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Related Clinical Coverage Policies

Refer to http://dma.ncdhhs.gov/ for the related coverage policies listed below:

10A, Outpatient Specialized Therapies
5A-1, Physical Rehabilitation Equipment and Supplies
5A-2, Respiratory Equipment and Supplies
5A-3, Nursing equipment and Supplies
5B, Orthotics & Prosthetics
1H, Telemedicine and Telepsychiatry
3D, Hospice Services

1.0 Description of the Procedure, Product, or Service

Home Health Services include medically necessary skilled nursing services, specialized therapies (physical therapy, speech-language pathology, and occupational therapy), home health aide services, and medical supplies provided to beneficiaries in any setting in which normal life activities take place, other than a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities; except for home health services in an intermediate care facility for Individuals with Intellectual Disabilities that are not required to be provided by the facility under subpart I of part 483 or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. Home health services cannot be limited to services furnished to beneficiaries who are homebound in accordance with 42 CFR 440.70.

1.1 Definitions

Descriptions of the services available under the home health policy are listed below.

1.1.1 Skilled Nursing

Skilled nursing components are the assessment, judgment, intervention, and evaluation of interventions by a licensed registered nurse (RN), or a licensed practical nurse (LPN) under the supervision of the RN, and in accordance with the plan of care (POC), in the amount, frequency and duration as outlined in **Subsection 5.3.3**.

Skilled nursing responsibilities are assessing, caring, counseling, teaching, referring and implementing of prescribed treatment in the maintenance of health, prevention and management of illness, injury, disability or the achievement of a dignified death. It is ministering to; assisting; and sustained, vigilant, and continuous care of those acutely or chronically ill; supervising patients during convalescence and rehabilitation; the supportive and restorative care given to maintain the optimum health level of individuals, groups, and communities; the supervision, teaching, and evaluation of those who perform or are preparing to perform these functions; and the administration of nursing programs and nursing services in accordance with GS 90-171.20 (4).

Skilled nursing services are covered when furnished by an RN or an LPN. An RN shall complete the initial assessment visit and shall appropriately supervise the LPN within the scope of the North Carolina Board of Nursing (NCBON).

The initial assessment visit is conducted to determine the immediate care and support needs of the patient within 48 hours of referral, or within 48 hours of the patient's return to service location. The comprehensive assessment is patient specific and must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care. These assessments will be completed by the RN, unless specialized therapy service is the only service ordered by the physician. In this case the appropriate specialized therapy skilled professional will complete these assessments in accordance with the federal conditions of participation 42 CFR 484.55.

Services must be medically necessary and reasonable for the diagnoses and to the treatment of the beneficiary's illness or injury. The services include:

a. Observation, assessment, and evaluation of the beneficiary's condition when only the specialized skills and training of a licensed nurse can determine the beneficiary's medical status;
b. Management and evaluation of the beneficiary's POC to ensure that the care is achieving its purpose;
c. Teaching and training the beneficiary, the beneficiary's family, or other caregivers about how to manage the beneficiary's treatment regimen; and
d. Skilled nursing procedures medically necessary and reasonable for the treatment of the beneficiary's illness or injury.

1.1.2 Specialized Therapies

Refer to clinical coverage policy 10A, *Outpatient Specialized Therapies* on the Division of Medical Assistance (DMA)'s Web site at (https://dma.ncdhhs.gov/documents/specialized-therapies-clinical-coverage-policies, for a complete description.

1.1.2.1 Physical Therapy

Physical therapy services are covered when provided by a licensed physical therapist (PT) or by a licensed physical therapy assistant (PTA) under direct supervision of a licensed PT. These services help relieve pain; restore maximum body function; and prevent disability following disease, injury, or loss to a part of the body.

Medicaid and NCHC accepts the medical necessity criteria for initiating, continuing, and terminating treatment as published in Clinical Coverage Policy 10A, *Outpatient Specialized Therapies.*

1.1.2.2 Speech Therapy

Speech-language pathology (SLP) services are covered when provided by a licensed speech-language pathologist or by a licensed speech language pathology assistant (SLPA) under direct supervision of a licensed (SLP) to treat speech and language disorders that result in communication disabilities. The services are also provided to treat swallowing disorders (dysphagia), regardless of the presence of a communication disability.

Medicaid and NCHC accepts the medical necessity criteria for speech-language therapy treatment outlined in Clinical Coverage Policy 10A, *Outpatient Specialized Therapies*

1.1.2.3 Occupational Therapy

Occupational therapy services are covered when provided by a licensed occupational therapist (OT) or by a licensed occupational therapy assistant (OTA) under direct supervision of a licensed OT. Services help improve and restore functions impaired by illness or injury. When a beneficiary's functions are permanently lost, or reduced, occupational therapy helps improve the beneficiary's ability to perform the tasks needed for independent living.

Medicaid and NCHC accepts the medical necessity criteria for beginning, continuing, and terminating treatment as published in the clinical coverage policy 10A, *Outpatient Specialized Therapies.*

1.1.3 Home Health Aide Services

Home health aide services are hands-on paraprofessional services provided by a Nurse Aide I or II (NA I or NA II) under the supervision of the RN. The services are provided in accordance with the established plan of care (POC), in the amount, frequency and duration outlined in **Subsection 5.3.3.** Services will be provided in accordance with the federal conditions of participation (CoP) 42 CFR 484.80.

Home health aide services help maintain a beneficiary's health and facilitate treatment of the beneficiary's illness or injury. Home Health Aide services can be provided without other skilled services being ordered, but will require skilled nursing supervision as indicated in Subsection 3.2.1.4.

Typical tasks include:

a. Assisting with activities such as bathing, caring for hair and teeth, eating, exercising, transferring, and eliminating.
b. Assisting a beneficiary in taking self-administered medications that do not require the skills of a licensed nurse to be provided safely and effectively.
c. Maintaining of a clean, safe, and healthy environment to support a beneficiary's medical care needs, such as doing light cleaning, preparing meals, taking out trash, and shopping for groceries.
d. Performing simple delegated tasks such as taking a beneficiary's temperature, pulse, respiration, and blood pressure; weighing the beneficiary; changing dressings that do not require the skills of a licensed nurse; and reporting changes in the beneficiary's condition and needs to an appropriate health care professional.

1.1.4 Clinical manager

Must be a licensed physician, physical therapist, speech-language pathologist, occupational therapist, audiologist, social worker, or a registered nurse.

1.1.5 Representative

The patient's legal representative, such as a guardian, who makes health-care decisions on the patient's behalf, or a patient-selected representative who

participates in making decisions related to the patient's care or well-being, including but not limited to, a family member or an advocate for the patient. The patient determines the role of the representative, to the extent possible.

