

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Effective Date: 12/01/10
Section: Home Health	Section: 40.02	
Subject: Criteria for Coverage	Pages: 1 Cross Reference: Certification Requirements 40.05	

Medicaid reimburses home health services for beneficiaries who are under the care of an attending physician and the services are prescribed by the beneficiary's attending physician. The attending physician's order is part of a written plan of care that the physician reviews and recertifies every 60 days.

The following criteria must be satisfied for a beneficiary to be eligible for benefits for home health agency services for nursing care, aide, physical therapy or speech therapy on an intermittent basis:

There is documentation in the beneficiary's medical record which justifies that the services are medically necessary and reasonable for the treatment of the beneficiary's illness, injury, or condition.

Beneficiary's medical condition, illness, or injury requires services that must be delivered at the place of residence rather than an office, clinic, or other outpatient facility because:

- a) There is reasonable expectation that the beneficiary's medical condition, illness or injury poses a serious and significant impediment to receiving intermittent, medically necessary services outside the home setting at the frequency and duration ordered by the physician; or
- b) Leaving home is medically contraindicated and would increase the medical risk for exacerbation or deterioration of the medical condition, illness, or injury; or
- c) Due to the nature of the beneficiary's medical condition, illness or injury, going to a physician/practitioner's office, clinic, or other out-patient setting for a needed service would create a medical hardship for the beneficiary and could result in an exacerbation of the beneficiary's medical condition, illness, or injury. Any medical hardship must be supported by the totality of the beneficiary's medical record.

All absences from the home will be evaluated for the frequency and purpose of the absence and the beneficiary's medical record must accurately justify the purpose and frequency of all absences as known by the home health agency.

Place of residence for the purpose of determining home health services is wherever the beneficiary lives. This may be the beneficiary's own private home, apartment, a relative's home, or a home for the aged/boarding home. To qualify for home health benefits, the beneficiary cannot be a resident of an institution which meets the basic definition of a hospital or nursing facility.

Certain home health services must be 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.

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. 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.

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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~~

Medicaid reimburses home health services for beneficiaries who are under the care of an attending physician and the services are prescribed by the beneficiary's attending physician. The attending physician's order is part of a written plan of care that the physician reviews and recertifies every 60 days.

The following criteria must be satisfied for a beneficiary to be eligible for benefits for home health agency services for nursing care, aide, physical therapy or speech therapy on an intermittent basis:

There is documentation in the beneficiary's medical record which justifies that the services are medically necessary and reasonable for the treatment of the beneficiary's illness, injury, or condition.

Beneficiary's medical condition, illness, or injury requires services that must be delivered at the place of residence rather than an office, clinic, or other outpatient facility because:

- d) There is reasonable expectation that the beneficiary's medical condition, illness or injury poses a serious and significant impediment to receiving intermittent, medically necessary services outside the home setting at the frequency and duration ordered by the physician; or
- e) Leaving home is medically contraindicated and would increase the medical risk for exacerbation or deterioration of the medical condition, illness, or injury; or
- f) Due to the nature of the beneficiary's medical condition, illness or injury, going to a physician/practitioner's office, clinic, or other out-patient setting for a needed service would create a medical hardship for the beneficiary and could result in an exacerbation of the beneficiary's medical condition, illness, or injury. Any medical hardship must be supported by the totality of the beneficiary's medical record.

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