

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Healthy Connections  
MEDICAID



# HOME HEALTH SERVICES PROVIDER MANUAL

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South Carolina Department of Health and Human Services

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# 1

## PROGRAM OVERVIEW

The Medicaid Home Health program is administered in South Carolina by the South Carolina Department of Health and Human Services (SCDHHS). All home health agencies must contract with the SCDHHS prior to providing home health services to eligible Medicaid beneficiaries.

A Home Health Agency (HHA) is a public agency or private organization or a part of an agency or organization that is primarily engaged in providing nursing services, aide services, supplies, and other therapeutic services. The function of a HHA does not include care provided primarily for treatment of mental diseases.

Home health services are those services provided by a HHA or individual provider to eligible beneficiaries who are affected by illness or disability. Home health services are based on physician's orders and services are rendered by a health care professional.

A visit is a face-to-face encounter between a patient and any qualified home health professional whose services are reimbursed under the Medicaid program. When care is provided, the service a patient receives is counted in visits. For example, if a patient receives one home health service twice in the same day or two different types of home health services in the same day, two visits would be counted.

**NOTE:** References to supporting documents and information are included throughout the manual. This information is found at the following locations:

- [Provider Administrative and Billing Manual](#)
- [Forms](#)
- [Section 4 - Procedure Codes](#)

# 2

## ELIGIBLE PROVIDERS

### PROVIDER QUALIFICATIONS

A HHA must provide skilled nursing services, home health aide services, and at least one of the following optional professional services: physical, speech, or occupational therapy. In areas where it is not possible or feasible to obtain professional services on a salaried basis or through the staff of the agency, these services are arranged on an as-needed basis through the use of an individual or agency contract or agreement.

The agency must have policies established by a group of professional personnel, including one or more physicians and one or more registered professional nurses, to govern the services that it provides. Supervision of such services by a physician or registered professional nurse is required.

### LICENSURE AND CERTIFICATION

The HHA must be certified to participate under Title XVIII (Medicare), meet the conditions governing participation as certified by the South Carolina Department of Health and Environmental Control (SCDHEC), and have an approved Certificate of Need (CON). The HHA must also be in compliance with all federal, state, and local laws.

The HHA that provides Pediatric Home Health must obtain Community Health Accreditation Program (CHAP) accreditation in core services and private duty nursing services, meet the conditions governing participation as certified by the SCDHEC, and have an approved Pediatric Home Health CON. The HHA must also be in compliance with all federal, state and local laws.

The Centers for Medicare & Medicaid Services (CMS) grant deemed status to the CHAP for the purpose of certification for home health services. SCDHHS recognizes this accreditation as certification for Medicaid- only providers of Pediatric Home Health Services.

Any changes in licensure, certification or ownership must be immediately reported to:

Department of Health and Human Services  
Division of Contracts  
Post Office Box 8206  
Columbia, SC 29202-8206

### Enrollment

All HHAs must complete an online provider enrollment application and agreement form to participate in the South Carolina Medicaid program. This process is described in detail in Section 1,

“Requirements for Provider Participation.”

The enrollment process includes screening, licensure verification and site visits (if applicable), to ensure that all enrolling providers are in good standing and meet the requirements for which they are seeking enrollment. Refer to <http://provider.scdhhs.gov> for the eligible provider listing of South Carolina Medicaid provider types and specialties.

Once the provider has been approved for Medicaid enrollment, official notification of enrollment will be sent to the provider.

SCDHHS will utilize Medicare certification site visits conducted by Palmetto GBA for HHA compliance with provider enrollment and screening.

## FINGERPRINT-BASED CRIMINAL BACKGROUND CHECKS

Certain types of health care providers are considered “high risk” and are required to submit to fingerprint-based criminal background checks (FCBC). High risk providers are defined as a provider or a person with 5 percent or more direct or indirect ownership interest in the provider. Failure to comply with the fingerprinting requirement will lead to termination from the Medicaid program. Providers who are also enrolled as a high-risk provider with Medicare and comply with Medicare’s FCBC requirements will be deemed in compliance with the Healthy Connections Medicaid requirements. Both newly enrolling and revalidating high-risk providers will be required to meet the FCBC requirements during the initial enrollment and revalidation processes.

### **Reimbursement**

SCDHHS will reimburse the home health provider for services agreed to in the contract, according to the interim rates provided by the Department of Ancillary Reimbursements, Bureau of Reimbursement Methodology and Policy of SCDHHS. Payment will be made at a fixed rate per visit for the following services: 1. Skilled Nursing visits

2. Home health aide visits

3. Therapy visits (Physical Therapy, Speech Therapy and Occupational Therapy)

Payment for allowable medical supplies is based on reasonable cost. The cost may not exceed the amount a prudent buyer would pay for the same item and is comparable to the cost of similar items to other medical providers. Medical supplies that are used in the provision of routine home health services are initially reimbursed based on charges; however, during the fiscal year-end cost settlement, an adjustment is made reflective of the cost-to-charges ratio for medical supplies.

