Title 23: Division of Medicaid

Part 215: Home Health Services

Part 215 Chapter 1: Home Health Services

Rule 1.3: Covered Services

A. The Division of Medicaid covers the following home health services:

1. Skilled nursing visits.

a) Intermittent or part-time skilled nursing services must be provided during the visit by a registered nurse (RN) or a licensed practical nurse (LPN) under the supervision of a RN employed by a home health agency in accordance with Mississippi State Department of Health, Division of Health Facilities Licensure and Certification (MSDH-DHFLC) standards or an RN when no home health agency exists in the area.

b) The RN must be a graduate of an approved school of professional nursing, who is licensed as an RN by the State in which they practice.

2. Home health aide visits for home health aide services.

a) Home health aide services must be provided directly by an aide employed by a home health agency and in accordance with MSDH-DHFLC standards.

b) The home health aide must be an individual who has successfully completed a state-established or other home health aide training program approved by the MSDH-DHFLC.

c) A supervisory visit must be made every sixty (60) days by an RN.

d) Home health aide services may be provided without the requirement of receiving skilled nursing services.

3. Durable medical equipment, medical supplies and appliances as described in Miss. Admin. Code Title 23, Part 209.

B. The Division of Medicaid covers up to thirty-six (36) home health visits per state fiscal year.

C. Home health services must be medically necessary and reasonable for the treatment of the beneficiary's disability, illness, or injury.

D. To receive home health services a beneficiary must:

1. Be unable to travel to an outpatient setting for the needed services, or

2. Have a condition that is so fragile or unstable that the beneficiary cannot receive the services in an outpatient setting, and

3. Be seen by a physician or allowed non-physician practitioner (NPP) at least every sixty (60) days for the purpose of recertification of home health services.

E. Home health services must be provided to a beneficiary at the beneficiary's place of residence defined as any setting in which normal life activities take place, other than:

1. A hospital,

2. Nursing facility,

3. Intermediate care facility for individuals with intellectual disabilities except when the facility is not required to provide the home health service, or

4. Any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

F. The beneficiary's physician or allowed NPP, must document that a face-to-face encounter occurred no more than ninety (90) days before or thirty (30) days after the start of home health services. The face-to-face encounter must be related to the primary reason the beneficiary requires the home health service.

G. Home health services must be provided in accordance with an order written by a physician, nurse practitioner, or physician assistant working in accordance with State law as part of a written plan of care, which must be reviewed every sixty (60) days.

H. Recertification must occur at the time the plan of care is reviewed, and must be signed and dated by the physician or allowed NPP who reviews the plan of care.

I. The home health agency providing home health services must be certified to participate as a home health agency under Medicare, and comply with all applicable state and federal laws and requirements.

J. Home health services are covered for beneficiaries eligible for both Medicare and Medicaid if:

1. The beneficiary is not receiving and does not qualify for home health services covered under Medicare,

2. The beneficiary is eligible for home health services provided by Medicaid,

3. The home health services are medically necessary, and

4. All requirements of Miss. Admin. Code Title 23, Part 215 are met.

K. The Division of Medicaid covers home health services furnished to a beneficiary in another state to the same extent that home health services are covered in-state if:

1. Home health services are needed because of a medical emergency,

2. It would cause the beneficiary's condition to decline if they were required to return to Mississippi in order to receive necessary home health services,

3. The Division of Medicaid determines, on the basis of medical advice, the medically necessary home health 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, or

5. The beneficiary has not been a resident for more than thirty (30) days in the state where the home health agency operates.

L. The Division of Medicaid requires the following guidelines for an out of state home health agency:

1. 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 the Mississippi Division of Medicaid would not reimburse for services provided, or

2. If the beneficiary has not been a resident for more than thirty (30) days in the state where the home health agency operates, the Mississippi Division of Medicaid would reimburse for services.

M. Out-of-state providers are required to request a provider number and meet all home health agency requirements.

Source: 42 C.F.R. § 440.70; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with MS SPA 24-0006 (eff. 07/01/2024) eff. 11/01/2024; Revised eff. 07/01/2021; Revised eff. 07/01/2019.