1.1.6 In advance

The Home Health Provider (HHP) staff must complete the specified task prior to performing any hands-on care or any patient education.

1.1.7 Verbal order

A physician order that is spoken to appropriate personnel and later put in writing for the purposes of documenting as well as establishing or revising the patient's plan of care.

1.1.8 Medical Supplies

Medical supplies include those items listed on the Home Health Services Fee Schedule. This list is available on the DMA Web site at http://dma.ncdhhs.gov.

Items not listed on the fee schedule may be considered for coverage when submitted by a provider or a beneficiary via their service provider for prior authorization (PA) review of medical necessity. Refer to Subsection 3.2.1.5 and Section 5.2.2.for specific PA requirement information.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(*The term "General" found throughout this policy applies to all Medicaid and NCHC policies*)

a. An eligible beneficiary shall be enrolled in either:
   1. the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
   2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise)* Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
b. Provider(s) shall verify each Medicaid or NCHC beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.
d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

(***The term "Specific" found throughout this policy only applies to this policy***)

a. Medicaid
None Apply.

b. NCHC
None Apply.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

1. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

   Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

   This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

   Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

   EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

   1. that is unsafe, ineffective, or experimental or investigational.
   2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

   Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

2. **EPSDT and Prior Approval Requirements**

   1 If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.

   2. IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

EPSDT provider page: http://dma.ncdhhs.gov.

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

The Division of Medical Assistance (DMA) shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

2.3 Managed Care Participation

Beneficiaries participating in Community Care of North Carolina/Carolina ACCESS programs (CCNC/CA) shall gain access to home health services through their primary care physicians.

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when medically necessary, and:

a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

3.2.1.1 Specific Criteria: All Home Health Visits

Nursing, home health aide, and specialized therapy services are provided on a per-visit basis. Services provided are deemed appropriate when the service can be more effectively provided through Home Health Services due to either the frequency of the service or the beneficiary's condition. The medical records must include documentation supporting one or more of the following reasons that the services must be provided through Home Health Services instead of in the physician's office, clinic, or other outpatient setting.

a. The beneficiary requires assistance, such as with opening doors and other routine activities, due to a physical impairment or a medical condition, making it difficult getting to and from the physician's office, clinic, or other outpatient setting.
b. The beneficiary is non-ambulatory or wheelchair bound.
c. The beneficiary would require ambulance transportation.
d. The beneficiary is medically fragile or unstable:
    1. Infants up to 6 weeks of age who have acute needs, who are at medical risk, or both.
    2. Post-surgery beneficiaries who are restricted from activity except for short periods of time.
    3. Travel is ill-advised due to:
        a. Exacerbation of the condition;
        b. Being detrimental to the beneficiary's health;
        c. Shortness of breath becoming exacerbated.
    4. Beneficiaries who are experiencing severe pain.
    5. Beneficiaries who, because of their medical condition, must be protected from exposure to infections.
    6. Beneficiaries who have just had major surgery.
e. Leaving the home health service location would interfere with the effectiveness of the services:
    1. Beneficiaries, especially young children, with an extreme fear of the hospital or physician's office.
    2. Beneficiaries living in an area where travel time to outpatient services would require 1 hour or more of driving time.
    3. Beneficiaries who need a service repeated at frequencies that would be difficult to accommodate in the physician's office, clinic, or other outpatient setting.
    4. Beneficiaries requiring regular and PRN (as needed) catheter changes.
    5. Beneficiaries who have a) demonstrated a failure to comply with medical appointments at a physician's office, clinic, or other outpatient facility due to a medical condition or cognitive impairment and b) suffered adverse consequences as a result.
    6. Beneficiaries requiring complex wound care, such as irrigation and packing, twice a day or more often.
f. The beneficiary requires training for the use of assistive devices specifically customized for his or her environment (such as bath chairs and shower grab bars).

3.2.1.2 Specific Criteria: Skilled Nursing Services

A Medicaid or NCHC-eligible beneficiary qualifies for skilled nursing services when he or she meets the criteria listed in **Subsections 3.1** and **3.2** and all the following requirements are met.

a. The services are ordered by the beneficiary's attending physician and provided according to an approved POC.
b. The beneficiary requires medically necessary skilled nursing care that can be provided only by an RN or LPN.
c. The beneficiary requires repeated skilled nursing assessments and ongoing monitoring that can be provided on an intermittent or part-time basis.
d. Refer to **Subsection 5.3.3, Amount, Frequency, and Duration of Service,** for more details.

3.2.1.3 Specific Criteria: Specialized Therapy Services

A Medicaid or NCHC-eligible beneficiary qualifies for specialized therapy (physical therapy, occupational therapy, and speech-language therapy) assessment, evaluation, and treatment services when the criteria listed in **Subsections 3.1** and **3.2** are met.

Medical necessity for outpatient specialized therapies is defined by the policy guidelines recommended by the authoritative bodies for each discipline. Refer to **Subsection 1.1.2, Specialized Therapies,** for resources. A comprehensive explanation of outpatient specialized therapy coverage can be found in Clinical Coverage Policy 10A, *Outpatient Specialized Therapies,* (on DMA's website at http://dma.ncdhhs.gov/).

Refer to **Attachment A, Claims-Related Information,** for billing information on home health–provided specialized therapies.

3.2.1.4 Specific Criteria: Home Health Aide Services

Home health aide services are ordered by the beneficiary's attending physician and delivered according to a POC that is established by the RN or licensed therapist and authorized by the attending physician. Home Health Aide services can be provided without other skilled services being ordered, but will require skilled nursing supervision. An eligible Medicaid beneficiary qualifies for home health aide services when the criteria listed in **Subsections 3.1** and **3.2** are met and all of the following requirements apply.

a. The beneficiary requires help with personal care, ADLs, or other non-skilled health care as designated in the POC.
b. The service is provided under the professional supervision of an RN or licensed therapist in accordance with 21 NCAC 36.0401 and 42 CFR 484.80.
c. The tasks performed by the home health aide are those specified in the POC. The tasks must be within the scope of home care licensure rules as set forth by 10A NCAC 13J.