Based on the availability of federal and/or state matching funds, the Medicaid reimbursement methodology used to determine the interim home health rates is the lesser of allowable Medicare costs, charges or the Medicare cost limits by discipline. These interim rates are calculated based on the most recent Medicare cost report, Medicare cost limits, and charges as submitted by the

provider to the Department of Ancillary Reimbursements. Effective October 1, 2000, HHAs entering the Medicaid program for the first time will be reimbursed at the lesser of Medicare cost limits based on the per-visit limits as published in the August 5, 1999 Federal Register, charges or an interim rate established by the Medicaid State Agency until the submission of actual costs.

Each provider is required to submit to Medicaid a copy of their cost report (CMS 1728 or CMS 2552), with accompanying Medicaid data, no later than five months after the provider's financial year end. If the cost report is not submitted in a timely fashion, as stated in the contract, all funds may be withheld by SCDHHS. A desk review is done by the staff of the Department of Ancillary Reimbursements on the "As Filed" Medicare cost report and accompanying Medicaid data, and Medicaid statistics obtained from Medicaid Management Information System (MMIS). The initial cost settlement is determined based on the lesser of the allowable Medicare costs, charges or the Medicare cost limits, in the aggregate, factoring in an adjustment in accordance with Medicare cost charges ratio for medical supplies. A final settlement is made for each financial year based on the Medicare audit of the cost report. The Medicaid provider should notify the Department of Ancillary Reimbursements of the Medicare audit findings within 30 days of the receipt of the Medicare audit report, as these findings are utilized in determining the final Medicaid settlement. Final cost settlement and payment is limited to the lesser of allowable Medicare costs, Medicare cost limits or charges in the aggregate.

Questions pertaining to interim reimbursement rates, cost reports and cost settlements should be directed to the Department of Ancillary Reimbursements, SCDHHS.

# 3

## COVERED SERVICES AND DEFINITIONS

### Homebound Criteria

Medicaid home health services cannot be restricted to a requirement that the individual be homebound or otherwise be restricted to services furnished in the home. A Medicaid home health beneficiary can receive home health services in the beneficiary's place of residence, a doctor's office, an outpatient clinic, an adult day center or in another type of outpatient facility. Home Health services cannot be provided in a hospital, nursing facility, 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. Medicare remains the primary payer for dually eligible beneficiaries, and providers will remain obligated to comply with the homebound requirements set forth by Medicare.

### Nursing Services

According to 42 CFR 440.70, nursing services must be provided on a part-time or intermittent basis. The South Carolina Medicaid program adopts the policy of intermittency as followed by the Medicare (Title XVII) intermediary. Services that medically meet the patient's need with a single visit are no longer covered for payment.

Reimbursement will not be made for nurses assisting with activities of daily living when a home health aide could perform such services. Supervisory visits are non-billable. According to 42 CFR 484.36(2), federal law requires that, in cases where a patient is receiving home health aide services, the registered nurse, or appropriate professional staff member if other services are provided, make a supervisory visit to the patient at least every two weeks.

Nursing services are further defined for those dually eligible (Medicare/Medicaid) patients who still require nursing care, but are denied Medicare coverage because their condition has stabilized. For such patients, nursing services can only be performed by a licensed nurse, must be prescribed by the attending physician and must be included in the plan of care. The beneficiary's chart documenting nursing visits for a stabilized patient must reflect all of the following:

1. Reason for the visit and documentation of when skilled care changed to nursing visits for a stabilized patient
2. Medical condition and diagnosis
3. Last date of physician visit

#### 4. Other disciplines of care currently rendered

South Carolina Medicaid provides coverage for nursing services, nurse aide services and medical supplies for dually eligible clients whose conditions have stabilized and who are no longer Medicare eligible.

Psychiatric Skilled Nursing is not a covered Medicaid home health service.

#### **Pediatric Home Health**

Pediatric Home Health is provided by HHAs that specialize in providing intermittent skilled nursing care to children ages 0 to 18. Only one Pediatric HHA per South Carolina county is issued a certificate of need. Only providers who are enrolled to provide Pediatric Home Health services may bill for this service. A Pediatric Home Health visit must be made in response to a referral from a physician. A HHA providing Pediatric Home Health must provide skilled nursing services, home health aide services and at least one of the following optional professional services: physical, speech or occupational therapy.

In addition to the requirements in the Nursing Services section above, Pediatric Home Health nursing visits must be provided by a registered nurse who meets one of the following three criteria:

- Pediatric experience including a minimum of six months of experience in a hospital or clinic in the last two years.
- Completion of a community/public health course from an accredited School of Nursing.
- All of the following: Completion of a comprehensive pediatric assessment course followed by a satisfactory demonstration of pediatric assessment skills. In-service review of the postpartum assessment given by a qualified medical doctor or nurse practitioner with experience in this area. A minimum of six months' experience in a Community or Public Health field with documented experience in performing environmental assessments.

