

Division of Medicaid	New:	Date:
State of Mississippi	Revised: X	Date: 07/01/05
Provider Policy Manual	Current:	01/01/09
Section: Home Health	Section: 40.02	
	Pages: 1	
Subject: Criteria for Coverage	Cross Reference: <u>Certification Requirements 40.05</u>	

To qualify for home health benefits under the Medicaid program, the beneficiary must be:

- (1) homebound or confined to the home **and**
- (2) under the care of a physician **and**
- (3) in need of home health services on an intermittent basis

All Certain home health services must be ~~prior authorized~~ certified through the DOM Utilization Management and Quality Improvement Organization (UM/QIO). Refer to section 40.05 in this manual for certification requirements. Procedures and criteria set forth by the UM/QIO are applicable to home health agencies and physicians and are approved by the Division of Medicaid.

~~Effective for dates of service beginning July 1, 2005,~~ Medicaid will allow twenty-five (25) home health visits per fiscal year (July 1 - June 30) for beneficiaries age 21 and over. The visits may be a combination of skilled nurse and/or home health aide. ~~if approved by the Division of Medicaid's Utilization Management and Quality Improvement Organization (UM/QIO) based on medical necessity.~~ Home health aide visits will be allowed without the requirement for skilled care by a nurse. Physical therapy (physical therapist or physical therapist assistant) and speech therapy visits will not be covered through the home health program for beneficiaries age 21 and over. Additional nurse and/or aide visits, as well as physical therapy or speech therapy home visits, are available for children under age twenty-one (21) through the Early and Periodic Diagnostic, Testing, and Screening (EPSDT) program when approved for medical necessity by the UM/QIO. This change does not apply to home visits covered through the Home and Community Based Waiver (HCBS) programs.

The beneficiary's residence shall not include a hospital, skilled nursing facility, mental or criminal Institution.

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: 07/01/08 01/01/09
Section: Home Health	Section: 40.03	
Subject: Covered Services	Pages: 1	
	Cross Reference:	
	Certification Requirements 40.05	

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 Certain 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). Refer to section 40.05 in this manual for certification requirements.

- 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 UB04 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 allow 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.

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: 07/01/05 01/01/09
Section: Home Health	Section: 40.05	
Subject: <u>Prior Authorization/Precertification Certification Requirements</u>	Pages: 2 Cross Reference:	

~~Prior authorization or precertification serves as a utilization review measure and quality assurance mechanism for the Mississippi Medicaid program. Federal regulations permit DOM to require authorization for any service where it is anticipated or known that the services could either be abused by providers or beneficiaries or could easily result in excessive, uncontrollable Medicaid costs. Certification as referred to in this policy is synonymous with prior authorization.~~

As a condition for reimbursement, DOM requires that all certain home health services be ~~prior authorized certified~~ through the Division of Medicaid's Utilization Management and Quality Improvement Organization (UM/QIO). Failure to obtain ~~prior authorization certification~~ will result in denial of payment to the providers billing for services. All procedures and criteria set forth by the UM/QIO are applicable to home health agencies and ordering physicians and are approved by the Division of Medicaid.

The designated UM/QIO will determine the medical necessity and the quality of services to be provided in the home, the appropriateness of the agency, the types of services, and the number of visits reasonably required to treat the beneficiary's condition.

~~The Beginning with visit 26, the UM/QIO will precertify certify all home health skilled nursing, speech therapy, physical therapy and home health aide services rendered for beneficiaries under age twenty-one (21) except those rendered to beneficiaries who reside in a hospice or have Medicare Parts A & B. For beneficiaries over age twenty-one (21) the UM/QIO will precertify all home health skilled nursing and home health aide services rendered excepted those rendered to beneficiaries who reside in a hospice, have Medicare Parts A & B, or are enrolled in the Elderly and Disabled Waiver Program. No certification is required for the initial 25 visits for children and adults.~~

Submitting a Certification Request

~~Precertification is required for all home health services. Certification acknowledges only the medical necessity and appropriateness of the services and does not guarantee payment.~~

Processes related to certification and recertification for home health services must be handled according to the procedures set forth by the UM/QIO provider manual for home health agencies.