3.2.1.5 Specific Criteria: Medical Supplies

Medical supplies are covered when they are:

a. ordered by a physician, physician assistant, or nurse practitioner;

b. documented in the beneficiary's POC;
c. medically necessary as part of the beneficiary's home health services, and reasonable for treatment of a beneficiary's illness or injury;
d. for a therapeutic or diagnostic purpose for a specific beneficiary and are not convenience or comfort items which are defined as items often used by persons who are not ill or injured, such as soaps, shampoos, lotions and skin conditioners, and pantiliners or pads;
e. specifically ordered by the physician and included in the POC. The physician's order in itself does not make an item "medically necessary" for the purposes of Medicaid or NCHC coverage. The order authorizes the agency to provide the item, but the agency should bill Medicaid or NCHC for the item only if it meets Medicaid or NCHC criteria;
f. not items routinely furnished as part of beneficiary care (minor medical and surgical supplies routinely used in beneficiary care, such as alcohol wipes, applicators, lubricants, lemon-glycerin mouth swabs, thermometers, nonsterile gloves, and thermometer covers). These items are considered part of an agency's overhead costs and cannot be billed and reimbursed as separate items;
g. items that Medicaid or NCHC considers to be a home health medical supply item. Items such as drugs and biologicals, medical equipment (i.e. Blood pressure cuffs, glucometers, etc.), orthotics and prosthetics, and nutritional supplements are examples of items not considered home health medical supplies;
h. assessed for need and appropriateness every 60 calendar days. When incontinence supplies are being provided and the only service being rendered is physical or occupational therapy, the assessment for incontinence supplies may be conducted by the therapist.;
i. items needed in the provision of physical therapy, occupational therapy, speech language therapy, skilled nursing, or home health aide services are covered under the home health policy. Medical supplies not needed in the provision of these other home health services, are available for consideration under Medical Equipment Clinical Coverage Policies; and
j. documented by the agency and the documentation supports the medical necessity and quantity of supplies for the beneficiary's need.

Note: Nonsterile gloves for agency staff use are considered an overhead cost to the agency and cannot be billed for Medicaid or NCHC reimbursement. Gloves for use by the beneficiary or caregiver can be billed but must meet medical necessity criteria to be covered. There must be a need for immediate contact with the beneficiary's bodily fluids or infectious waste to meet this criterion. Incontinence supplies for children under age 3 are considered age appropriate and not medically necessary and are, therefore, not covered.

Note: The Home Health Services Fee Schedule is a list of national HCPCS codes, as mandated under the Health Insurance Portability and Accountability Act (HIPAA) that can be found on DMA's Website at http://dma.ncdhhs.gov. Periodic updates are made to the fee schedule to accommodate coding changes made by CMS.

3.2.1.6 Medical Supply Items Not Listed on the Fee Schedule

In compliance with the CMS Home Health Final Rule Title 42, §440.70, items not listed on the home health fee schedule may be considered for coverage if requested by a provider, or a beneficiary through a provider, and submitted for prior authorization (PA) review of medical necessity. Non-listed items may be requested in accordance with the circumstances detailed below in section B:

For beneficiaries under age 21, please request an "EPSDT review" using NCTracks. Refer to section **2.2 Special Provisions** for more information about EPSDT. For beneficiaries aged 21 and older, please submit the request directly to the Division of Medical Assistance (DMA) per the procedure detailed in **Attachment B**.

a. Miscellaneous Supply Procedure Code
Every effort is made to include on the fee schedule the items that are medically necessary and reasonable to treat the illnesses, diseases, and injuries common to the Medicaid or NCHC home care population. Items that are medically necessary for treatment but not included on the fee schedule may be billed and reimbursed with the miscellaneous supply procedure code. The supply must meet Medicaid's and NCHC's coverage criteria.

When considering the use of the miscellaneous supply procedure code, do the following.

1. Determine whether the item is classified as a home health medical supply. Medical supplies are defined as consumable non-durable supplies that:
   A are usually disposable in nature;
   B cannot withstand repeated use by more than one beneficiary;
   C are primarily and customarily used to serve a medical purpose;
   D are not useful to a beneficiary in the absence of illness or injury; or
   E are ordered or prescribed by a physician.
2. Determine whether the item meets the medical necessity criteria outlined in Subsection 3.6.1.
3. Document the medical reason for using this item instead of one listed on the fee schedule. Retain this information in the beneficiary's medical records.

b. Use of the Miscellaneous Supply Procedure Code

Items not listed on the fee schedule, may be requested by the provider or the beneficiary via their service provider using the process outlined in Attachment B for the following circumstances:

1. The maximum miscellaneous billing limit of $250 is the total for using the code without prior approval per beneficiary per year.
2. Prior approval is required for miscellaneous supply billing, greater than $250 for a maximum of $1500 per beneficiary per year. Prior approval must be submitted to DMA for a manual review, as referenced in **Attachment B.**
3. A request for a HCPCS Code may be submitted to DMA by the provider or the beneficiary via their service provider, if the medical supply item would be used continuously but is not listed on the fee schedule, for information on requesting a HCPCS code addition, refer to **Attachment C: Request for HCPCS Code Addition.**

Note: For information related to manual pricing calculations, please see Update to Manual Pricing Calculation for Prior Approval and Claims Processing at https://dma.ncdhhs.gov/providers/programs-services/medical/durable-medical-equipment.

3.2.2 Medicaid Additional Criteria Covered

None Apply.

3.2.3 NCHC Additional Criteria Covered

None Apply.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0;**
b. the beneficiary does not meet the criteria listed in **Section 3.0;**
c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

Medicaid and NCHC shall not cover the following home health services:

a. Any services that were not ordered by a physician and included on the authorized POC or verbal order.

b. Medical supply items routinely furnished as part of beneficiary care, such as alcohol wipes, applicators, lubricants, mouth swabs, nonsterile gloves, or thermometers.
c. Medical supplies considered convenience or comfort items which are defined as items often used by persons who are not ill or injured, such as soaps, shampoos, lotions and skin conditioners, and pantiliners or pantiliners.
d. Any services when there is no evidence that the Home Health services are the most appropriate. (refer to **Subsection 3.2**).
e. Provision of any service without documentation (in clinical or progress notes) to support that the service was provided in accordance with policy guidelines. All documentation must be signed and dated in accordance with accepted professional standards. The service provision must be supported by the POC.
f. Any services related to the terminal illness when the beneficiary has elected Medicare or Medicaid hospice benefits (home health services may be provided when they are unrelated to the terminal illness).

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

4.2.3 NCHC Additional Criteria Not Covered

NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:

1. No services for long-term care.
2. No nonemergency medical transportation.
3. No EPSDT.
4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

5.1 Prior Approval

Prior approval for home health services is required for the following:

a. Beneficiaries with Medicaid for Pregnant Women coverage. Submit prior approval requests to the NC DMA, on a Request for Prior Approval form (372-118), along with the documents to support necessity for services related to pregnancy or due to complications of pregnancy.
b. Refer to Clinical Coverage Policy 10A, *Outpatient Specialized Therapies*, (on DMA's website at http://dma.ncdhhs.gov/) for specific instructions.
c. Miscellaneous Therapeutic Items and Supplies: Supply Procedure Code. Refer to **Attachment A: Code(s)** for prior approval and limit specifications. Submit prior

approval requests via the secure NC Tracks Provider portal. PA requests cannot be submitted by paper via fax, email, postal service, or by phone.

