

SECTION 2

POLICIES AND PROCEDURES

TABLE OF CONTENTS

| | |
|--|----------|
| PROGRAM OVERVIEW | 1 |
| ADMINISTRATION..... | 1 |
| TERMS..... | 1 |
| PROGRAM REQUIREMENTS | 3 |
| PROVIDER QUALIFICATIONS | 3 |
| Licensure and Certification | 3 |
| Enrollment | 4 |
| Reimbursement | 5 |
| DOCUMENTATION REQUIREMENTS..... | 7 |
| Homebound Criteria..... | 7 |
| Plan of Care..... | 7 |
| VERBAL ORDERS | 8 |
| PHYSICIAN'S ORIGINAL DRUG ORDERS AND CHANGES IN ORDERS | 8 |
| PROGRAM SERVICES | 9 |
| COVERED SERVICES | 9 |
| Visit Limitation | 9 |
| Prior Authorizaton | 9 |
| Nursing Services..... | 10 |
| Pediatric Home Health..... | 11 |
| <i>Nursing and Dually Eligible Beneficiaries</i> | 12 |
| <i>Nursing/DME Evaluation</i> | 12 |
| Home Health Aide Services..... | 13 |
| Therapy Services..... | 13 |
| <i>Therapy and Dually Eligible Beneficiaries</i> | 14 |
| <i>Physical Therapy</i> | 14 |
| <i>Speech Pathology and Audiology Therapy</i> | 14 |
| <i>Occupational Therapy</i> | 15 |
| <i>Maintenance Therapy for Physical, Speech Pathology, Audiology, and Occupational Therapy</i> | 16 |
| Social Work Services..... | 16 |
| Medical Supplies..... | 16 |
| UTILIZATION OF MEDICAL SUPPLIES | 18 |
| INCONTINENCE SUPPLIES | 19 |

SECTION 2
POLICIES AND PROCEDURES

TABLE OF CONTENTS

Medical Necessity Criteria 19
Authorization/ Frequency 19
Referrals 20
Process..... 21
NON-COVERED SERVICES 21

SECTION 2 POLICIES AND PROCEDURES

PROGRAM OVERVIEW

ADMINISTRATION

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.

TERMS

A **home health agency** 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 home health agency does not include care provided primarily for treatment of mental diseases.

Home health services are those services provided by a home health agency 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.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM OVERVIEW

This page was intentionally left blank.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

PROVIDER QUALIFICATIONS

A home health agency 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 home health agency 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, and have an approved Certificate of Need (CON). The home health agency must also be in compliance with all federal, state, and local laws.

The home health agency 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 South Carolina Department of Health and Environmental Control, and have an approved Pediatric Home Health Certificate of Need (CON). The home health agency must also be in compliance with all federal, state, and local laws.

The Centers for Medicare and Medicaid Services (CMS) grant deemed status to the Community Health Accreditation Program (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:

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Licensure and Certification (Cont'd.)

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

Enrollment

All home health agencies 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 SC 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 Home Health agency compliance with provider enrollment and screening.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

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.

Reimbursement (Cont'd.)

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, Home Health Agencies 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

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

obtained from MMIS (Medicaid Management Information System). 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, South Carolina Department of Health and Human Services.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

DOCUMENTATION REQUIREMENTS

Homebound Criteria

Medicaid Home Health services cannot be restricted to a requirement that the individual be homebound. The use of a homebound requirement under the Medicaid Home Health benefit violates Federal regulatory requirements at 42 CFR Section 440.230(c) and Section 440.240(b). Home Health services cannot otherwise be restricted to services furnished in the home itself. A Medicaid Home Health beneficiary can receive home health services in the beneficiary's place of residence, a doctor's office, outpatient clinic, an adult day center, or in another type of outpatient facility, not including a hospital or skilled nursing facility. Medicare remains the primary payer for dually eligible beneficiaries, and providers will remain obligated to comply with the homebound requirements set forth by Medicare.

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 home health agency.

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 home health agency. A significant financial or contractual relationship is defined as involving business transactions that amount to \$25,000 per year or 5% of the home health agency'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

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Plan of Care (Cont'd.)

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 home health agency:

- 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

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

COVERED SERVICES

Visit Limitation

Effective February 1, 2011, home health agency 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 1st and ends June 30th of each year. Providers may verify the visit count by utilizing the South Carolina Medicaid Web-based Claims Submission Tool (Web Tool) eligibility screen.

Prior Authorizat

Effective October 1, 2012, prior authorization from the SCDHHS designated Quality Improvement Organization, 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 Home Health agency. In order to be approved, requests must substantiate medical necessity and be received by KePRO prior to the service being provided.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Prior Authorizaton (Cont'd.)

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>.