The full assessment by the registered nurse is not allowed to be delegated.

The reimbursement rate for Pediatric Home Health nursing care, T1030, has been established at the same rate reimbursed for a skilled nursing home health visit. This rate was chosen due to the comparability of resources used and services provided.

Two Pediatric Home Health nursing visits, medically justified, for the same date of service shall be allowed under procedure code T1030 with a modifier 76 (repeat procedure or service by same physician or other qualified health care professional). Modifier 76 shall be recorded for the second visit only, and reflected on the CMS-1500 Form, Item 24.C



### **Nursing and Dually Eligible Beneficiaries**

Medicare remains the primary payer for dually eligible beneficiaries, and providers will remain obligated to comply with the requirements covering the coordination of benefits between the two programs. Agencies should carefully assess dually eligible clients who are stabilized and whose nursing visits may exceed four per month to determine whether they should be served under Medicare rather than Medicaid.

### **Nursing/Durable Medical Equipment Evaluation**

A HHA may evaluate a patient's need for durable medical equipment (DME). This assessment should include the usefulness of the recommended equipment in the setting, consistent with the medical condition, at the lowest durable medical equipment cost and the training of the patient in the utilization of equipment. This information is communicated to the physician who issues a referral, if deemed appropriate, to the HHA. Evaluative visits may be incurred without a home health need; therefore, this benefit will characterize one visit per patient per 12-month period.

Stabilized and DME evaluation nursing visits shall be reimbursed at the respective agency's nursing care per visit cost.

**Note:** Medicaid does not cover any home health services during the same period home health benefits are being sponsored by Medicare, except as indicated above.

### **Venipuncture Services/Visits**

The South Carolina Medicaid program provides coverage for venipuncture nursing visits and associated home health aide visits, provided that such services are medically necessary.

In determining whether venipuncture by a home health provider is medically necessary in a particular case, the SCDHHS requires the following criteria to be met:

A physician must order the venipuncture

- The physician's order for the venipuncture for a laboratory test must be associated with a specific symptom or diagnosis, and the treatment must be recognized as being reasonable and necessary for such diagnosis.
- The collection of a venous specimen must be necessary for diagnosis and treatment of a patient's illness or injury, and the venipuncture cannot reasonably be performed in the course of regularly scheduled absences from the home to acquire medical treatment.
- The frequency of testing must be consistent with accepted standards of medical practice for continued monitoring of a diagnosis, medical problem, or treatment regimen. Even when the laboratory results are consistently stable, periodic venipunctures may be reasonable and necessary because of the nature of the treatment.

- The nursing visit must include skilled observation, reporting and coordination with the physician.
  - The medical necessity for venipuncture visits must be fully substantiated in each patient record.

Examples of reasonable venipunctures for stabilized patients include, but are not limited to, the following:

- Venipuncture to monitor white blood cell count and differential count every three months for patients taking Captopril when the results are stable and the patient is asymptomatic.
- Venipuncture every three months for phenytoin, digoxin, phenobarbital, lithium, Depakote and certain psychotropic drug levels when the results are stable and the patient is asymptomatic.
- Venipuncture to monitor complete blood count and other immunocompromised conditions when ordered by a physician for patients receiving chemotherapy.
- Venipuncture for fasting blood sugar (FBS) once every two to three months for a stable diabetic.
- Venipuncture on a monthly basis for prothrombin (“pro-time”) when the results are stable within the therapeutic range.
- Venipuncture to monitor white blood cell count and differential count every three months for patients taking Captopril when the results are stable and the patient is asymptomatic.
- Venipuncture every three months for phenytoin, digoxin, phenobarbital, lithium, Depakote and certain psychotropic drug levels when the results are stable and the patient is asymptomatic.
- Venipuncture to monitor complete blood count and other immunocompromised conditions when ordered by a physician for patients receiving chemotherapy.
- Venipuncture for fasting blood sugar (FBS) once every two to three months for a stable diabetic.
- Venipuncture on a monthly basis for prothrombin (“pro-time”) when the results are stable within the therapeutic range.

All options must be explored for possible Medicare coverage before billing Medicaid for this service.

Patients who receive a skilled nursing service for venipuncture may also receive aide visits under the Medicaid Home Health program if ordered.

### **Home Health Aide Services**

Home health aide services are of a personal care nature, are medically oriented and include assistance in activities of daily living and retaining self-help skills; for example, helping with bathing, helping with prescribed exercises or assisting in ambulation. Household services must be incidental and must not add appreciable time to the duration of the aide's presence. A visit by a registered nurse to supervise these home health aide services is not reimbursable.