Review Outcomes

The UM/QIO will issue a Notice of Review Outcome to the provider at the completion of the review process. If the criteria are met for home health, a Treatment Authorization Number (TAN) will be assigned for billing of services. If the criteria are not met or the review outcome results in less visits being approved than requested or a denial, written notification is sent to the beneficiary/ representative, home health agency and the physician.

Procedures related to certification for home health services must be handled according to the procedures set forth by the UM/QIO.

Appeals Reconsiderations

When the UM/QIO is unable to determine medical necessity, the review outcome may result in fewer visits being approved than requested or in a denial. If the beneficiary, home health agency, or physician disagrees with the determination, and wishes to ~~appeal~~, ~~the appeal must be made to the UM/QIO~~. request a reconsideration, the request must be submitted to the UM/QIO within 30 days of the date of notice.

Administrative Appeals

If a ~~denial~~ determination has been upheld through the ~~appeals-reconsideration~~ process to the UM/QIO, the beneficiary may make an administrative appeal to the Division of Medicaid. Administrative appeals shall be made available to any beneficiary who requests such a review because Medicaid services are denied, ~~terminated~~ or reduced as a result of the UM/QIO review.

The beneficiary or beneficiary's legal representative must request the appeal in writing within thirty (30) days from the date the UM/QIO mails the appropriate notice to the beneficiary of its decision regarding services. Administrative appeals cannot be made by the home health agency or physician.

Division of Medicaid	New:	Date:
State of Mississippi	Revised: X	Date: 07/01/05
Provider Policy Manual	Current:	01/01/09
Section: Home Health	Section: 40.06	
	Pages: 1	
Subject: Physician Responsibilities	Cross Reference:	

All services provided by a home health agency must be ordered by a licensed physician of medicine or osteopathy. All professional and institutional providers participating in the Medicaid program are required to maintain records that disclose services rendered and billed under the program and, upon request, to make such records available to representatives of DOM to substantiate any or all claims. These records must be retained a minimum of five (5) years to comply with all state and federal regulations and laws. The ordering physician has full responsibility for maintaining auditable records that will verify services provided by the home health agency are medically necessary. At a minimum, the records must contain the following for each beneficiary:

- Copy of the initial certification (Plan of Care/HGFA CMS-485)
- Copy of all recertifications
- Copy of any new orders, medications, or other treatment changes
- Documentation of all examinations and evaluations which clearly indicate the medical necessity for ordering home health services and ~~for recertifying~~ the need for continuation of those services
- Copy of the case conference report(s) covering all disciplines
- Copy of any lab and/or x-ray results, O2 saturations, or other diagnostic test results
- Copy of discharge summary to include all transfers and hospital stays
- Documentation of all verbal communications between the home health agency and the physician
- It is the responsibility of the home health agency to supply the ordering physician with copies of reports or records as needed for the physician office files.

Certification and Recertification Statement

The physician has a major role in determining utilization of health services furnished by providers. He/she must provide a statement of certification that shows the medical necessity for home health services, the type of services required, and the period of time home health services will be needed. This written statement must be provided to the home health agency for submissions and retained in the beneficiary's record and submitted to the Division of Medicaid's Utilization Management and Quality Improvement Organization (UM/QIO) as required for the review process in determining the need for admission to the home health program. It is mandatory that an individual requiring a level of care which would make him/her eligible for home health benefits be seen by the specializing physician or the primary care physician at least once every sixty (60) days. The physician must provide a written recertification statement stating there is a continuing need for home health services and approximately how long services will be needed. The certification and the recertification statements must be signed by the attending physician and kept in the beneficiary's record.