Nursing Services

Nursing services provide direct patient care including, but not limited to, assessment, teaching, injections, changing dressings, catheter care, and skilled monitoring of symptoms. Nursing services must be provided to patients on a part-time or intermittent basis by registered nurses or licensed practical nurses. The nurse must be currently licensed by South Carolina and trained in administrative and clinical record keeping. The nursing care must be in accordance with written orders by the patient's physician and must be documented.

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.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Nursing Services (Cont'd.)

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 home health agencies that specialize in providing intermittent skilled nursing care to children ages 0 to 18. Only one Pediatric Home Health agency 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 home health agency 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.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Pediatric Home Health (Cont'd.)

- 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. 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/DME Evaluation

A home health agency 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

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Nursing/DME Evaluation (Cont'd.)

the home health agency. 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 Durable Medical Equipment 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.

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 Home Health agencies providing home health aide services must follow the service requirements as outlined above for all home health agencies.

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 home health agency or by a person or facility licensed by the state of South Carolina to provide medical rehabilitation services. Pediatric Home Health agencies providing any of the therapy services must follow the service requirements as outlined below for all home health agencies.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

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.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Speech Pathology and Audiology Therapy (Cont'd.)

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

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Occupational Therapy (Cont'd.)

- 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.

Social Work Services

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

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

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Medical Supplies (Cont'd.)

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 Durable Medical Equipment 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.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Medical Supplies (Cont'd.)

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 home health agencies 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 Durable Medical Equipment 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 Durable Medical Equipment (DME) provider with a physician's order.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

INCONTINENCE SUPPLIES

Medical Necessity Criteria

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

1. Must be age 4 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.
4. The assessment conducted by the SCDHHS nurse will determine the frequency of incontinence and this determination will establish the amount of supplies authorized.

Authorization/ Frequency

Authorization of diapers/pull-ups and underpads 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. For bladder-Indicates two or more times a week but not daily. 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).

Note: Extended state plan waiver services for incontinence supplies above and beyond the state plan monthly limit are available in the Community Supports (CS) waiver, Head and Spinal Cord Injury (HASCI) waiver and the Intellectual Disabilities/Related Disabilities (ID/RD)

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Authorization/ Frequency (Cont'd.)

waiver programs. Beneficiaries in these three waiver programs should contact their service coordinator or case manager with any questions.

Authorization for children (age 4 to 20) is based on the frequency of incontinence. For children requiring more than the 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 incontinent and additional cases in excess of the one case per month may be authorized.

Note: If the beneficiary has an ostomy or catheter for urinary control and an ostomy for bowel control, no diaper or pull-ups should be authorized, but under pads may be authorized. If the beneficiary has an appliance for bowel OR bladder control, but not both, diapers/pull-ups may be authorized based on the frequency of incontinence.

Authorization of wipes is based on the presence of incontinence. The frequency will be determined by the assessment conducted by the nurse; however the maximum allowed is one box per month.

Note: For those beneficiaries enrolled in a South Carolina Department of Disabilities and Special Needs (SCDDSN) waiver, the service coordinator/case manager will conduct the assessment to determine the frequency of incontinence supplies authorized and obtain the Physician Certification of Incontinence DHHS Form 168IS from the primary physician initially and every 12 months at a minimum.

Referrals

Referrals for incontinence supplies can be made to the Division of Community Long Term Care (CLTC) centralized intake by one of the methods below:

- Electronic (Preferred Method) https://phoenix.cltc.state.sc.us/cltc_referrals/new
- Telephone: 855-278-1637
- Fax: 803-255-8340
- Mail: South Carolina DHHS
Community Long Term Care
Intake-J7
PO Box 8206
Columbia, SC 29202-8206

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Process

Once a beneficiary is determined eligible for incontinence supplies, by meeting the medical necessity criteria and a phone assessment has been conducted through CLTC centralized intake to determine the frequency of incontinence and the amount of supplies authorized; a provider choice form will be sent to the beneficiary to select a provider to receive the incontinence supplies from. The SCDHHS nurse will monitor periodic recertification for incontinence supplies per beneficiary with the Physician Certification of Incontinence DHHS Form 168IS on file every 12 months at a minimum.

Authorizations for incontinence supplies will be made through the SCDHHS Phoenix web-based case management and authorization system. This system notifies the provider with an email directing the provider to a secure website. All providers requesting enrollment as an incontinence provider to distribute incontinence supplies must be trained and utilize the Phoenix web-based case management and authorization system. Please refer to the [Community Long Term Care \(CLTC\)](#) provider manual for more information on provider enrollment and incontinence supply reimbursement.

Note: South Carolina Department of Disabilities and Special Needs (SCDDSN) does not currently participate in the Phoenix web-based authorization system. Service coordinators/case managers will send authorizations and terminations to providers for incontinence supplies for beneficiaries in the CS, HASCI and ID/RD waivers.

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

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

NON-COVERED SERVICES (CONT'D.)

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