Home Health Services
Fee-for-Service Medicaid
Briefing Date: 19 October 2016

Utah Office of
Inspector General

Bottom Line Up Front

The Utah OIG and Utah Medicaid ACOs have built a strong partnership that has culminated in regular information sharing meetings. The offices are able to share lessons learned and best practices to improve the Medicaid Fee-for-Service (FFS) and Accountable Care Organization (ACO) operations. This collaboration helps improve the Medicaid program for the benefit of the recipients and the taxpayers of Utah.

We want to continue to build upon this partnership.

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Inspector General

Home Health Services Provider Manual

- Updated January 2016
  - OIG has completed 3 comprehensive reviews of previous Home Health Services/Agencies provider manuals.
    - Part of the OIG policy review mission.
- Conjunction with Section I: General Information Provider Manual and provider type specific manuals, e.g., Personal Care Services.

- Definition of Home Health Services:
  - "Home health services are medically necessary, part-time, intermittent health care services provided to eligible persons in their place of residence when the home is the most appropriate and cost effective setting consistent with the client's medical need, and when the medical need can be safely met in the home through one of two nursing skill levels with support from family care-givers."

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Home Health Services Provider Manual

- Goal of Home Health Care:
  - Determine medical necessity, appropriate method and delivery of care.
  - Designed to be more cost effective than alternative options.
  - Minimize effects of disability or pain.
  - Promote, maintain or protect health.
  - Prevent premature or inappropriate institutionalization.
  - Allow beneficiary to live at home - personal dignity and independence.
  - Support from family is essential for some beneficiaries.
  - Must be based upon physician's order and a Plan of Care.
  - Services limited to one visit per day – unless otherwise authorized.

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Covered Services

- Covered Services – Generally:
  - Home is most appropriate and cost effective place for services.
  - Skilled Nursing (RN or LPN)
    - Skilled nursing levels based upon severity of illness, intensity of service.
  - Physical Therapy
  - Home Health Aides (Supportive Maintenance)
  - Occupational Therapy (EPSDT)
  - Speech-Language/Audiology (EPSDT)
  - IV Therapy:
    - Placement, demonstration, blood draws (infusion therapy), teaching.
  - Private Duty Nursing
    - Early Periodic Screening, Diagnosis and Treatment (EPSDT)
    - Pregnant Women
- Procedure Codes:
  - Listed on the Medicaid Website: https://Medicaid.Utah.gov
  - The *Coverage and Reimbursement Lookup Tool* provides additional policy.

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Responsibilities

- Home Health Agency:
  - Coordinates all care services to meet:
    - Medical, nursing and related health needs in the home.
  - When skilled nursing is authorized – other medically necessary services must be provided at the same time.
  - All home health services must be supervised by a RN employed by an approved, certified home health agency.
  - Nursing and therapy services provided by appropriately licensed professional.
- Physician:
  - Identifies home health needs and provides written physician's order detailing required services.
- RN:
  - Makes initial assessment and recertification visits.
    - Initiates the plan of care.
    - Counsels beneficiary and family in meeting needs – provides training.
    - Supervises and teaches other nursing personnel.
    - Nursing Assessment (condition changes, medication box fill, IV dressing)
      - **Note**: Additional visits are not authorized for services that could be provided during other visits.
- Family Support:
  - Committed and capable of assisting in care.
  - Must receive adequate training.

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Initial Assessment

- In-depth Physical and Psychosocial
- Completed by a RN initially.
- Assess:
    - Beneficiaries Overall Condition
    - Needs
    - Adaptability of Patient's Residence to Provision of Care
    - Capability of Patient to Participate in His/Her Own Care
    - Identify Family Support Systems/Persons Willing to Assist
    - Establish Plan for Delivery of Care
- Outcome of Initial Assessment:
    - Documented Plan of Care
    - Based upon physician's written orders and RN's assessment.

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Plan of Care

- Basics:
  - Must be in writing and signed by physician.
  - Cooperatively by home health agency and physician in accordance with the physician referral and orders.
  - Establishes approved services and limits for home health services.
  - Designed for agency to adequately meet needs of patient.
  - Developed to support care in patient's residence.
  - Must be incorporated into agency's permanent record for the patient:
    - Must maintain records in accordance with Medicaid policy.
    - Supply copies and supporting documentation to OIG upon request.
    - Records sufficient to substantiate services.