These services must be prescribed by a physician in accordance with a plan of care and supervised by a registered nurse.

All home health aides must have completed a training and competency evaluation program in accordance with the requirements as stated in 42 CFR 484.4.

Pediatric HHAs providing home health aide services must follow the service requirements as outlined above for all HHAs.

### **Therapy Services**

All professional therapy services must be reasonable and necessary for the treatment of the patient's illness or injury to be considered for coverage. Therapies must be provided by the HHA or by a person or facility licensed by the state of South Carolina to provide medical rehabilitation services. Pediatric HHAs providing any of the therapy services must follow the service requirements as outlined below for all HHAs.

### **Therapy and Dually Eligible Beneficiaries**

Because the Medicaid program utilizes the same criteria, with the exception of the homebound requirement, as Medicare for the provision of therapies (physical, speech pathology and audiology and occupational), any therapy provided under these criteria should be billed to Medicare as the primary payer. If Medicare declines payment because the services did not meet the criteria, Medicaid will also deny payment for the same reason.

### **Physical Therapy**

Physical therapy covers those generally recognized physical therapy services prescribed by a physician and provided by a qualified therapist. A qualified therapist is a graduate of a program approved by the American Physical Therapy Association or an equivalent program. The therapist must be licensed by the state of South Carolina.

There must be an expectation that the therapy will result in a significant practical improvement in the patient's functioning within a reasonable and predictable period of time.

Types of services covered by physical therapists include:

- Diagnosis and evaluation (including range of motion levels).

- Teaching of task-oriented therapeutic activities and exercises to restore physical functioning.

Teaching patient or non-agency caregivers necessary techniques, exercises or precautions is covered to the extent that they are reasonable and necessary to treat the illness or injury.

### **Speech Pathology and Audiology Therapy**

To be considered for coverage, speech therapy services must be reasonable and necessary for the treatment of speech and language disorders that result in a communication disability. A physician must prescribe services for individuals with speech, hearing and language disorders.

These diagnostic, screening, preventive or corrective services are covered when provided by a speech pathologist or audiologist approved by the American Speech and Hearing Association or its equivalent, and who is licensed by the state of South Carolina.

There must be acute changes in the patient's language functioning and/or history of prior speech-language pathology services for the condition currently being treated. In addition, there must be an expectation that the patient's language/communication ability will improve significantly in a reasonable and generally predictable period of time. If at any point during treatment of the disorder it is determined that the expectations for improvement will not be met, the services will no longer be considered reasonable and necessary.

Types of services covered by a speech-language pathologist include:

- Diagnosis and evaluation (including language assessment tests).
- Therapeutic services for medical disorders and resulting communication disorders such as:
  - Cerebral vascular disease (CVA) with dysphagia, aphasia, dysphasia, apraxia and dysarthria.
  - Neurological diseases, which manifest with dysarthria, dysphasia or inadequate respiratory volume/control.
  - Laryngeal carcinoma requiring laryngectomy and resulting aphonia.

### **Occupational Therapy**

To be considered for coverage, occupational therapy services must be reasonable and necessary for the treatment of the patient's illness or injury. There must be an expectation that the therapy will result in a significant practical improvement in the patient's functioning within a reasonable period of time. Therapy must be performed by a qualified occupational therapist (i.e., one who is approved by the American Occupational Therapy Association). The therapist must be licensed by the state of South Carolina.

Types of services covered by an occupational therapist include:

- Diagnostic and prognostic tests to evaluate/re-evaluate a patient's level of functioning.
- Teaching of task-oriented therapeutic activities to restore physical function.
- Planning and implementing of tasks and activities to restore sensory-integrative function (e.g., providing motor and tactile activities to increase sensory input and improve responsiveness for a stroke patient with functional loss resulting in a distorted body image).
- Teaching activities of daily living and energy conservation to improve the level of independence for the patient's diagnosis and restorative condition.
- Designing, fabricating and fitting orthotic devices related to the patient's condition.
- Planning, implementing and supervising an individualized therapeutic activity program as a part of an overall "activity treatment" program.

### **Maintenance Therapy for Physical, Speech Pathology, Audiology and Occupational Therapy**

If full recovery or improvement is not possible, therapy may be authorized to allow the beneficiary to maintain his or her current function. There are three basic situations for which a beneficiary who is at a maintenance level may require one of the therapies:

- The repetitive services designed to maintain function involve the use of complex and sophisticated procedures that may only be performed by a licensed therapist.
- Special medical complications exist that necessitate therapists to perform or supervise the service or to observe the beneficiary.
- A therapist is needed to manage and periodically re-evaluate the appropriateness of a maintenance program because of an identified danger to the patient.

