MDHHS Michigan Department of Health & Human Services

Medical Services Administration

BULLETIN MSA

Bulletin Number: MSA 18-13

Distribution: Medicaid Home Health Agencies, Medicaid Health Plans, MI Choice Waiver Agencies, Home Help Agencies, Practitioners

Issued: May 25, 2018

Subject: Clarification of Home Health Face-to-Face Requirements

Effective: July 1, 2018

Programs Affected: Medicaid, MI Choice Waiver

NOTE: Implementation of this policy is contingent upon State Plan Amendment Approval from the Centers for Medicare & Medicaid Services (CMS)

This policy is pursuant to the February 2, 2016 Centers for Medicare & Medicaid Services (CMS) Home Health Final Rule, CMS-2348-F. This Final Rule implements section 6407(b) of the Patient Protection and Affordable Care Act (ACA) and section 504 of the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA). It also amends the Code of Federal Regulations at 42 CFR 440.70.

Provisions of the final rule and changes to the Medicaid Provider Manual include:

(1) Changes to the face-to-face encounter requirements to align with Medicare requirements for the initial ordering of Medicaid home health services.

(2) Clarification that home health services may not be subject to a requirement that the individual be "homebound."

(3) Notification that Medicaid home health services may not be limited to services furnished in the home.

(4) Notification that home health aide services cannot be contingent upon the beneficiary needing nursing or therapy services.

(5) An amendment to the definition of durable medical equipment (DME) and the related face-to-face encounter requirements. Policy changes pertaining to DME and the face-to-face requirements are outlined bulletin MSA 18-17.

I. Face-to-Face Encounter for Home Health Nursing, Therapy and Home Health Aide Services

The Michigan Department of Health and Human Services (MDHHS) issued bulletin MSA-13-19 on June 1, 2013, related to the requirements of home health agencies (HHAs) for the initial face-to-face encounter. One of the requirements is that the certifying physician's documentation of the face-to-face encounter must provide a narrative of clinical findings to support home health services, and be a separate and distinct section of, or an addendum to, the certification.

Per CMS-2348-F, the following requirements for the face-to-face narrative will be removed from Medicaid policy:

- The requirement for the certifying physician to provide a narrative of the face-to-face encounter.
- The requirement for this information to appear in a separate and distinct section of the order, or as an addendum to the certification.
- The requirement for the certification be clearly titled (e.g., face-to-face).

Although the narrative is no longer necessary, the certifying physician must document a face-to-face encounter that is related to the primary reason for home health services. Prior to the start of services, home health agencies should obtain as much documentation as necessary from the certifying physician's medical records and/or acute and post-acute settings to validate the beneficiary's eligibility and need for home health services.

Remaining provisions of the face-to-face requirement in Medicaid policy include:

- Initial ordering of home health services must occur not more than 90 days before or 30 days after the start of services.
- The face-to-face encounter for home health may be performed by the certifying physician or certain authorized non-physician practitioner (NPP).
- An allowed NPP may conduct the face-to-face encounter and must report the findings to the certifying physician.
- Only the certifying physician may document the face-to-face encounter occurred and must identify the allowed NPP who conducted the encounter.
- The certifying physician must sign and date the encounter and state the primary reason for the home health services.

II. Home Health Services May Not Be Subject to a Requirement that an Individual be "Homebound"

In accordance with the Final Rule and as established in Medicaid policy, an individual does not need to be homebound to receive home health services. In addition, home health services are not restricted to the home itself.

III. Home Health Services May Not Be Limited to Services Furnished in the Home

The provision of home health services may not be limited to services furnished in the home and may be provided, as appropriate, in any setting in which normal life activities take place, other than a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF/IID), or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

"Normal life activities" refers to activities that could occur in or out of an individual's home. The authorization and subsequent provision of home health services will continue to be based on medical necessity, not the setting.