Note: Prior approval is granted based on medical necessity only. It does not guarantee payment or ensure beneficiary eligibility on the date of service. All service requirements must be met for the provider to receive payment.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

a. the prior approval request; and
b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.

5.2.2 Specific

Medical supplies, appliances, and equipment not listed on the fee schedule may be considered for coverage, if submitted for prior authorization (PA) review of medical necessity. For beneficiaries aged 21 and older, please follow the procedure detailed in Attachment B and posted on the Home Health Services webpage at https://dma.ncdhhs.gov/providers/programs-services/long-term-care/home-health-services.

5.3 Limitations or Requirements

5.3.1 Physician's Orders and Documenting the Plan of Care

An order from the attending physician's is required for all home health services as a condition for Medicaid and NCHC reimbursement. The physician shall certify in writing that Home Health services are the most appropriate and provide a statement supporting the certification. Refer to specific criteria in **Subsection 3.2** of this policy.

With verbal authorization from the physician, the Home Health provider (HHP) can begin services prior to receiving written orders. Verbal orders must be documented and signed by the physician according to NC Home Care Licensure rules 10A NCAC 13J within 60 calendar days.

5.3.1.1 Face to Face Encounter

The physician shall provide a written attestation statement that face-to-face contact (including the use of telemedicine), was made with the beneficiary within the last 90 days in accordance with Section 6407 of the Patient Protection and Affordable Care Act.

Note: Telehealth may be implemented in accordance with 42 CFR 440.70 and NCDMA Clinical Coverage Policy 1H, *Telemedicine and Telepsychiatry* (refer to, http://dma.ncdhhs.gov).

The attestation should be a brief narrative describing the patient's clinical condition and how the patient's condition supports the needs

for skilled services. The required contact must be with the physician or an allowed non-physician practitioner (NPP). The encounter must occur within the 90 days prior to the start of care or within the 30 days after the start of care. A copy of the statement must be kept in the beneficiary's records. home health providers shall establish internal processes to comply with the face-to-face encounter requirement mandated by the Patient Protection and Affordable Care Act for purposes of certification of eligibility for Medicaid and NCHC covered home health services.

a. Qualified Non-Physician Practitioner
   The NPP allowed to perform the face to face encounter must be one of the following, as defined by the Social Security Act and accepted by Medicaid and NCHC:
   1. a nurse practitioner or clinical nurse specialist as defined in section 1861(aa) (5) of the Social Security Act, who is working in collaboration with a physician in accordance with state law;
   2. a certified nurse mid-wife as defined in section 1861(gg) of the Social Security Act; or
   3. a physician's assistant as defined in section 1861(aa) (5) of the Social Security Act, working under the supervision of a physician.

b. Documenting the Face to Face Encounter
   Must include the following:
   1. the date of the face to face encounter with the physician or the appropriate non-physician practitioner (NPP);
   2. a brief narrative composed by the certifying physician who describes how the patient's clinical condition as seen during that encounter supports the patient's need for skilled services

   If the certifying physician or NPP has not seen the beneficiary within 90 calendar days of the start of care, a face to face encounter is required within 30 calendar days after the start of services.

5.3.1.2 Documenting the Plan of Care

The physician shall authorize a POC by signing a completed Form CMS-485 submitted by the Home Health provider. The POC must be re-certified every 60 calendar days if the services continue to be medically necessary.

Home Health Agencies shall provide beneficiaries with a generalized version of the POC. This copy must include service types, frequencies, and tasks that will be provided to the individual receiving the service. The legal signature may be handwritten or electronic (faxed copy) and shall comply with Division of Health Service Regulation (DHSR) and CMS regulations. The ordering physician is responsible for the authenticity of the signature.

Note: The use of a signature stamp is not acceptable.

5.3.1.3 Developing the Plan of Care

The POC is developed by the home health nurse or therapist in collaboration with the physician and according to home care licensure rules and federal conditions of participation 42 CFR 484.60. The documentation must indicate that all ordered services are medically necessary.

5.3.1.4 Components of the Plan of Care

The POC must include the following in accordance with 42 CFR 484.60:

a. All pertinent diagnoses, including the beneficiary's mental, psychosocial, and cognitive status;
b. The type of services, supplies, and equipment ordered;
c. The frequency and duration of visits for skilled nursing, therapy, and home health aide services;
d. The beneficiary's prognosis, rehabilitation potential, functional limitations, permitted activities, nutritional requirements, medications, treatments, goals, allergies, and ~~teaching~~ requirements;
e. Safety measures to protect against injury;
f. Discharge plans;
g. A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors;
h. Patient and caregiver education and training to facilitate timely discharge;
i. Patient-specific interventions and education;
j. Measurable outcomes and goals identified by the HHA and the patient;
k. Information related to any advanced directive; and
l. All patient care orders, including verbal orders, must include date, time, and be recorded in the plan of care.

Note: For skilled nursing or therapy services, the POC must additionally include defined goals for each therapeutic discipline; specific content, duration, and intensity of service for each therapeutic discipline; and a delineation of whether the visit is for evaluation or treatment.

5.3.1.5 Changing the Plan of Care

The physician shall authorize any change in the amount, type, or frequency of home health services provided.

a. The physician's orders may be verbal or written. Verbal orders shall be transcribed and signed by the physician in accordance with 10A NCAC 13J and 42 CFR 484.2.
b. A face to face encounter is recommended for a significant change in the beneficiary's condition.
c. Any revision to the plan of care due to a change in patient health status must be communicated to the patient, representative (if any),

caregiver, and all physicians issuing orders for the HHA plan of care.

d. Any revisions related to plans for the patient's discharge must be communicated to the patient, representative, caregiver, all physicians issuing orders for the HHA plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) in accordance with 42 CFR 484.60.

5.3.2 Location of Service

Home Health Services are covered when provided in any setting in which normal life activities take place, other than a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities; except for home health services in an intermediate care facility for Individuals with Intellectual Disabilities that are not required to be provided by the facility under subpart I of part 483 or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. Home health services cannot be limited to services furnished to beneficiaries who are homebound.

5.3.3 Amount, Frequency, and Duration of Service

Home health services are provided through visits made by the skilled nurse, specialized therapy staff or a home health aide.