### **Medical Supplies**

Medical supplies sponsored by Medicaid are items that, due to their therapeutic or diagnostic characteristics, are essential in enabling home health personnel to carry out effectively the care that the physician has ordered for the treatment or diagnosis of the patient's illness or injury. Certain items that by their very nature are designed only to serve a medical purpose are obviously considered to be medical supplies (e.g., catheters, needles, syringes, surgical dressing and material used in aseptic techniques). Other medical supplies include, but are not limited to, irrigating solutions, intravenous fluids and colostomy supplies.

Other items may be considered medical supplies, but only where the following applies:

- The item is recognized as having the capacity to serve a therapeutic or diagnostic purpose in a specific situation.
- The item is required as a part of the actual physician-prescribed treatment of a patient's existing illness or injury.

Items that generally serve a hygienic purpose (i.e., soaps and shampoos) and items that generally serve as skin conditioners (i.e., baby oil, skin softeners, powders, lotions, etc.) would not be considered medical supplies unless the particular item is recognized as serving a specific therapeutic purpose in the physician-prescribed treatment of the patient's existing disease/injury.

A separate charge may be made for the reasonable costs of medical supplies that are not routinely furnished in conjunction with patient care visits. In order for a separate medical supply charge to be made, the item(s) must be:

- Ordered at the direction of the patient's physician.
- Directly identifiable to an individual patient.
- Specifically identified in the plan of care.
- Used/expended during the actual course of a covered visit.

The patient can obtain some of these items through other sponsored Medicaid programs such as the DME program.

A patient's record must include an itemized list of non-routine medical supplies charged per visit, to include type, quantity and total amount charged for each type of supply.

**Note:** Non-routine medical supply charges are totaled by date of service on the CMS-1500 claim form.

Routine supplies are not billable as medical supplies. Routine supplies are those minor medical and surgical supplies frequently furnished to all patients or utilized in small quantities, which would not be expected to be specifically identified in a physician's plan of care. Routine supplies are further defined as items that are used for all patients and purchased in bulk. The cost of these routine supplies are apportioned to all patients, and included in the reimbursement rate for covered visits. Examples of routine supplies include, but are not limited to, the following items:

- Alcohol (Swabs/Prep).

- Applicators (tongue blades, cotton-tipped).
- Band Aids.
- Cotton Balls.
- Lubricants (K-Y Jelly, Vaseline).
- Thermometers.

All HHAs are expected to separately identify and maintain a record of medical supplies that are routinely furnished in conjunction with patient care visits and included in the overall allowable per visit costs.

Equipment and appliances covered under the DME program must be obtained through that program.

### **Utilization of Medical Supplies**

The teaching component must be included in the plan of care and the documentation must specify which family member the skilled nurse teaches during his or her visit. Follow-up supervision to ensure that proper procedures are followed is allowable. The time frame for teaching should be short-term and supplies may be left while the family is learning care procedures. Medicaid beneficiaries are eligible to receive bulk supplies when ordered by a physician. Families should be advised and assisted by the teaching nurse in obtaining bulk supplies, which may be provided by the DME provider with a physician's order.

### **Incontinence Supplies**

The following criteria must be met for beneficiaries to receive incontinence supplies under the South Carolina Medicaid State Plan Home Health benefit:

1. Must be a Medicaid beneficiary aged four or above.
2. Inability to control bowel or bladder function. This must be confirmed by a prescriber in writing.
3. An order must be obtained from the prescriber that the beneficiary is incontinent. The Prescriber Certification of Incontinence Department of Health and Humans Services Form 168IS must be completed by the primary prescriber initially and every 12 months at a minimum for waiver beneficiaries. Certifications for non-waiver beneficiaries are effective for timeframes of three months, six months, nine months or 12 months and are based on the selection chosen by the prescriber.

The assessment conducted by the SCDHHS nurse will determine the frequency of incontinence and this determination will establish the amount of supplies authorized.

Authorization of incontinence supplies for adults (age 21 and older) must be based on frequency of incontinence as follows:

1. Occasionally incontinent allows up to one case per quarter.
  - A. For Bladder-Indicates two or more times a week but not daily.
  - B. For Bowel-Indicates once a week.
2. Frequent incontinence allows up to two cases every quarter. For Bladder-Indicates daily incontinence, but some control, OR if the beneficiary is being toileted (extensive assistance) on a regular basis, i.e. every two hours.
3. Total incontinence allows one case per month. Indicates total incontinence and no control (or an indwelling catheter or ostomy that controls the beneficiary's bladder or bowel).

The Medicaid State Plan Home Health benefit covers the following incontinence supplies:

- One case of diapers or briefs (one case = 96 diapers or 80 briefs).
- One case of incontinence pads/liners (one case = 130 pads).
- One case of underpads.
- One box of wipes.

Authorization for children (age four to 20) is based on the frequency of incontinence and may exceed the State plan frequency limits per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) policy. For children requiring more than the State plan frequency limits set above, exception must be requested and approved by the SCDHHS nurse. Exception will be given for children who exceed the definition of total incontinence and additional cases in excess of the one case per month may be authorized if medically necessary.

