The following services are covered in the Home Health program when they are provided to eligible beneficiaries in their place of residence and are ordered by a physician. All home health services must be reviewed and approved for medical necessity by the Division of Medicaid's Utilization Management and Quality Improvement Organization (UM/QIO).

- Twenty-five (25) home health visits are allowed per Medicaid fiscal year. For beneficiaries over age twenty-one the home health visits may be a combination of skilled nurse or home health aide visits. For beneficiaries under age twenty-one (21) the visits may be a combination of skilled nurse, home health aide, physical therapy (physical therapist or physical therapist assistant) and speech therapy visits. Additional visits are available for children under age 21 through the Expanded EPSDT Program when approved for medical necessity by the UM/QIO.
- Home health agencies should bill using only the following revenue codes:
  - 270 – Medical/Surgical Supplies and Devices
  - 421 – Physical Therapy (beneficiaries under age 21)
  - 441 – Speech-Language Pathology (beneficiaries under age 21)
  - 551 – Skilled Nursing
  - 571 – Home Health Aide
- Reimbursement for the cost of medical supplies reported in the medical supplies cost center of the Medicare cost report, which are directly identifiable supplies furnished to individual patients and for which a separate charge is made, will be included in the payment for the visit. Medical supplies must be relevant to the beneficiary's home health plan of care. Medical supplies are medically necessary disposable items, primarily serving a medical purpose, having therapeutic or diagnostic characteristics enabling a patient to effectively carry out a physician's prescribed treatment for illness, injury or disease, and are appropriate for use in the patient's home. Although separate payment will not be made in addition to the visits, home health agencies must report the related charges for supplies under revenue code 270 on the UB92 claim form. Routine medical supply charges should not be reported under revenue code 270 because the costs of these items are reported in the administrative and general cost center on the Medicare cost report. DOM will not reimburse for Durable Medical Equipment (DME), orthotics or prosthetics supplied through a home health agency.

Waiver Services

Mississippi Medicaid currently operates Home and Community Based Waiver Programs. The Elderly and Disabled Waiver allows beneficiaries expanded home health services when approved for medical necessity by the waiver case manager. Beneficiaries enrolled in other waivers may receive home health services under the State Medicaid plan in accordance with policy.

Processes and services related to waiver services must be handled according to procedures set forth by the Home and Community-Based Waiver Program manual.