Medical supply items needed in the provision of physical therapy, occupational therapy, speech language therapy, skilled nursing, or home health aide services are covered under the home health policy. Medical supplies not needed in the provision of these other home health services, are available for consideration under Medical Equipment Clinical Coverage Policies.

A visit is a personal contact with a beneficiary by the employee or a contracted employee of a certified home health agency for providing home health services. A visit begins when a service is initiated and does not end until the delivery of the service is completed.

If multiple services are required and can be performed during the same visit, then all the services shall be completed in only one visit.

Skilled nursing and home health aide visits are provided on a part-time or intermittent basis. For purposes of this policy, part-time or intermittent is defined as skilled nursing or home health aide services combined to total less than 8 hours per day and 28 or fewer hours each week. Based on the need for care, on a case-by-case basis, the weekly total may be increased to up to 35 hours.

5.3.3.1 Skilled Nursing

Skilled nursing is provided under the Medicaid and NCHC programs on a per-visit basis. Skilled nursing visits are limited to the amount, frequency, and duration of service authorized by the attending

physician and documented in the beneficiary's POC. The visits must be provided on a part-time or intermittent basis.

Skilled nursing shall comply with the physician-approved POC; 10A NCAC 13J; 21 NCAC 36; and NCGS 90, Article 9.

Skilled nursing visits are limited according to the purpose of the visit. Refer to chart on **Attachment A (c)-Revenue Codes**.

Limitations on skilled nursing visits include the following:

a. Pre-filling insulin syringes/Medi-Planner visits must be limited to a maximum of every two (**2**) weeks with one (**1**) PRN visit allowed each month.
b. **75** total maximum skilled nursing visits per year per beneficiary.

5.3.3.2 Home Health Aide Services

Home health aide services are limited to the amount, frequency, and duration of service ordered by the physician and documented in the POC.

Home health aide services must be limited to 100 total visits per year per beneficiary.

5.3.3.3 Specialized Therapies

The type, amount, frequency, and duration of specialized therapy treatment visits are limited to what is ordered by the physician and documented in the POC. Specialized therapy treatment is subject to the limits and requirements and prior approval process listed in **Subsection 5.1, Prior Approval,** and in clinical coverage policy 10A, *Outpatient Specialized Therapies* (refer to http://dma.ncdhhs.gov/).

5.3.3.4 Miscellaneous Therapeutic Items and Supplies

Refer to **Attachment A: Code(s**) for miscellaneous therapeutic items and supplies.

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid or NCHC qualifications for participation in accordance with 42 CFR 409, 410, 418, 440, 484, 485, and 488;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity in accordance with 42 CFR 484.115.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

Home Health Provider (HHP) staff are required to meet the standards set forth in 42 CFR 484.115.

6.1.1 Provision of Service

Skilled nursing care must be provided by an RN or an LPN. The RN shall supervise the skilled nursing care. The services must be provided within the scope of practice, as defined by the Nurse Practice Act and Home Care Licensure Rules.

All services provided by a home health aide must be supervised by an RN or a licensed therapist. Supervisory on-site visits must be made at least once every two weeks when other skilled services are rendered in accordance with 42 CFR 484.80.

Specialized therapy services must be provided by the appropriate licensed therapist or a qualified therapy assistant under the direction and supervision of a licensed therapist.

Note: If Home Health Aide services are provided to a patient who is not receiving skilled nursing care, physical or occupational therapy, or speech language pathology services, the registered nurse must make an on-site visit to the location where the patient is receiving care no less frequently than every 60 days in accordance with the federal conditions of participation 42 CFR 484.80.

6.1.2 Home Health Aide Services

NA, I and II training, qualifications, and tasks must comply with the administrative rules for the NCBON and 42 CFR 484.80.

The aide shall be listed as either a Nurse Aide I on the NA Registry at the N.C. Department of Health and Human Services, DHSR, or as a Nurse Aide II on the NA registry and on the NCBON registry.

6.2 Provider Certifications

To qualify for enrollment as a Medicaid home health provider, the agency shall be Medicare certified and licensed by DHSR to provide home health services. All services must be provided by staff employed by or under contract to the home health provider.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and

b. All DMA's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).
c. The HHP must develop, implement, evaluate, and maintain an effective, ongoing, HHP-wide, data-driven quality assessment and performance improvement QAPI program in accordance to 42 CFR 484.65.
d. The HHP must maintain and document an infection control program which has as its goal the prevention and control of infections and communicable diseases in accordance with 42 CFR 484.70.

7.2 DMA Compliance Reviews

The Home Health Provider Organization shall:

a. Cooperate with and participate fully in all desktop and on-site quality, compliance, post-payment audits that may be conducted by DMA or its designee;
b. Meet DMA requirements for addressing identified program deficiencies, discrepancies, and quality issues through the DMA corrective action process and any overpayment recovery or sanctioning process imposed by DMA's Program Integrity Section; and
c. Maintain all clinical records and billing documentation in an accessible location in a manner that will facilitate regulatory reviews and post payment audits.

7.3 Patient Self Determination Act

The Patient Self Determination Act of 1990, Sections 4206 and 4751 of the Omnibus Budget Reconciliation Act of 1990, P.L.101-508 requires that Medicaid-certified hospitals and other health care providers and organizations, give patients information about their right to make their own health decisions, including the right to accept or refuse medical treatment. Providers shall comply with these guidelines.

7.4 Beneficiary Rights

The patient and representative (if any), have the right to be informed in advance of the patient's rights in a language and manner the individual understands. The HHP must protect and promote the exercise of these rights. The HHP must make sure the patient is informed in accordance with the federal conditions of participation (42 CFR 484.50)

7.4.1 Notice of rights

The patient has the right to participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate in accordance with 42 CFR 484.5

a. The HHP must provide the patient and the patient's legal representative (if any), the following information during the initial evaluation visit, **in advance** of furnishing care to the patient:
    1. Written notice of the patient's rights and responsibilities under this rule, an**d** the HHP's transfer and discharge policies. Written notice must be understandable to persons who have limited English proficiency and accessible to individuals with disabilities;

2. Contact information for the HHP administrator, including the administrator's name, business address, and business phone number in order to receive complaints.
3. An OASIS privacy notice to all patients for whom the OASIS data is collected.

b. Obtain the patient's or legal representative's signature confirming that he or she has received a copy of the notice of rights and responsibilities.
c. Provide verbal notice of the patient's rights and responsibilities in the individual's primary or preferred language and in a manner the individual understands, free of charge, with the use of a competent interpreter if necessary, no later than the completion of the second visit from a skilled professional as described in 42 CFR 484.75.
d. Provide written notice of the patient's rights and responsibilities under this rule and the HHP's transfer and discharge policies must also be provided to a patient selected representative within 4 business days of the initial evaluation visit.

