SERVICE | MAXIMUM FEE |
|-------------|-----------------|--|--------------------|
| S9122 | | Personal care rendered by a home health aide (2 to 24 hours per day)* | \$15.00/hr |
| S9122 | TT | Personal care rendered by a home health aide (2 to 24 hours per day)* provided to more than one recipient in the same setting. | \$15.00/hr |

*Any portion of the hour that exceeds 30 minutes may be rounded up to the next hour, but the total may not exceed the daily authorized number of hours.

APPENDIX B

MEDICAID INSTRUCTIONS FOR CMS FORM 485 – PLAN OF CARE

ITEM 1 – PATIENT’S HIC NUMBER

For Medicaid agencies, enter the patient’s Medicaid number.

ITEM 2 – START OF CARE DATE (SOC)

This is the date service originally began. This date will remain the same on subsequent plans of care as long as the reason(s) for providing home health care remains the same.

ITEM 3 – CERTIFICATION PERIOD

This identifies the period covered by the plan of care. Enter the six-digit month, day and year, i.e., MMDDYY

FROM DATE

- The first day this POC covers includes this day.
- On the initial certification, the “FROM” date will be the same as start of care date.

TO DATE

- This is the end of the certification. The “TO” date is the last day of the plan of care.
- The “TO” date can include up to, but never exceed, 60 calendar days.
- On subsequent recertifications the next sequential “FROM” date will be the day after the “TO” date on the previous plan of care.

ITEM 4 – MEDICAL RECORD NUMBER

No entry needed.

ITEM 5 – PROVIDER NUMBER

Enter the provider number assigned by Medicaid. This number is comprised of nine digits.

ITEM 6 – PATIENT’S NAME AND ADDRESS

Enter the recipient’s last name, first name, and middle initial as shown on the recipient’s Medicaid eligibility file. List the address where care is being rendered.

ITEM 7 – PROVIDER’S NAME AND ADDRESS

Enter your agency’s name and address.

ITEM 8 – DATE OF BIRTH

Enter the recipient’s date of birth in six-digit format, i.e., MMDDYY.

Medicaid Instructions for CMS Form 485 – Plan of Care, continued

ITEM 9 – SEX

Check the appropriate box.

M – Male

F – Female

ITEM 10 – MEDICATIONS

Enter all medications including over-the-counter drugs.

Enter dosage, frequency and route of administration.

Enter an “N” after the medication(s) that are “new” orders for the current certification period.

Enter a “C” after the medication(s) that are “change” orders either in dose, frequency or route of administration for the current certification period.

(New or changed medications indicate and support changes or exacerbations in the recipient’s condition that may warrant additional or continuing home health services.)

Note: N = new medication within last 30 days.

C = changed medication (dosage, frequency, or route of administration) within last 60 days.

ITEM 11 – PRINCIPAL DIAGNOSIS

Enter a valid ICD-9 code which best describes the principal reason for home health services. The code is the full ICD-9-CM diagnosis code including all digits.

If more than one diagnosis is treated concurrently, enter the diagnosis that represents the most acute condition and requires the most intensive services.

The principal diagnosis may change on subsequent forms only if the patient develops an acute condition or an exacerbation of a secondary diagnosis requiring intensive services different than those on the established plan.

Enter the date of onset or exacerbation in six-digit format (MMDDYY).

Indicate if the diagnosis is a new onset (“O”) or an exacerbation (“E”) of a pre-existing or chronic condition by placing an “O” or an “E” after the diagnosis date.

If the diagnosis is neither new nor an exacerbation or flare-up of a condition, enter the original date of onset of the condition.

Diagnosis date does not refer to dates of the certification period on the plan of care.

ITEM 12 – SURGICAL PROCEDURE, DATE and ICD-9-CM Code

Enter a valid ICD-9-CM surgical code and date of the surgical procedure. At a minimum, the month and year should be present for date of surgery.

This entry is only necessary if relevant to services being rendered or if the surgical procedure was within the last six months.

Medicaid Instructions for CMS Form 485 – Plan of Care, continued

ITEM 13 – OTHER PERTINENT DIAGNOSES

Enter all pertinent diagnoses relevant to the care rendered. Place in order of seriousness to justify the discipline and services being rendered.

Other pertinent diagnoses are all conditions that coexisted at the time the plan of care was established or developed subsequently.

Enter the date of onset, if it is a new diagnosis, or the most recent exacerbation of a previous diagnosis. Enter the date in MMDDYY format.

ITEM 14 – DME AND SUPPLIES

List supplies and equipment needed for care.

ITEM 15 – SAFETY MEASURES

Enter the physician's instructions for safety measures or those identified by the home health agency.