Authorization of wipes is based on an incontinence need and the beneficiary must receive diapers/pull-ups and/or underpads and/or incontinence pads/liners to receive wipes. The frequency will be determined by the assessment conducted by the nurse; however, the maximum allowed is one box per month for adults (age 21 and older).

Children (age four to 20) may exceed the maximum of one box of wipes per month if medically necessary per EPSDT policy. Authorization of additional wipes for children is based on the frequency of incontinence and must be requested and approved by the SCDHHS nurse.



Incontinence supply providers will be responsible for obtaining the Prescriber Certification of Incontinence SCDHHS Form 168IS prior to delivering incontinence supplies. The Prescriber Certification of Incontinence SCDHHS Form 168IS is mandatory for all beneficiaries receiving incontinence supplies as a State Plan Home Health benefit. The form must be completed by the prescriber both initially and at every certification period as selected by the prescriber.

### Incontinence Supply Deliveries

Providers of incontinence supplies are responsible for delivery. The provider may deliver directly to the participant or a designee. Note the relationship of the designee to the beneficiary on the delivery slip and the signature should be legible. Providers, their employees and others with a financial interest in the delivery of the item are prohibited from signing and accepting an item on behalf of the participant (i.e., acting as a designee on behalf of the participant).

Providers must maintain proof of the delivery of supplies (i.e., return receipt to include the participant's name, quantity delivered, detailed description of the delivered item, brand name, serial number) in their place of business for a minimum of five years. Proof of delivery documentation must be made available to Medicaid upon request. Any claims for services that do not have a documented proof of delivery from the supplier shall be denied and payments recovered.

Delivery confirmation slips must show ship dates, mailing dates, delivered dates and addresses to which deliveries were made. The delivery confirmation slip must document if someone signed for the package, or if it was delivered without a signature, and where it was left for the participant.

Medical supply providers can access the delivery confirmation information maintained by the delivery companies online. Providers must keep delivery confirmation records for five years. Medicaid will not accept a tracking number without the follow-up delivery confirmation data.

### NON-COVERED SERVICES

Services not covered by the Medicaid Home Health program include:

Services not reasonable and necessary for diagnosis or treatment of illness or injury

- Full-time nursing care
- Drugs and biologicals
- Meals delivered to the home
- Homemaker services
- Care primarily for treatment of mental diseases

- Separate medical rehabilitation facilities
- Routine supplies
- Supervisory nurse visits

### **Social Work Services**

Effective July 1, 2011, Medical Social Work Services has been eliminated and will no longer be reimbursed by Medicaid.

# 4

## UTILIZATION MANAGEMENT

### PRIOR AUTHORIZATION

Effective October 1, 2012, prior authorization (PA) from the SCDHHS designated Quality Improvement Organization (QIO), KEPRO, will be required for situations where it is medically necessary for a beneficiary to exceed the home health visit limitation. KEPRO will utilize evidence-based and nationally recognized criteria for evaluating and determining medical necessity for the type of services requested and the number of visits required to appropriately treat the beneficiary's condition.

Authorization requests include the request form, an executive summary describing in detail the extenuating circumstances which make additional visits medically necessary, and supporting medical documentation that justifies the medical necessity for the additional home health visits. Supporting medical documentation can include the plan of care and clinical service notes per home health service being requested.

Home health providers are required to track and request additional home health visits prior to the expiration of the 50-visit limitation by utilizing the South Carolina Medicaid Web-based Claims Submission Tool (Web Tool) eligibility screen.

Requests for additional visits must be submitted by the HHA. In order to be approved, requests must substantiate medical necessity and be received by KEPRO prior to the service being provided.

Authorization requests are for a 60-day plan of care period. Requests for extended service beyond the initial authorization period must be submitted prior to the last authorized day in the certification period.

All requests for prior authorization of additional visits must be submitted to KEPRO using one of the following methods:

KEPRO Customer Service Phone: 855-326-5219

KEPRO Fax #: 855-300-0082

Online via Atrezzo Connect: <http://scdhhs.KEPRO.com>

The Outpatient Prior Authorization Request Form can be found at:

<https://scdhhs.kepro.com/content/forms.aspx>.

All requests for a PA must be received by the QIO before the service is performed. In an emergency or any unplanned situation, the request must be received by the QIO within five business days of the date of service.

The response time for a decision by the QIO is five business days from the receipt of the request. If a review requires a physician consultation, the QIO will have one additional business day to render the decision.

All requests for additional information from the QIO must be received by the QIO within two business days of the date requested.

If a beneficiary receives Medicaid eligibility after the service has been performed, providers must indicate this at the time of the request. KEPRO will not validate these retro requests, however SCDHHS will audit these cases on a monthly basis.