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Reassessment

- ***At Least*** Every Sixty (60) Days
- Physician to review new Plan of Care and recertify continuing need.
- Medicaid must approve updated plan of care at least every 60 days.
- Must include a 60 day summary of care from previous certification period on every care plan after the initial authorized period.
- Reassessment – 5 Days before to 2 Days after previous plan.
- Changes must be approved in writing by the physician or by a RN on the staff of the agency receiving the physician's oral order.
  - Oral orders from physician must be subsequently documented on or before next plan review.
- Discontinue service if patient does not require home health care.
  - When significant changes occur must reassess needs.

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Non-Covered Services

- Home Health Services not covered in following situations:
  - Patient capable of self-care.
  - Patient is in a hospital, skilled nursing facility or intermediate care facility.
  - Personal care services, except when determined necessary for skilled care.
  - Housekeeping service.
  - Supportive skilled nursing visits without hands-on-care.
  - Respite care.
  - Care for social needs.
  - Visits to supervise home health employees (admin expense of agency).
  - Medical supplies, except where indicated/authorized.
  - Palliative care for speech, occupational and physical therapy.

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Coverage Limitations

- Limitations for Home Health Services:
  - One visit per day – except limited circumstances.
  - RN Assessment/Reassessment limited to one every 60 days.
  - Aide may visit only once per day unless for extended level service.
  - Same day service for personal care aide and home health aide not reimbursable – must coordinate.
  - Skilled nursing for observation, monitoring and ongoing assessments must accompany hands on care.
  - PRN visits by an RN are limited to two in 30 day period.
  - Acute skilled nursing care visit by RN limited to twice a day for maximum of 21 visits and limited to first month of service unless patient reverts to acute phase of chronic condition.
  - Teaching visits limited to four per certification period in skilled nursing. Teaching for supportive maintenance must include hands-on care.

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Limitations – Continued

- ***"A Plan of Care exceeding established limits will not be approved."***
  - *Home Health Services Provider Manual, Section 5-2 "Limitations"*
- Medicine box refills must cover 2 week period.
- Medical supplies furnished by agency are limited to initial visit.
- Home health services must be cost effective.
  - Less than long term than nursing or other institutional setting.
- Wound Management: Patients able to leave home should see physician.
- One IV Dressing Change or IV Site Change per 7 day period.
- No carryover hours from discharge from home health agency and readmission. New nursing assessment must be completed.
- Chemotherapy by infusion technique: 5-FU only drug for home coverage.
- Hemophilia blood factors limited to University Home Infusion Services.
- Prior authorization required for physical, occupational and speech therapy.
- Prior authorizations are provider specific:
  - If another agency assumes care, that agency must apply for separate prior authorization.

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Private Duty Nursing (PDN)

- Optional Program
  - Designed to prevent prolonged institutionalization.
  - As optional service, subject to continued legislative funding.
  - Services for the medically necessary skilled nursing needs of patient.
  - EPSDT eligible members only.
    - In certain cases, agency staff may determine that proposed PDN services are both medically necessary and cost effective than alternative services. *"Agency may exceed the limitation of PDN coverage beyond EPSDT eligibility members."*
      - Quality and cost effectiveness justify over alternative care.
  - Only available if parent, guardian or primary care giver is committed to and capable of performing necessary support for the plan.

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Private Duty Nursing (PDN)

- Requirements:
  - Member is only intended recipient of PDN services.
    - Not intended for other members of the household.
  - Not authorized if care is a duplication of care reimbursed from another benefit or funding source.
  - Skilled management by licensed nurse is required (RN/LPN).
  - Request is submitted through Prior Authorization Unit.
    - Reviewed by Utilization Review Department or Utilization Review Committee
  - Eligible for patients that require greater than 4 hours of skilled nursing care per day while in transition from hospital to home.
    - Allow sufficient training of caregiver.
  - Eligible for patients who are dependent on mechanical ventilation.
    - Required during active weaning or as ongoing service.

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Private Duty Nursing (PDN)

- PDN not covered for:
  - Custodial or sitter care to ensure compliance with treatment.
  - Respite care to allow caregiver to work or sleep.
  - Behavioral or eating disorders.
  - Observation or monitoring for medical conditions not requiring skilled nursing.
- Documentation:
  - Physician Order – Establish need for PDN services.
  - Prior Authorization Form with supporting documentation.
  - Plan of care:
    - Consistent with diagnosis, severity of illness and intensity of care.
    - 60 day summary of care from previous certification – if not initial.
    - Verification of caregiver receiving specialized training.
  - PDN Acuity Grid:
    - Used to determine medical necessity and PDN hours at home.
    - Including supporting documentation to justify score:
      - Average daily care from previous period.
      - Two weeks of documentation (progress notes, flow sheets, medications, communications, documented care).

