

Bulletin Number: MSA 16-34

Distribution: Medicaid Home Health Agencies, Medicaid Health Plans

Issued: November 1, 2016

Subject: Home Health Policy Changes and Clarifications; Notification of New Home Health Codes for Skilled Nursing Services

Effective: As Indicated

Programs Affected: Medicaid

The purpose of this bulletin is to notify Medicaid home health agencies of policy changes to better align with Medicare conditions of participation (CoPs) at 42 CFR §484, and to explain the Centers for Medicare & Medicaid Services (CMS) change request #9369, which mandates two new codes for billing Medicaid home health nursing services. This bulletin also provides general reminders and clarifications to ensure understanding and consistent administration of the Medicaid home health benefit.

Content of the Plan of Care (POC)

The mandatory elements of the POC will be revised effective December 1, 2016 to reflect those found in the Medicare CoPs. These components are the minimum information that must be included in each POC. The POC should be further developed to address a beneficiary's individual needs as necessary.

The POC must contain at a minimum the beneficiary's:

- Start of care date
- Certification period
- Pertinent diagnoses
- Mental status
- Types of services, supplies, and equipment required
- Frequency of visits
- Prognosis
- Rehabilitation potential
- Functional limitations
- Activities permitted
- Nutritional requirements
- All medications and treatments

- Safety measures to protect against injury
- Attending physician's signature and date signed
- Goals, referrals and discharge planning
- Orders for therapy services, which include the specific procedures and modalities to be used and the amount, frequency, and duration
- Any additional items the home health agency or physician chooses to include

New Codes

Effective for dates of service on and after January 1, 2016, in accordance with CMS Change Request #9369, Medicaid recognizes two new G-codes to differentiate levels of nursing services provided during a hospice stay or home health episode of care. Healthcare Common Procedure Coding System (HCPCS) code G0154 (direct skilled nursing services of a licensed practical nurse [LPN] or registered nurse [RN] in the home health or hospice setting) has been discontinued and the following HCPCS codes are now covered:

G0299 – Direct skilled nursing services of an RN in the home health or hospice setting.
G0300 – Direct skilled nursing services of an LPN in the home health or hospice setting.

Providers will need to select the correct code when billing MDHHS for skilled nursing services through a home health agency. Home health payment amounts have not changed.

For more information please see the CMS change request, which can be found at the following link: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3378CP.pdf>.

Physician Orders for Home Health Services and Physician Signatures on the POC

Per established Medicaid policy, home health services must be ordered, in writing, by the beneficiary's attending physician as part of a written POC. The POC must also be signed and dated by the beneficiary's attending physician. Home health agencies are reminded that if a service is rendered prior to the date the physician signed the POC, and there is no pre-existing written or verbal order, Medicaid will not reimburse the service(s) provided. Recoupment of Medicaid payment will be undertaken if post payment review demonstrates that services were provided without a physician order or if a POC is not signed and dated by the attending physician.

Supervision of Home Health Agency Staff

Medicaid policy requires that certain home health agency staff (Physical Therapy Assistants [PTA], Occupational Therapy Assistants [OTA], Home Health Aides, and Speech Language Therapy [SLP] candidates/students) be supervised and that there must be evidence of supervision documented in the medical record. The Home Health Chapter of the Medicaid Provider Manual explains the supervision requirements for each of these providers and home health agencies are responsible for ensuring that all documentation by a PTA, OTA, home health aide and SLP candidate/student are supervised and co-signed by the appropriate staff

member. Additionally, clarification is being added to the Medicaid Provider Manual to indicate that nursing care by an LPN must be under the supervision of an RN and the RN must co-sign the LPN's documentation.

Prior Authorization for Therapy Services

Per the Home Health Chapter of the Medicaid Provider Manual, prior authorization (PA) is needed when physical therapy (PT), occupational therapy (OT) and speech therapy (ST) is required beyond the initial 60-days of service and also when therapies resume within 12 months for the same diagnosis. To request PA, home health agencies must submit a completed MSA-115 – Occupational Therapy – Physical Therapy – Speech Therapy Prior Approval Request/Authorization form. Medicaid forms are available within the Forms Appendix of the Medicaid Provider Manual, or on the MDHHS website at www.michigan.gov/medicaidproviders >> Policy and Forms >> Forms. Effective March 25, 2016, a Community Health Automated Medicaid Processing System (CHAMPS) edit was implemented that rejects claims submitted without the necessary PA.

Receipt of Medicaid Policy Updates

Home health agency providers are responsible for being informed of all Medicaid updates and to maintain current contact information in CHAMPS. MDHHS notifies affected providers of policy changes and updates based on this information.

An e-mail ListServ is also available for providers to receive automated announcements regarding the Michigan Medicaid Program (i.e., changes to policy, billing issues, training opportunities, etc.). Providers may access subscription instructions posted on the MDHHS website at www.michigan.gov/medicaidproviders >> Click "ListServ Instructions" under Provider Resources.

Home health agencies may also access policy updates on an as needed basis through accessing the MDHHS website located at www.michigan.gov/medicaidproviders and then navigating to the various MDHHS topics and communications.

Advance Directives

In accordance with the Medicare CoPs at 42 CFR §484.10 (2) (ii), a home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives. The home health agency may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided. The act of presenting information on advance directives should be noted in the beneficiary's record. This requirement is not new but providers are being reminded of the need for compliance with this rule as a condition of participation with Medicare and Medicaid.

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

A handwritten signature in black ink that reads "Chris Priest". The signature is written in a cursive style with a large initial "C" and a long horizontal stroke at the end.

Chris Priest, Director
Medical Services Administration