7.5 Post-Payment Validation Reviews

Medicaid, NCHC, or agents acting on behalf of Medicaid or NCHC will perform reviews for monitoring utilization, quality, and appropriateness of all services rendered. Post-payment validation reviews will be conducted using a statistically valid random sample from paid claims. Overpayments will be determined using monthly paid claims data. Written notice of the finding(s) will be sent to the provider who is the subject of the review and will state the basis of the finding(s), the amount of the overpayment, and the provider's appeal rights. Case reviews may also show the need for an educational notification to the provider.

7.6 Coordination of Home Care Services

The home health provider is responsible for determining what other services the beneficiary is receiving and for coordinating care to ensure there is no duplication of service as outlined in 42 CFR 484.60(d). The HHP must:

a. Assure communication with all physicians involved in the plan of care.
b. Integrate orders from all physicians involved in the plan of care to assure the coordination of all services and interventions provided to the patient.
c. Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines.
d. Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities.
e. Ensure that each patient, and his or her caregiver(s) where applicable, receive ongoing education and training provided by the HHP, as appropriate, regarding the care and services identified in the plan of care. The HHP must provide training, as necessary, to ensure a timely discharge.

7.6.1 Coordination with Private Duty Nursing

Home health skilled nursing services are not covered on the same day as private duty nursing (PDN) services. The PDN nurse shall provide all of the nursing care needed in the home for the PDN beneficiary. The PDN provider shall assume the responsibility for providing medical supplies, when medical supplies are the only

home health service needed, and shall bill Medicaid and NCHC for the supplies as part of the PDN service.

Specialized therapies may be provided during the same time period that a beneficiary is receiving PDN services.

Home health aide services are not covered on the same day as PDN services.

7.6.2 Coordination with In-Home Drug Infusion Therapy

Home health skilled nursing services are not covered for the provision of drug infusion therapy when the beneficiary is receiving services from a Medicaid Home Infusion Therapy(HIT) provider. Nursing services related to the drug infusion are provided by the HIT provider and covered in the HIT per diem payment. Home health skilled nursing may be covered for medical needs not related to the provision of drug therapy. Home health services must be coordinated with other home care service providers to avoid more than one person working with the beneficiary at the same time.

Note: HIT services cannot be provided for beneficiaries receiving Medicare-covered home health nursing services. HIT services include a nursing component billed at an all-inclusive rate, which would result in a duplication of service if billed concurrently with home health nursing services.

7.6.3 Coordination with In-Home Nutrition Therapy

Home health skilled nursing care may be provided to beneficiaries who need enteral or parenteral nutrition therapy. DME suppliers and HIT providers may furnish the equipment, supplies, and formulae needed for enteral nutrition. However, only HIT providers may provide these items for parenteral nutrition.

7.6.4 Coordination with Hospice

Hospice provides all skilled nursing care related to the terminal illness. Home health agencies may provide only those services that are not related to the terminal illness.

7.6.4.1 Concurrent Care for Children

Children means Medicaid beneficiaries under 21 years of age, and NCHC beneficiaries age 6 through 18.

Hospice providers shall comply with Sections 1905(o)(1) and 2110(a)(23) of the Social Security Act, and The Patient Protection and Affordable Care Act, Section 2302.

Hospice services are available to children without requiring the waiver of any rights of the child to be provided with, or to have payment made for, services that are related to the cure or treatment of the child's condition for which a diagnosis of terminal illness has been made. Concurrent care is available to the child after the provision of hospice care.

The Patient Protection and Affordable Care Act does not change the criteria for receiving hospice services. The hospice provider shall provide all services covered under the hospice benefit. Concurrent care does not duplicate the services covered in the hospice benefit.

7.6.5 Coordination with Community Alternatives Programs

If a beneficiary is eligible under one of the Community Alternatives Programs (CAP), including CAP for Disabled Adults (CAP/DA), CAP for Children (CAP/C), CAP for Individuals with Intellectual/Developmental Disabilities (CAP- I/DD), or CAP/Choice, the home health provider shall coordinate services with the responsible CAP case manager.

CAP case managers are responsible for keeping the cost of home care services within the limits of the CAP program in which the beneficiary is enrolled.

Note: In order to receive home health services, CAP beneficiaries shall meet all home health guidelines for coverage.

7.7 Medical Record Documentation

The home health provider is responsible for maintaining all financial and medical records and documents necessary to disclose the nature and extent of services billed to Medicaid.

7.7.1 Clinical or Progress Notes

Services rendered to the beneficiary must be documented in the medical record, in the form of clinical notes or progress notes. The clinical notes or progress notes must adhere to the definitions outlined in 42 CFR 484. 110. Each entry must include the following:

a. A full description of the nature and extent of the service provided;
b. The employee's signature, initial of first name, full last name, and abbreviation of licensure (such as RN, LPN, PT, OT) or job title (NA, personal care technician (PCT), PTA).
c. The date (month/day/year) and the time the entry is made; and
d. The beneficiary’s name and identification (medical record number or history number) written or stamped on each page or report at the time it becomes a part of the medical record.
e. A copy of the completed CMS-485 or similar POC form signed and dated by the physician supporting the services documented; and
f. A copy of physician written certification of face-to-face encounter.

7.7.2 Record Retention

These records must be maintained:

a. at the home health pproviders’ office responsible for providing services to the beneficiary except for financial records, which may be maintained in a central location and made available to DMA upon request; and
b. in an accessible location and in a manner that will facilitate regulatory review.
c. Clinical records must be retained for 6 years after the discharge of the patient in accordance with DHHS provider participation agreement.

Upon request, the home health agency will provide to DMA all financial and medical records and other documents for beneficiaries whose care and treatment has been billed in whole or in part to DMA.

7.7.3 Discharge or Transfer Documentation

The Home Health Provider will forward the discharge summary or the transfer summary to the primary care practitioner, other health care professional, or health care facility who will be responsible for providing care and services to the patient after discharge from the HHP in accordance with 42 CFR 484.110.

