DESCRIPTION OF SERVICES

A home health agency (HHA) enrolled in the Louisiana Medicaid Program provides patient care services in the beneficiary's residential setting, under the order of a physician, that are necessary for the diagnosis and treatment of the beneficiary's illness or injury. Such services include part-time skilled nursing services, extended skilled nursing services (for beneficiaries under 21 years of age), home health aide services, physical therapy (PT), speech therapy (ST), occupational therapy (OT) and medical supplies recommended by the physician as required in the care of the beneficiary and suitable for use in any setting in which normal life activities take place.

Home health services are reimbursable only when ordered by a licensed physician who certifies that the beneficiary meets the medical necessity criteria (Refer to section 23.3) to receive services in a residential setting on an intermittent basis. The beneficiary's residential setting **cannot** be a hospital, nursing home, or intermediate care facility for individuals with intellectual disabilities (ICF-IID). However, beneficiaries in an ICF-IID **may** receive short-term home health care from a registered nurse (RN) during an acute illness to avoid the beneficiary being transferred to a nursing home.

The certification and physician's plan of care (POC) must be maintained in the beneficiary's record and on file at the HHA. The physician must review the POC every 60 days. During the home visit, the clinician should define a specific goal or reason for the appointment to substantiate the need for the visit (medical necessity) and the reason it is occurring in the home setting.

Covered Home Health Services

Covered home health services include the following:

1. **Skilled nursing** (Intermittent or part-time);

2. **Home health aide services** provided in accordance with the POC as recommended by the attending physician;

3. **Extended skilled nursing services (**also referred to as **extended home health),** as part of early and periodic screening, diagnostic and treatment (EPSDT) services. This service is extended nursing care by an RN or a licensed practical nurse (LPN) and may be provided to beneficiaries under age 21 who are considered "medically fragile";

4. **Rehabilitation services** including physical, occupational and speech therapies, including audiology services; and

5. **Medical supplies, equipment and appliances** as recommended by the physician, required in the POC for the beneficiary and suitable for use in any setting in which normal life activities take place. Medical supplies, equipment and appliances are covered under the Durable Medical Equipment (DME) program when approved by the Prior Authorization Unit (PAU).

Skilled Nursing Services

Nursing services provided on a part-time or intermittent basis by an RN or LPN that are necessary for the diagnosis and treatment of a beneficiary's illness or injury. Examples of skilled nursing services include, **but are not limited to, the following:**

1. Frequently monitoring blood pressure, fluid status, or blood glucose;
2. More rigorous assessment of symptoms, including pain, dyspnea, or constipation;
3. Management of complex wounds;
4. Patient education around therapy (e.g., home glucose monitoring and insulin administration); and
5. Assessment of medication adherence.

These services shall be consistent with the following:

1. Established Medicaid policy;
2. The nature and severity of the beneficiary's illness or injury;
3. The particular medical needs of the patient; and
4. The accepted standards of medical and nursing practice.

The requested services must meet all of the following:

1. Be ordered and directed by a treating practitioner or specialist (M.D., D.O);
2. Care must be delivered or supervised by a licensed professional in order to obtain a specific medical outcome;
3. Be skilled care, in nature;

4. Be part-time or intermittent ; and

5. Be clinically appropriate and not more costly than an alternative health service.

Psychiatric Services

Home health services provided to beneficiaries whose primary diagnosis is psychiatric, must be provided in accordance with state requirements as published in the Minimum Standards for HHAs. One requirement stipulates that only RNs shall make psychiatric nurse visits.

RN qualifications for psychiatric home health visits are taken from the Minimum Standards for Licensing Home Health Agencies (LAC 48:1. Chapter 91). Only RNs who have these credentials shall make psychiatric nurse visits.

Additionally, experience must have been within the last five years or documentation must show psychiatric re-training, classes, or continued education units (CEUs) to update psychiatric knowledge.

RN requirements include the following:

1. RN with a master's degree in psychiatric or mental health nursing;

2. RN with a bachelor's degree in nursing with one year of experience in an active treatment unit in a psychiatric or mental health hospital or outpatient clinic; or

3. RN with a diploma or associate degree with two years of experience in an active treatment unit in a psychiatric or mental health hospital or outpatient clinic.