IV. Coverage of Medicaid Home Health Services Cannot be Contingent Upon the Beneficiary Requiring Skilled Nursing or Therapy Services

Current Medicaid policy states that home health aide services are covered only when ordered by the attending physician and performed in conjunction with direct, ongoing skilled nursing care and/or physical therapy (PT). In accordance with CMS-2348-F, Medicaid policy will reflect that skilled nursing, therapy services (physical therapy, occupational therapy, or speech therapy), home health aide services, and medical supplies are stand-alone services. Therefore, each service may be rendered independently, and home health aide services are not contingent upon the need of skilled nursing or therapy services.

The certifying physician may order any one or a combination of the four components of home health services dependent upon the completion of a face-to-face encounter, and the development of a plan of care. The plan of care must identify all components as identified in the Medicare Conditions of Participation and Medicaid policy to validate medical necessity.

V. MI Choice Waiver Program Beneficiary and Home Health Nursing Services

When home health skilled nursing is ordered for a MI Choice Waiver beneficiary, the service must be provided through the Medicaid program in accordance with established policy. MI Choice nursing services shall not duplicate services available through the Medicaid home health benefit. MI Choice waiver agencies cannot authorize State Plan services.

VI. Home Health Aide Services

The home health aide is a Medicaid home health benefit for health services on an intermittent basis. The services provided by the home health aide must be medically necessary and ordered by the attending physician. Home health aide services are not to be used solely for personal care needs, respite, heavy cleaning, household repairs, or for the convenience of the beneficiary. The plan of care must clearly outline the duties to be performed by the home health aide. The HHA must identify the availability of other caregiver(s) (e.g., family member or another caregiver).

VII. Home Health Aide Services, MI Choice Waiver and Home Help

Previously, Medicaid only covered home health aide services when ordered by the attending physician and performed in conjunction with direct, ongoing skilled nursing care and/or PT. Pursuant to CMS-2348-F, home health aide services may now be ordered without other skilled services. However, home health aide services shall not duplicate services provided by the MI Choice Waiver and/or Home Help.

It is the responsibility of the HHA to assess the ability and willingness of the family, caregiver or another entity (e.g., Home Help Program or MI Choice Waiver) to perform personal care services. For beneficiaries enrolled with another entity (e.g., Home Help program or MI Choice Waiver), the HHA must contact either the adult services worker or the waiver agent to ensure coordination and verify there is no duplication of care.

VIII. HHA and Durable Medical Equipment, Prosthetics, Orthotics & Supplies (DMEPOS)

Routine medical supply items are included in the reimbursement for the HHA skilled nurse or home health aide visit. Medicaid policy maintains that the HHA or the medical supplies provider may bill separately for additional quantities. For quantities that exceed what is listed on the MDHHS Home Health Database, the supplies must be billed by a DME or medical supplies provider.

IX. HHAs as DMEPOS Providers

In accordance with CMS-2348-F and the ACA, HHAs are required to provide medically necessary equipment and supplies either directly or through arrangement with DME providers when providing medically necessary home health skilled nursing or aide services.

Except for items identified in the Home Health chapter of the Medicaid Provider Manual as routine medical supplies and those items listed on the MDHHS Home Health Database as separately reimbursed to HHAs, HHAs that choose to provide equipment and medical supplies must enroll with Medicaid as a DME provider. The HHA must comply with all federal and state DMEPOS provider rules, policies, and regulations.

For further instruction, refer to the General Information for Providers chapter and Medical Supplier chapter of the Medicaid Provider Manual. The Medicaid Provider Manual is available on the MDHHS website at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

Public Comment

The public comment portion of the policy promulgation process is being conducted concurrently with the implementation of the change noted in this bulletin. Any interested party wishing to comment on the change may do so by submitting comments in writing to:

Attn: Michelle Tyus
MDHHS/MSA
PO Box 30479
Lansing, Michigan 48909-7979
Or
E-mail: TyusM@michigan.gov

If responding by e-mail, please include "Home Health Face-to-Face Requirements" in the subject line.

Comments received will be considered for revisions to the change implemented by this bulletin.

Manual Maintenance

Retain this bulletin until the information is incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Kathy Stiffler, Acting Director
Medical Services Administration