8.0 Policy Implementation and History

Original Effective Date: Month Day, Year

History:

Date	Section or Subsection Amended	Change
09/01/2005	Subsection 2.2	A special provision related to EPSDT was added.
12/01/2005	Subsection 2.2	The Web address for DMA's EDPST policy instructions was added to this section.
12/01/2006	Sections 2 through 5	A special provision related to EPSDT was added.
05/01/2007	Sections2.2, 3.0, 4.0, and 5.0	EPSDT information was revised to clarify exceptions to policy limitations for beneficiaries under 21 years of age
05/01/2007	Attachment A	Added UB-04 as an accepted claim form.
08/01/2007	Sections 3.2, 5.1, 6.0, and 6.2	Changed the name of Division of Facility Services (DFS) to Division of Health Service Regulation (DHSR).
08/01/2007	Subsection 3.6.2; Attachment D	Updated the form number and illustration of the DMA-3400 form.
08/01/2007	Subsections 5.3.2 and 7.1; Attachment B	Changed Medical Review of North Carolina (MRNC) to The Carolinas Center for Medical Excellence (CCME); updated Web site address, telephone, and fax information.
08/01/2007	Subsection 5.3.2 and Attachment B	Updated prior approval instructions to include electronic submission; added CCME URL for further instructions.
08/01/2007	Subsection 5.4.1	Added "medical supplies" to the list of items that may be provided in a private residence.
08/01/2007	Subsection 7.2.5	Deleted CAP/AIDS and added CAP/Choice.
08/01/2007	Attachment C	Clarified the requirements for a PRN skilled nursing visit.
02/01/2008	Attachment D	Updated form DMA3400 and corrected a reference to its former designation (A001).
12/01/2009	Subsection 1.2	Added sources for standards of care for outpatient specialized therapies (moved from former Att. B).
12/01/2009	Subsection 2.3	Deleted references to colors of Medicaid ID cards.

Date	Section or Subsection Amended	Change
12/01/2009	Subsection 2.5	Moved information on transfer of assets policy to this section from Section 4.2.
12/01/2009	Subsection 3.6.2, former Attachment D	Moved description of the Home Health Services Fee Schedule to the body of the policy from former Attachment D.
12/01/2009	Subsection 4.2	Deleted "any services that do not justify provision of care in the home" and its examples; added items b through h in the list.
12/01/2009	Subsection 7.3.1	Clarified requirements for coordination with private duty nursing.
12/01/2009	Former Att. B	Deleted "Home Health Outpatient Specialized Therapy Guidelines" and condensed information into body of policy.
12/01/2009	All sections and attachment(s)	Revised wording and added sections to match DMA's current standards for documentation.
05/11/2010	Attachment B	Code for Venipuncture corrected from 551 to 580
12/01/2011	Subsections 3.6.1	Added language to descriptions of non-covered supplies prompted by questions received on T1999 billing
12/01/2011	Subsection 3.6.2.a	Added information to clarify the definition of a medical supply.
12/01/2011	Section 5.0	Added Face-to-Face and MD orders
12/01/2011	Subsection 5.4.1	Added nursing visit limitation
12/01/2011	Subsection 7.2	Added Patient Self Determination Act
12/01/2011	Subsection 7.4.1	Clarified HIT and HH services
12/01/2011	Subsection 7.5.1	Changed numbering to separate clinical notes instruction from requiring a 485. Added F2F statement as requirement for record keeping
12/01/2011	Attachment A	Changed reference section to 7.5.1 to match renumbered section
07/01/2013	All sections and attachment(s)	Technical changes to merge Medicaid and NCHC current coverage into one policy.
07/01/2013	Subsection 5.5.4	Added prior approval requirements and limitations on use of T1999
07/01/2013	Subsection s 5.5.1, 5.5.2	Added limitations on nurse and nurse aide visits.
07/01/2013	All sections and attachment(s)	Replaced "recipient" with "beneficiary."
07/01/2013	All sections and attachment(s)	Replaced "residence, private residence or home" with "primary private residence."
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.

Date	Section or Subsection Amended	Change
11/15/2015	Subsection 5.1	Added: "c. T1999 Miscellaneous Supply Procedure Code. Refer to Section 5.3.3.4 for prior approval and limit specifications. Submit T1999 prior approval requests via the secure NCTracks Provider portal. T1999 PA requests cannot be submitted by paper via fax, email, postal service, or by phone."
03/01/2018	All Sections and Attachments	Technical changes to comply with Medicaid Program; Face-to-Face Requirements for Home Health Services; Policy Changes and Clarification Related to Home Health; 42CFR 440.70 - Effective Date: July 1, 2016; Implementation Date: July 1, 2017 as well as 42 CFR Parts 409, 410, 418, 440, 484, 485 and 488 – Medicare and Medicaid Program: Conditions of Participation for Home Health Agencies. All references have been verified and updated as needed. Attachment A: F. Place of Services updated. Attachment B: Skilled Nursing Services Billing Guide has been removed for consistency of policy formatting per DMA processes. Attachment B: Home Health Services Medical Supplies Prior Approval Request for Adults: Medical Supply Items Not Listed on The Fee Schedule Or Exceeding The Miscellaneous Procedure Code Limits has been added for ease of use. Attachment C: Request for a HCPCS Code Addition was updated for Ease of use.
03/13/2018	All Sections and Attachments	Policy posted with an Amended Date of March 1, 2018.

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, DMA's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

A. Claim Type

Institutional (UB-04/837I transaction)

B. International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

The revenue codes used for billing skilled visits, home health aide visits, and specialized therapies are listed in the table below.

For specialized therapies, it is essential to distinguish between therapy visits for the purpose of evaluation (or re-evaluation) and therapy visits for treatment. Document the distinction in the physician's orders and keep the documentation in the beneficiary's record. Bill with the appropriate revenue code. Refer to codes 420, 424, 430, 434, 440, and 444 in the table below. Additional information on specialized therapies can be found in Clinical Coverage Policy 10A, *Outpatient Specialized Therapies.* Refer to http://dma.ncdhhs.gov/).

Revenue Code	Use	Unit of Service
THERAPIES		
420	Physical therapy	1 visit
424	Physical therapy evaluation	1 visit
430	Occupational therapy	1 visit
434	Occupational therapy evaluation	1 visit
440	Speech-language pathology services	1 visit
444	Speech-language pathology services evaluation	1 visit

SKILLED NURSING VISITS		
550	Skilled nursing: Initial assessment/re-assessment (Initial assessment of a new patient or 60-calendar-day re-assessment)	1 visit
551	Skilled nursing: Treatment, teaching/training, observation/evaluation	1 visit
559	Skilled nursing: For a dually eligible beneficiary when the visit does not meet Medicare criteria (for example, the beneficiary is not homebound)	1 visit
580	Skilled nursing: venipuncture	1 visit
581	Skilled nursing: Pre-filling insulin syringes/Medi-Planners	1 visit
589	Supply only visit; no other skilled service provided	1 visit
HOME HEALTH AIDE		
570	Home Health Aide	1 visit

Home health medical supplies are billed using revenue code 270, along with the applicable HCPCS code for the individual supply.