ITEM 16 – NUTRITIONAL REQUIREMENTS

Enter the physician's orders for the diet including:

- Therapeutic diets;
- Specific dietary requirements; and
- Fluid restrictions or requirements.

Total parenteral nutrition (TPN) can be listed under this item or under medications.

ITEM 17 – ALLERGIES

Enter medicine allergies or other allergies or "NKA."

ITEM 18A – FUNCTIONAL LIMITATIONS

Check current limitations as assessed by the physician or home health agency. If "other" is checked, provide detail below other or in an addendum to the POC.

ITEM 18B – ACTIVITIES PERMITTED

Check all activities allowed by physician. If "Other" is checked, a narrative explanation is required.

ITEM 19 – MENTAL STATUS

Check the most appropriate blocks that describe the patient's mental status. If "Other" is checked, specify here.

ITEM 20 – PROGNOSIS

Check the box that specifies the most appropriate prognosis for the patient.

Medicaid Instructions for CMS Form 485 – Plan of Care, continued

ITEM 21 – ORDERS FOR DISCIPLINE AND TREATMENTS

List the frequency and duration of visits for each discipline.

List all the services and treatments to be provided by each discipline.

Frequency denotes the number of visits per discipline to be rendered, stated in days, weeks, or months.

Duration identifies the length of time the services are to be rendered and may be expressed in days, weeks or months.

Note: If this field incorporates the physician treatment order (initial or continuation), it must include the requirements for physician treatment orders listed in Chapter 2 of the Home Health Services Coverage and Limitations Handbook.

ITEM 22 – GOALS/REHABILITATION POTENTIAL/DISCHARGE PLANS

Enter the physician's description of achievable goals and the patient's ability to meet these goals.

Address discharge plans, including plans for care after discharge.

Rehabilitation potential should include the expected health outcomes and the patient's ability to achieve goals and estimate of time needed to achieve them. This information should be pertinent to nature of the patient's condition and ability to respond and include more than words "Fair" or "Poor".

ITEM 23 – NURSE'S SIGNATURE AND DATE OF VERBAL START OF CARE

This field identifies the person who spoke with the attending physician and received verbal authorization to either begin or continue services. Enter the date the verbal order was received. This date may precede the SOC date in Field 2 and may precede the "From" date in Field 3

ITEM 24 – PHYSICIAN'S NAME AND ADDRESS

Enter the name and address of the attending physician that established the plan of care.

ITEM 25 – DATE HHA RECEIVED SIGNED POC

Enter the date the agency received the signed, but *not dated*, POC. Enter "N/A" if Item 27 is completed.

It is recommended that agencies date stamp every plan of care upon return from the physician.

ITEM 26 – PHYSICIAN CERTIFICATION STATEMENT

No entry needed.

Medicaid Instructions for CMS Form 485 – Plan of Care, continued

ITEM 27 – ATTENDING PHYSICIAN'S SIGNATURE AND DATE SIGNED

The form must be signed prior to submission of precertification request. If a rubber stamp signature is used, it must be initialed by the physician.

Faxed signatures are acceptable; however, the physician must retain the plan with his original signature in the recipient's medical record. The home health agency is responsible for obtaining original signatures if an issue surfaces that would require verification of an original signature.

The plan of care may be signed by another physician who is authorized by the attending physician to care for his or her patients in his or her absence, i.e., partnership agreement.

Do not pre-date or write the date in this field. If the physician does not date his/her signature, leave it blank and document in Item 25.