Division of Medicaid	New:	Date:
State of Mississippi	Revised: X	Date: 10/01/03
Provider Policy Manual	Current:	01/01/09
Section: Home Health	Section: 40.08	
	Pages: 1	
Subject: Documentation Requirements	Cross Reference:	

All professional and institutional providers participating in the Medicaid program are required to maintain records that disclose the services rendered and billed under the program and, upon request, to make such records available to representatives of DOM to substantiate any or all claims. These records should be retained a minimum of five (5) years in order to comply with all state and federal regulations and laws.

In order for DOM to fulfill its obligations to verify services provided to Medicaid beneficiaries as well as the Medicaid payment for those services, the home health agency must maintain auditable records that will substantiate the claim submitted to Medicaid. At a minimum, the records must contain the following on each beneficiary:

- Physician referral
- Appropriate identifying information
- Name of the physician
- Original signed copy of the initial certification (Plan of Care/HGFA-**CMS-485**)
- Original signed copy of all recertifications
- Original signed copy of any new orders, change in orders, medications, medical supplies, or other treatment changes
- Original copy of case conference report(s) covering all disciplines
- Original copy of all lab results, O2 saturations, other diagnostic test results
- Original copy of discharge summary to include transfers and hospital stays
- Documentation of all verbal communications between the home health agency and the physician
- Signed copy of drug, dietary, treatment and activity orders including any new changes

Providers must maintain proper and complete documentation to verify the services and medical supplies provided. The provider has full responsibility for maintaining documentation to justify the services and medical supplies provided.

DOM, the fiscal agent, Medicaid fraud control unit, state auditor, U. S. Department of Health and Human Services, Office of the Inspector General, and any of their designated representatives, have the authority to request any beneficiary records at any time to conduct a random sampling review and/or document any services billed by the home health provider.

If a home health agency's records do not substantiate services paid for under the Mississippi Medicaid program, as previously noted, the agency will be asked to refund to the Mississippi Medicaid program any money received for such non-substantiated services. If a refund is not received within sixty (60) days, a sum equal to the amount paid for such services will be deducted from any future payments that are deemed to be due the provider.

A home health provider who knowingly or willfully makes, or causes to be made, false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under federal and state laws. A false attestation can result in civil monetary penalties as well as fines, and may automatically disqualify the home health provider as a provider of Medicaid services.

Division of Medicaid	New:	Date:
State of Mississippi	Revised: X	Date: 07/01/05
Provider Policy Manual	Current:	01/01/09
Section: Home Health	Section: 40.09	
	Pages: 1-2	
Subject: Home Health Services Provided in Another State	Cross Reference: Certification Requirements 40.05	

Based on 42 CFR 431.52, Mississippi Medicaid is required to pay for services furnished in another state to the same extent that it would pay for services furnished within the boundaries of Mississippi if the services are furnished to a beneficiary who is a resident of this state, and any of the following conditions is met:

- (1) Medical services are needed because of a medical emergency;
- (2) Medical services are needed and the beneficiary's health would be endangered if he were required to travel to his state of residence.
- (3) The State determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;
- (4) It is general practice for beneficiaries in a particular locality to use resources in another state.

Home health agencies in other states may be issued temporary provider numbers for specific dates of services, for certain types of beneficiaries if the provider meets all home health agency requirements.

In conjunction with 42 CFR 431.52, DOM applies the following guidelines when a request for an out of state home health agency provider number is received:

- If the beneficiary has been a resident for more than thirty (30) days, in the state where the home health agency operates, the beneficiary would be considered a resident of that state and Mississippi Medicaid would not reimburse for services provided, **OR**
- If the beneficiary has not been a resident for more than thirty (30) days, in the state where the home health agency operates, Mississippi Medicaid would reimburse for services in accordance with the requirements stated in 42 CFR 431.52.