### **Incontinence Supplies**

#### **Medical Necessity Criteria**

The following criteria must be met for beneficiaries to receive incontinence supplies under the South Carolina Medicaid State Plan Home Health benefit:

1. Must be a Medicaid beneficiary age four or above.
2. Inability to control bowel or bladder function. This must be confirmed by a physician in writing.
3. An order must be obtained from the primary physician that the beneficiary is incontinent. The Physician Certification of Incontinence DHHS Form 168IS must be completed by the primary physician initially and every 12 months at a minimum for waiver beneficiaries. Certifications for non-waiver beneficiaries are effective for timeframes of three months, six months, nine months or 12 months and are based on the selection chosen by the physician.

The assessment conducted by the SCDHHS nurse will determine the frequency of incontinence and this determination will establish the amount of supplies authorized.

### **OTHER SERVICE/PRODUCT LIMITATIONS**

#### **Visit Limitation**

Effective February 1, 2011, HHA visits are limited to a total of 50 per recipient age 21 and older per state fiscal year for all mandatory and optional home health services. The state fiscal year begins July 1 and ends June 30 of each year. Providers may verify the visit count by utilizing the South Carolina Medicaid Web-based Claims Submission Tool (Web Tool) eligibility screen.

# 5

## ADDITIONAL REQUIREMENTS

### REPORTING/DOCUMENTATION

#### **Face-to-Face Documentation**

Effective October 1, 2013, as mandated by Section 6407(d) of the Affordable Care Act, prior to certifying a patient's eligibility for the home health benefit, the certifying physician must document that he or she, an allowed non-physician practitioner (NPP), or a physician caring for the patient in an acute or post-acute facility, has had a face-to-face encounter with the patient.

The face-to-face encounter requirement is effective only for the patient's initial home health certification and not for recertification.

In addition to the certifying physician, NPPs who may perform the face-to-face include:

- Nurse Practitioner or Clinical Nurse Specialist (as defined in section 1861 (aa)(5) of the Social Security Act) who is working in collaboration with the physician in accordance with State law
- Physician Assistant (as defined in section 1861 (aa)(5) of the Social Security Act) under the supervision of the physician

The face-to-face requirement ensures that the orders and certification for Home Health services are based on a physician's or NPP's current knowledge of the beneficiaries' clinical condition.

An encounter between the home health patient and the attending physician who cared for the patient during an acute/post-acute stay can satisfy the face-to-face encounter requirement.

- A physician who attended to the patient in an acute or post-acute setting, but does not follow the patient in the community may certify the need for home health care based on his/her contact with the patient, and establish and sign the plan of care. The acute/post-acute physician would then transfer/hand off the patient's care to a designated community-based physician who assumes care for the patient
- A physician who attended to the patient in an acute or post-acute setting may certify the need for home health care based on his/her contact with the patient, initiate the orders for home health services, and transfer the patient to a designated community-based physician to review and sign off on the plan of care.

### Face-to-Face Timeframes

The physician or allowed NPP must document that the face-to-face encounter is related to the need for home health services, and that the encounter has occurred no more than 90 days prior or 30 days after the start of care.

In situations when a physician orders home health care for the patient based on a new condition that was not evident during a visit within the 90 days prior to start of care, the certifying physician or an allowed NPP must see the patient again within 30 days after admission. Specifically, if a patient saw the certifying physician or NPP within the 90 days prior to start of care, another encounter would be needed if the patient's condition has changed to the extent that standards of practice would indicate that the physician or NPP should examine the patient in order to establish an effective treatment plan.

Documentation regarding these encounters must be present on certifications for beneficiaries with start of care dates on and after October 1, 2013.

### Face-to-Face Documentation Requirements

Face-to-face documentation must meet the following requirements listed below:

- Prior to billing, the HHA should ensure that all certifications are complete, including that the face-to-face documentation has been clearly titled, dated and signed by the certifying physician. Electronic signatures are acceptable. Stamped signatures are not acceptable.
- The documentation must include the date when the physician or allowed NPP saw the patient, and a brief narrative which describes how the patient's clinical condition as seen during that encounter supports the patient's need for skilled services
- The certifying physician must document the encounter either on the certification, which the physician signs and dates, or a signed addendum to the certification. It may be written or typed.
- It is acceptable for the certifying physician to dictate the documentation content to one of the physician's support personnel to type. It is also acceptable for the documentation to be generated from a physician's electronic health record.
- It is unacceptable for the physician to verbally communicate the encounter to the HHA, where the HHA would then document the encounter as part of the certification for the physician to sign.
- NPPs may perform the face-to-face encounter and inform the certifying physician regarding the clinical findings exhibited by the patient during the encounter. However, the certifying physician must document the encounter and sign the certification.

- The certifying physician is statutorily required to document the face-to-face encounter. The certifying physician may choose to utilize a face-to-face encounter communication document received from the hospital physician as his/her face-to-face documentation, but in doing so must sign the encounter documentation.