Furthermore, the services must be medically necessary and provided only to beneficiaries who meet Medicaid's medical necessity criteria for home health services.

Home Health Aide Services Only

In some situations, a dually eligible beneficiary (one who has coverage from both Medicare and Medicaid) requires only home health aide visits. Medicare will not pay for this service unless skilled services (skilled nursing service, physical therapy, occupational therapy or speech-language therapy) are also required. However, Medicaid will reimburse for home health aide visits if only home health aide visits are required. Claims of this nature must either have a cover letter attached explaining the reasons for the lack of Medicare coverage or include this explanation in the remarks section of the claim.

Supervision of Home Health Aides

Periodic on-site supervision with the home health aide present is part of the Minimum Standards for HHAs.

It is required that if the beneficiary is receiving a skilled service (nursing, physical therapy, occupational therapy, or speech-language therapy), the beneficiary shall have an RN or appropriate therapist supervisory visit made **randomly every 14 days.**

Beneficiaries not receiving skilled services must have an RN supervisory visit at the beneficiary's residential setting at least **once every 62 days** while the home health aide is present and providing care. Supervisory visits are not billable services.

Extended Home Health

Extended home health, also known as extended skilled nursing services (a minimum of three or more hours of nursing services per day), may be provided to beneficiaries under the age of 21 by the HHA if determined to be medically necessary, ordered by a physician, and prior authorized by the PAU. The beneficiary must require skilled nursing care that exceeds the caregiver's ability without the extended home health services.

NOTE: Skilled nursing services are to be conducted in the beneficiary's residential setting. Extended home health services may be provided outside of the residential setting when the nurse accompanies the beneficiary for medical reasons such as doctor appointments, treatments or emergency room visit. Medicaid will not reimburse for skilled nursing services performed outside of state boundaries.

Rehabilitation Services

Physical, occupational and speech therapy services are covered when provided by the HHA. These services are covered with prior authorization (PA).

Physical Therapy

Physical therapy services are rehabilitative services necessary for the treatment of the beneficiary's illness or injury, or restoration and maintenance of function affected by the beneficiary's illness or injury.
These services are provided with the expectation, based on the physician's assessment of the beneficiary's rehabilitative potential, that:

1. The beneficiary's condition will improve, materially, within a reasonable and generally predictable period of time; or

2. The services are necessary for the establishment of a safe and effective maintenance program.

Physical Therapy Assistants

The use of physical therapy assistants (PTA) is regulated in the Minimum Standards for Home Health Agencies. The PTA must be currently licensed by the Louisiana State Board of Physical Therapy Examiners and must be supervised by a licensed physical therapist. The PTA must have, at a minimum, one year of experience as a licensed PTA before assuming responsibility for a home health caseload.

The PTA's duties must not include interpretation and implementation of referrals or prescriptions, performance evaluations, or the determination of major modifications of treatment programs.

Occupational Therapy

Occupational therapy is a medically prescribed treatment to improve or restore a function which has been impaired by illness, injury or, when the function has been permanently lost or reduced, to improve the beneficiary's ability to perform those tasks required for independent functioning.

Speech Therapy

Speech-language therapy services are those services necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of a communication disability.

Medical Supplies

Medical supplies recommended by the physician, required in the care of the beneficiary and suitable for use in any setting in which normal life activities take place are covered under the DME program when approved by the PAU.

NOTE: HHAs that enroll as DME providers may bill the program for supplies used under that service designation using the DME claim form.

Routine supplies, and supplies that are only covered when provided in conjunction with a home health visit, are listed in Section 23.5.

Chronic Needs Cases

Chronic needs cases pertain to DME, extended home health, personal care services (PCS), and rehabilitation services. The PA process has been altered to allow designation of some beneficiaries as "chronic needs case beneficiaries". Prior authorized services are continuous and are expected to remain at current levels based on the medical condition of these beneficiaries. Once a beneficiary is deemed a "*chronic needs case*", providers must only submit a PA request form accompanied by a statement from a physician, documenting that the beneficiary's condition has not improved and the services currently approved must be continued at the approved level.

Requests for an increase in these services will be treated as a traditional PA request and are subject to full review.

Beneficiaries meeting the "*chronic needs case"* status will be notified of the designation and the PAU will send a copy of the letter to the provider of services.