If the home health agency is determined eligible for a temporary number, the provider must complete a provider enrollment packet and meet all home health agency requirements. The provider enrollment packet can be obtained by contacting the Bureau of Reimbursement [downloaded at https://msmedicaid.acs-inc.com/msenvision](https://msmedicaid.acs-inc.com/msenvision); click on provider, provider enrollment then [download enrollment package or request an application by calling ACS Provider Enrollment at 1-800-884-3222](https://msmedicaid.acs-inc.com/msenvision). The completed enrollment packet, claims for dates of services, verification in writing of the agency's Medicaid rates for their state, and other required information must be mailed to:

DIVISION OF MEDICAID
Bureau of Reimbursement
Robert E. Lee Building, Suite 801
239 North Lamar Street
Jackson, MS 39225-1399

Division of Medicaid
Bureau of Reimbursement
550 High Street
Jackson, MS 39201

DOM will issue a rate letter assigning a temporary provider number for specific dates of services and the rates for disciplines in question. In addition, the letter would include the effective date and close date for the temporary provider number. Rate assignment is calculated by using the lesser of the assigned rates for the requesting state or Mississippi Medicaid ceilings.

It is required that all certain home health services be ~~prior approved~~ certified by the Division of Medicaid's Utilization Management and Quality Improvement Organization (UM/QIO). Refer to section 40.05 in this manual for certification requirements. DOM will initiate a review for medical necessity and forward claims to the appropriate source.

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: 07/01/05 01/01/09
Section: Home Health	Section: 40.12	
Subject: Reimbursement	Pages: 1	Cross Reference:

Home health agencies are to be reimbursed for covered services rendered to eligible beneficiaries on the basis of the reasonable costs of providing such services. Reasonable cost is determined in accordance with the Mississippi Medicaid Home Health Reimbursement Plan and with Title XVIII (Medicare) principles of reimbursement except when Medicare guidelines are contradictory to directives of the State Plan or DOM. In such a situation, the State Plan or DOM will prevail.

Medicaid cost reporting schedules must be included with the Medicare cost report to compute Medicaid reimbursement. These schedules are very similar in format to those used for Medicare reimbursement purposes. The various alternative methods of computing reimbursement have been provided for so that there will be consistency between Medicare and Medicaid.

A schedule must also be completed to reflect the lower of reasonable costs or customary charge provisions as they apply to Medicaid. The Medicaid schedule has the same format as the Medicare schedule. If the limitation is applicable, it must be carried to the appropriate Medicaid reimbursement schedule.

In addition to the lower of costs or charge limitations, reimbursement for home health services is limited to and cannot exceed the prevailing costs of providing nursing facility services in the Mississippi Medical Assistance (Medicaid) Program.

The criteria for reimbursement for the initial assessment visits and supervisory visits is listed below:

Assessment Visit For Skilled Services Only (HHSK, HHPT, and/or HHST):

1. If a beneficiary is assessed for skilled services (HHSK, HHPT, and/or HHST) without a skilled service being performed during the initial visit (assessment) and is not admitted to the home health program, the initial visit (assessment) is not approved and can be claimed as an administrative cost.
2. If a beneficiary is assessed for skilled services (HHSK, HHPT, and/or HHST) with a skilled service being performed during the initial visit (assessment) and is admitted to the home health program for continuation of skilled visits, the initial visit (assessment) is not an administrative cost and the visit should be certified with UM/QIO and can be billed on a home health claim.
3. ~~A. If a beneficiary is assessed for skilled services (HHSK, HHPT, and/or HHST) with a skilled service being performed during the initial visit (assessment) only, the agency may elect to claim this as an administrative cost without certifying the visit with UM/QIO,~~
~~OR the agency may elect the follow option:~~
~~B. If a beneficiary is assessed for skilled services (HHSK, HHPT, and/or HHST) and a skilled service is performed during the initial visit (assessment) only, the agency may elect to admit and discharge the beneficiary in the home health program for this one (1) visit. This is not an administrative cost and must be certified with the Division of Medicaid's Utilization Management and Quality Improvement Organization (UM/QIO).~~

3. If a beneficiary is assessed for skilled services (HHSK, HHPT, and/or HHST) with a skilled service being performed during the initial visit (assessment) only, the agency may:

A. elect to claim this as an administrative cost

or

B. elect to admit and discharge the beneficiary in the home health program for this one (1) visit. This is not an administrative cost and can be billed on a home health claim.