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Private Duty Nursing (PDN)

- **Additional Policy**:
  - PDN Hours May Not be Banked:
    - *Saving of unused PA hours to be used later for the convenience of family or agency is not covered.*
    - Agency may adjust or combine PDN hours within a 7 day period based upon the needs of the family. Should not be common practice.
      - Not authorized if agency could not staff a shift.
  - Unexpected Illness or Event:
    - Submit additional PA request to exceed approved units or hours.
  - Rural Counties:
    - Enhancement available for traveling to provide services in rural counties – when in excess of 50 miles roundtrip from caregiver's base of operations.
      - San Juan and Grand County – Exception
        - No distance requirement, enhancement for all residents.
    - Patient must reside in the same or adjacent rural county as provider.
  - Telehealth Skilled Nurse for Rural:
    - Must meet policy requirements.

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Related Policies and Provider Manuals

- **Personal Care Services Provider Manual, Updated April 2016**
  - Two Parts to Manual: Traditional and Employment Related Personal Care Services (EPAS)
  - Provide supportive care to participants at their residence.
  - Maximize independence and prevent or delay premature or inappropriate institutionalization by providing assistance with daily activities.
  - Limited to 60 hours per month and require prior authorization.
  - Cannot provide on the same day as home health aide services.
  - Delivered by a certified personal care aide or home health aide.
  - Examples of services: reminding to take and observing medication, minimal assistance or observation of bathing, personal hygiene, nail care, meal assistance (planning, preparation, feeding, cleanup), oral hygiene, emergency first aid, other services listed in manual.

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Related Policies and Provider Manuals

- **Section I: General Information Provider Manual, Updated July 2016**
  - General Utah Medicaid information applicable to all providers.
  - Policies on enrollment, submitting claims, eligibility, covered services, participation guidelines.
- **Physical Therapy and Occupational Therapy Services, Updated July 2015**
  - Policy for physical and occupational therapy programs to increase the ability for Medicaid patients to function at a maximum level through rehabilitative process.
  - Home Health Agency guidance on program participation.
- **Private Duty Nursing Acuity Grid, Updated April 2013**
  - Form to determine average amount of skilled nursing treatment for patient needs.
- **Speech-Language Pathology and Audiology Services, Updated October 2016**
  - Limited to Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) and pregnant women eligible recipients.
  - Can extend eligibility if determined proposed services are medically appropriate and more cost effective than alternative services.
  - Services are considered medically necessary only if realistic expectation treatment will achieve measurable improvement.

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OIG-ACO Collaboration
Metrics Development

- **Metrics**
  - OIG-ACOs jointly developed a set of 10 metrics to help identify fraud, waste and abuse within the home health services program:
    1. HHA used for housekeeping when inappropriate diagnoses:
       - Bipolar, obesity, depression.
    2. Tracheotomy patients on PDN for years – lack of caregiver training.
    3. Exceeding PA for allotted number of hours – excessive billing.
    4. Deceased member.
    5. Respite care – not a covered service.
    6. Overlapping claims for inpatient stays.
    7. Overlapping claims for skilled nursing stays.
    8. High average number of visits per beneficiaries.
    9. High percentage of beneficiaries for whom other HHAs billed.
    10. High average of therapy visits per beneficiary.
  - Effective and efficient measures to help identify suspect claims.
  - Identify potential vulnerabilities through collaboration of efforts.

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OIG-ACO Collaboration
Joint Issues Identified

- **Consolidated Joint Areas of Concern**
  - Medical Necessity:
    - Not always appropriate
    - Review determines services were not medically necessary for patient.
  - Lack of Documentation:
    - Cannot substantiate claims
  - Time Bandits:
    - Billing for services not rendered
    - Manipulating time to increase payment
    - Billing for greater than a 24 hour period
  - Improper billing:
    - Exceeding units allowed
    - Rounding to nearest hours rather than billable unit, e.g., 15 minute blocks
  - Deviation from Plan of Care:
    - Not following care plan.
- Adapt and changing issues based upon joint lessons learned and best practices.

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Questions?

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