### **Plan of Care**

Covered services must be ordered by the beneficiary's physician as part of a written plan of care consistent with the functions the practitioner is legally authorized to perform. The practitioner must review and sign this plan of care at least every 60 days and for every change during the plan of care period. The practitioner ordering home health services or reviewing the plan of care may not have a significant ownership interest in or a significant financial or contractual relationship with the HHA.

A practitioner has a significant interest if he or she owns 5% or more of the assets or is an officer, director or partner of the HHA. A significant financial or contractual relationship is defined as involving business transactions that amount to \$25,000 per year or 5% of the HHA's operating expenses, whichever is less.

The plan of care should specify the treatment, services, supplies, items or personnel needed by the patient, as well as the expected outcome. The care must be appropriate to the patient's needs. Goals and needs must also be documented. The objectives of the plan of care must be to improve the patient's level of health, relieve pain, and to prevent regression of the patient's stable condition. The plan of care should restrict such care to the minimum number of visits necessary to meet these objectives. Records must be maintained that document the medical necessity of the care and detail the type and amount of care rendered. Records should also document improvement, or lack thereof. When changes in the plan of care are made, records should show the reasons for the change and the new care requirement. Service notes must tie into the plan of care goals and list the orders addressed during the visit.

### **Verbal Orders**

Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist responsible for furnishing or supervising the ordered services. Verbal orders must be countersigned by the physician within 30 days from the date of the verbal order. Verbal orders and signatures after the plan of care date are not accepted.

### **Physician's Original Drug Orders and Changes in Orders**

The following are signed by the physician and incorporated in the patient's records maintained by the HHA:

- Original orders for drugs.

- Changes in orders for the administration of narcotics, those drugs subject to the Drug Abuse Control Amendments of 1965 and other legend drugs.



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## BILLING GUIDANCE

### Reimbursement

SCDHHS will reimburse the home health provider for services agreed to in the contract, according to the interim rates provided by the Department of Ancillary Reimbursements, Bureau of Reimbursement Methodology and Policy of SCDHHS. Payment will be made at a fixed rate per visit for the following services:

1. Skilled Nursing visits.
2. Home health aide visits.
3. Therapy visits (Physical Therapy, Speech Therapy and Occupational Therapy).

Payment for allowable medical supplies is based on reasonable cost. The cost may not exceed the amount a prudent buyer would pay for the same item and is comparable to the cost of similar items to other medical providers. Medical supplies that are used in the provision of routine home health services are initially reimbursed based on charges; however, during the fiscal year-end cost settlement, an adjustment is made reflective of the cost-to-charges ratio for medical supplies.

Based on the availability of federal and/or state matching funds, the Medicaid reimbursement methodology used to determine the interim home health rates is the lesser of allowable Medicare costs, charges, or the Medicare cost limits by discipline. These interim rates are calculated based on the most recent Medicare cost report, Medicare cost limits, and charges as submitted by the provider to the Department of Ancillary Reimbursements. Effective October 1, 2000, HHAs entering the Medicaid program for the first time will be reimbursed at the lesser of Medicare cost limits based on the per-visit limits as published in the August 5, 1999 Federal Register, charges or an interim rate established by the Medicaid State Agency until the submission of actual costs.

Each provider is required to submit to Medicaid a copy of their cost report (CMS 1728 or CMS 2552), with accompanying Medicaid data, no later than five months after the provider's financial year end. If the cost report is not submitted in a timely fashion, as stated in the contract, all funds may be withheld by SCDHHS. A desk review is done by the staff of the Department of Ancillary Reimbursements on the "As Filed" Medicare cost report and accompanying Medicaid data, and Medicaid statistics obtained from MMIS. The initial cost settlement is determined based on the lesser of the allowable Medicare costs, charges or the Medicare cost limits, in the aggregate, factoring in an adjustment in accordance with Medicare cost charges ratio for medical supplies. A

final settlement is made for each financial year based on the Medicare audit of the cost report. The Medicaid provider should notify the Department of Ancillary Reimbursements of the Medicare audit findings within 30 days of the receipt of the Medicare audit report, as these findings are utilized in determining the final Medicaid settlement. Final cost settlement and payment is limited to the lesser of allowable Medicare costs, Medicare cost limits or charges in the aggregate.

Questions pertaining to interim reimbursement rates, cost reports and cost settlements should be directed to the Department of Ancillary Reimbursements, SCDHHS.

### **Therapy and Dually Eligible Beneficiaries**

Because the Medicaid program utilizes the same criteria, with the exception of the homebound requirement, as Medicare for the provision of therapies (physical, speech pathology and audiology and occupational), any therapy provided under these criteria should be billed to Medicare as the primary payer. If Medicare declines payment because the services did not meet the criteria, Medicaid will also deny payment for the same reason.