NOTE: THE AGENCY MAY ELECT 3A OR 3B, BUT NOT BOTH.

Assessment Visit For Skilled Services (HHSK, HHPT, or HHST) and Aide (HHAD):

Same as above.

Assessment Visit For Aide Services Only (HHAD):

1. If a beneficiary is assessed for aide services only without a skilled service being performed during the initial visit (assessment) and not admitted to the home health program, the initial visit (assessment) is not approved and can be claimed as an administrative cost.

2. ~~A. If a beneficiary is assessed for aide services only and is admitted to the home health program and a skilled service is performed during the initial visit (assessment), the agency may elect to claim the assessment as an administrative cost without certifying the visit with UM/QIO.~~

~~OR, the agency may elect the following option:~~

~~B. If a beneficiary is assessed for aide services only and is admitted to the home health program and a skilled service is performed during the initial visit (assessment), the agency may elect to certify the assessment visit with UM/QIO as a skilled service.~~

2. If the beneficiary is assessed for aide services only and is admitted to the home health program and a skilled service is performed during the initial visit (assessment), the agency may:

A. elect to claim the assessment as an administrative cost

Or

B. elect to bill the assessment visit as a skilled service.

NOTE: THE AGENCY MAY ELECT 2A OR 2B, BUT NOT BOTH.

Initial assessment visits must be performed by a registered nurse. Criteria for claiming the initial assessment visit for either (1) administrative costs, or (2) a skilled visit is stated above.

In addition, if the beneficiary is receiving aide services only, a supervisory visit must be made every 60 days by a registered nurse. In order to ensure that the aide is properly caring for the patient, the supervisory visit must occur while the home health aide is providing patient care.

Supervisory visits are administrative costs and are not directly reimbursable.

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: 04/01/08 01/01/09
Section: Home Health	Section: 40.13	
Subject: Dual Eligibles	Pages: 1	Cross Reference: <u>Medicaid Cost Sharing for Medicare/Medicaid Dually Eligibles 2.05</u>

Medicare is the primary payor for dually eligible recipients, beneficiaries, and providers are obligated to comply with the requirements covering the coordination between the two programs. Persons eligible for Medicare and Medicaid are entitled to all services available under both programs, but a claim must be filed with Medicare if Medicare covers the services. A patient may not receive home visits under both programs simultaneously. For information on "Medicaid Cost Sharing for Medicare/Medicaid Dually Eligibles" for Medicare Part A crossover claims, refer to Provider Policy Manual Section 2.05.

If Medicare does not cover nurse visits, physical therapy visits, or speech therapy visits because skilled services are not being provided, Mississippi Medicaid will not cover the services.

If Medicare does not cover aide visits because a skilled service is not being provided, Mississippi Medicaid will cover medically necessary aide visits. the provider may request certification for the aide visits through the Division of Medicaid's Utilization Management and Quality Improvement Organization (UM/QIO). If approved by the UM/QIO, the provider may bill Mississippi Medicaid for the aide visit. The only justification for billing Medicaid for aide visits on a dual eligible beneficiary is that (1) the beneficiary does not qualify for a Medicare skilled service, and (2) the provider has obtained certification for the visit through the UM/QIO.

Twenty-five home health visits per fiscal year limit is applicable for beneficiaries age 21 and over. For beneficiaries under age 21, the UM/QIO may approve medically necessary visits beyond the limit of twenty-five (25).