ITEM 28 – ANTI-FRAUD STATEMENT

Home Health Services Coverage and Limitations Handbook

| | | | | | |
|---|---------------------------------------|--|---|---|--|
| Department of Health and Human Services Centers for Medicare & Medicaid Services | | | Form Approved OMB No. 0938-0357 | | |
| HOME HEALTH CERTIFICATION AND PLAN OF CARE | | | | | |
| 1. Patient's HI Claim No. | 2. Start Of Care Date | 3. Certification Period From: _____ To: _____ | | 4. Medical Record No. | |
| 5. Provider No. | | | | | |
| 6. Patient's Name and Address | | | 7. Provider's Name, Address and Telephone Number | | |
| 8. Date of Birth | | | 9. Sex <input type="checkbox"/> M <input type="checkbox"/> F | | |
| 11. ICD-9-CM | Principal Diagnosis | Date | | | |
| 12. ICD-9-CM | Surgical Procedure | Date | | | |
| 13. ICD-9-CM | Other Pertinent Diagnoses | Date | | | |
| 14. DME and Supplies | | | 15. Safety Measures: | | |
| 16. Nutritional Req. | | | 17. Allergies: | | |
| 18.A. Functional Limitations | | | 18.B. Activities Permitted | | |
| 1 <input type="checkbox"/> Amputation | 5 <input type="checkbox"/> Paralysis | 9 <input type="checkbox"/> Legally Blind | 1 <input type="checkbox"/> Complete Bedrest | 6 <input type="checkbox"/> Partial Weight Bearing | A <input type="checkbox"/> Wheelchair |
| 2 <input type="checkbox"/> Bowel/Bladder (Incontinence) | 6 <input type="checkbox"/> Endurance | A <input type="checkbox"/> Dyspnea With Minimal Exertion | 2 <input type="checkbox"/> Bedrest BRP | 7 <input type="checkbox"/> Independent At Home | B <input type="checkbox"/> Walker |
| 3 <input type="checkbox"/> Contracture | 7 <input type="checkbox"/> Ambulation | B <input type="checkbox"/> Other (Specify) | 3 <input type="checkbox"/> Up As Tolerated | 8 <input type="checkbox"/> Crutches | C <input type="checkbox"/> No Restrictions |
| 4 <input type="checkbox"/> Hearing | 8 <input type="checkbox"/> Speech | | 4 <input type="checkbox"/> Transfer Bed/Chair | 9 <input type="checkbox"/> Cane | D <input type="checkbox"/> Other (Specify) |
| | | | 5 <input type="checkbox"/> Exercises Prescribed | | |
| 19. Mental Status: | | | 1 <input type="checkbox"/> Oriented | 3 <input type="checkbox"/> Forgetful | 5 <input type="checkbox"/> Disoriented |
| | 2 <input type="checkbox"/> Comatose | 4 <input type="checkbox"/> Depressed | 6 <input type="checkbox"/> Lethargic | 7 <input type="checkbox"/> Agitated | 8 <input type="checkbox"/> Other |
| 20. Prognosis: | | | 1 <input type="checkbox"/> Poor | 2 <input type="checkbox"/> Guarded | 3 <input type="checkbox"/> Fair |
| | | | 4 <input type="checkbox"/> Good | 5 <input type="checkbox"/> Excellent | |
| 21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) | | | | | |
| 22. Goals/Rehabilitation Potential/Discharge Plans | | | | | |
| 23. Nurse's Signature and Date of Verbal SOC Where Applicable: | | | | 25. Date HHA Received Signed POT | |
| 24. Physician's Name and Address | | | 26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan. | | |
| 27. Attending Physician's Signature and Date Signed | | | 28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws. | | |
| Form CMS-485 (C-3) (02-94) (Formerly HCFA-485) (Print Aligned) | | | | | |

APPENDIX C

AUTHORIZATION FOR PRIVATE DUTY NURSING PROVIDED BY A PARENT OR LEGAL GUARDIAN

AUTHORIZATION FOR PRIVATE DUTY NURSING PROVIDED BY A PARENT OR LEGAL GUARDIAN

Home Health Agency Name _____ Date of Request _____

Medicaid Provider Number _____ Phone Number () _____ County _____

Street Address _____ City _____ State _____ Zip Code _____

This is to certify that

Child's Name _____ Date of Birth _____

Child's Medicaid Number _____

Street Address _____ City _____ State _____ Zip Code _____

has been evaluated and approved to receive private duty nursing services in the child's place of residence as outlined in the Florida Medicaid Home Health Services Coverage and Limitations Handbook. The private duty nursing services will be provided by a parent or legal guardian who meets the following criteria:

1. Has a valid license as a Registered Nurse (RN) or Licensed Practical Nurse (LPN) in the State of Florida; and
2. Employed by a Medicaid enrolled home health agency

Parent or Legal Guardian Name _____

Florida License Number (RN or LPN) _____ Expiration Date _____

Phone Number () _____

I certify that an initial assessment and all subsequent plan of care assessments for this child will be completed by a Registered Nurse that is not a household member while the parent or legal guardian is authorized to provide private duty nursing services. I understand that Medicaid will only reimburse a home health agency up to 40 hours per week of private duty nursing services provided by a parent or legal guardian. A non-relative RN or LPN employed by the home health agency must provide all other authorized private duty nursing hours above the 40 hour a week limit.

Home Health Agency Authorized Representative Date

Parent or Legal Guardian Date

Approval by Medicaid Representative Date

Submit the Form for Approval to:
Bureau of Medicaid Services, MS #20
Long Term Care and Behavioral Health Care Section
2727 Mahan Drive
Tallahassee, FL 32308

This form must be filed in the child's medical record



Charlie Crist
Governor

Holly Benson
Secretary

2727 Mahan Drive
Tallahassee, FL 32308

<http://ahca.myflorida.com>