Unlisted Procedure or Service
CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

HCPCS Code(s)	
T1999	Total maximum miscellaneous billing limit of $250 per patient per year without prior approval required. Prior approval required for total miscellaneous billing greater than $250. Total maximum miscellaneous billing limit of $1500 per beneficiary per year.

D. Modifiers

Not applicable

E. Billing Units

Provider(s) shall report the appropriate code(s) used, which determines the billing unit(s).

The home health agency furnishing the service shall bill for services with its individual NPI.

Providers may bill only for those services ordered by a physician and documented in the beneficiary's individual POC.

The scope, duration, and date of the service shall be documented in the clinical notes or progress notes to support the billing. (Refer to **Subsection 7.6.1 Clinical or Progress Notes** for documentation in the clinical record.)

Individual home health services shall be billed in accordance with the *NCTracks Provider Claims and Billing Assistance Guide:* https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html.

Supervisory visits are considered administrative costs and may not be billed as skilled nursing services.

A five-calendar day window is allowed for the sixty calendar day assessment visits to accommodate the scheduling of staff. This means that the 60-calendar day assessment for ongoing services or the 60-calendar day supply assessment visit may be provided within a 55 to 60 calendar day range.

The appropriate procedure code(s) used determines the billing unit(s). Each of the aforementioned billing codes has a unit of service of one (1) visit.

F. Place of Service

Services are provided in any setting in which normal life activities take place, other than a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities; or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. Home health services cannot be limited to services furnished to beneficiaries who are homebound in accordance with (42 CFR 440.70)

G. Co-payments

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at http://dma.ncdhhs.gov/.
For NCHC refer to G.S. 108A-70.21(d)

H. Reimbursement

Provider(s) shall bill their usual and customary charges.
For a schedule of rates, see: http://dma.ncdhhs.gov/

Attachment B: Home Health Services Medical Supplies Prior Approval Request For Adults: Medical Supply Items Not Listed On The Fee Schedule Or Exceeding The Miscellaneous Procedure Code Limits

Home Health Services policy 3A has been updated to comply with the Centers for Medicare & Medicaid Services (CMS) Home Health Final Rule, 42 CFR Part 440.70. Below are guidelines for providers when requesting medical necessity reviews for medical supply items not listed on the fee schedule or exceeding the miscellaneous procedure code limits for adults.

a. The general requirements and criteria set forth in clinical coverage policy 3A must be met. This includes:
    1. ordered by a physician, physician assistant, or nurse practitioner
    2. documented in the beneficiary's POC,
    3. medically necessary as part of the beneficiary's home health ~~care~~ services, and reasonable for treatment of a beneficiary's illness or injury.
    4. for a therapeutic or diagnostic purpose for a specific beneficiary and is not a convenience or comfort item (items that are often used by persons who are not ill or injured, such as soaps, shampoos, lotions and skin conditioners, and pantiliners or pads).
    5. specifically ordered by the physician and included in the POC. The physician's order in itself does not make an item "medically necessary" for the purposes of Medicaid or NCHC coverage. The order authorizes the agency to provide the item, but the agency should bill Medicaid or NCHC for the item only if it meets Medicaid or NCHC criteria.
    6. not items routinely furnished as part of beneficiary care (minor medical and surgical supplies routinely used in beneficiary care, such as alcohol wipes, applicators, lubricants, lemon-glycerin mouth swabs, thermometers, nonsterile gloves, and thermometer covers). These items are considered part of an agency's overhead costs and cannot be billed and reimbursed as separate items.
    7. items that Medicaid or NCHC considers to be a home health medical supply item. Items such as drugs and biologicals, medical equipment (i.e. Blood pressure cuffs, glucometers, etc.), orthotics and prosthetics, and nutritional supplements are examples of items not considered home health medical supplies.
    8. assessed for need and appropriateness every 60 calendar days. When incontinence supplies are being provided and the only service being rendered is physical or occupational therapy, the assessment for incontinence supplies may be conducted by the therapist.
    9. items needed in the provision of physical therapy, occupational therapy, speech language therapy, skilled nursing, or home health aide services covered under the home health policy. Medical supplies not needed in the provision of these other home health services, are available for consideration under Medical Equipment Clinical Coverage Policies.
    10. documented by the agency and the documentation supports the medical necessity and quantity of supplies for the beneficiary's need.
b. If the provider determines that the applicable requirements and criteria set forth in the related Home Health clinical coverage policy (3A), have been met, then the provider may submit a completed Certificate of Medical Necessity/Prior Approval (CMN/PA) and the usual supportive prior authorization documentation, to the N.C. Division of Medical Assistance (DMA) for a medical necessity review.

c. The documentation should be faxed to DMA at 919-715-9025 with a cover sheet to the attention of the Home Health Services. Do not submit these requests through NCTracks.
d. If approved, the provider will be notified and given instructions for submitting claims.
e. If denied, the provider and beneficiary will be notified, and normal beneficiary appeal rights will apply.
f. Providers will be notified if the item requested is covered by a different N.C. Medicaid policy area or waiver program.

Additional Resources:
For additional information, link to the DMA Home Health Services web page, the DMA Home Health Services (3A), Clinical Coverage Policies web page, and the CMS final rule at 42 CFR Part 440.70.

Attachment C: Request for a HCPCS Code Addition

REQUEST FOR HCPCS CODE ADDITION

MEDICAID HOME HEALTH FEE SCHEDULE

North Carolina Department of Health and Human Services - Division of Medical Assistance

This request can be submitted by the provider or the beneficiary via the provider.

PROVIDER NAME/ADDRESS:	**Contact Person**	**Phone Number**
	Provider Number	**Date Submitted**
	Name of item or supply	**Manufacturer**

Provide a brief description
Procedure (CPT or HCPCS) code. (Indicate if there is no HCPCS code for the item)
Can an existing HCPCS code from the fee schedule cover this item? YES No
Explain
Did this item replace another supply previously used for the medical condition? YES No
If yes, explain reason for change (examples: Is it less expensive to use the packaged item? Is there potential to alleviate an exacerbation of the patient's condition? etc.)
Diagnostic indication(s).
Duration and frequency of use.
Proposed advantages of the new care, service, or supply.
Estimates of charges for the requested coverage (charge billed to Medicaid by your agency)
Actual cost and source
Does Medicare and/or another insurance company cover this? (Attach verification, if available) YES No
Extent to which the requested coverage is currently in use in North Carolina (if known)
Attach any supporting data from research studies, peer-reviewed journals, etc.

This request can be submitted by the provider or the beneficiary via the provider.

Submit completed form with attachments to Home Health Program Consultant, DMA Clinical Policy and Programs, 2501 Mail Service Center, Raleigh, NC 27699-2501

Fax number (919) 715-9025

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