Section 27: Home Health Services

Introduction

This section serves as a general summary of the IHCP's policies regarding home health services. Additional information specific to this topic may be found in the *IHCP Provider Manual*, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, the HIP-ESP Plan, or any other plan, providers must contact the member's MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

IHCP members enrolled in *Care Select* receive the same benefit coverage and are subject to the same limitations as members enrolled in traditional Medicaid FFS program. Please refer to *Chapter 1* of the *IHCP Provider Manual* for detailed information about the FFS, *Care Select*, and RBMC delivery systems.

Description of Service

Home health services are available to IHCP members who are medically confined to home when services are ordered by the member's physician and performed in accordance with a written POC. IHCP members who, because of illness or injury, are unable to leave home without the assistance of another person or of an assistive device, such as a wheelchair or walker, or for whom leaving the home is contrary to medical advice, are considered to be medically confined to home. Home health services may be utilized for care and treatment of acute or chronic conditions, rehabilitation, education regarding care, coordination of community services, or to avoid prolonged or repeated hospitalizations and/or higher and more costly levels of care.

Reimbursement Requirements

IHCP reimbursement is available to home health agencies for skilled nursing care services provided by an RN or licensed practical nurse (LPN), home health aide (HHA) services; physical, occupational, or ST services; respiratory therapy (RT) services; renal dialysis; and tocolytic infusion therapy, subject to limitations in *405 IAC 5-3, 405 IAC 5-16,* and *405 IAC 5-22*.

All home health services require PA. The exception is services provided by RNs, LPNs, or HHAs, which are ordered in writing by a physician prior to a member's discharge from a hospital and which do not exceed 120 hours within 30 days of discharge. Services may not continue beyond 30 calendar days unless PA is received. Any combination of therapy services ordered in writing by a physician prior to the member's hospital discharge does not require initial PA but may not continue beyond 30 hours, sessions, or visits in 30 calendar days, unless PA is received.

Home health care is available to eligible IHCP members who are in need of intermittent or part-time home health services. The type and extent of service required must be documented in the plan of treatment and included with the PA request. Home health care services must be rendered as indicated on the plan of treatment. The plan of treatment must be signed by the

attending physician and reviewed every 60 days. The PA request, the plan of treatment, supporting documentation, and hourly determination guidelines will be considered when evaluating the number of hours to approve for home health care services. The hourly determination guidelines are used as an aid, but do not take the place of clinical judgment when determining appropriate hours of service.

Diabetes self-management training services can be provided in a home setting but are not included under home health care services.. See see the Diabetes Self-Management Training policy in Section 13 of this manual for details.

Definitions

Encounter – An encounter occurs when a home health care provider enters a home, provides services to one or more individuals within that home, and departs.

Multiple member care situation – A home care situation in which more than one member of a single household is receiving home health services. When this situation occurs, care must be coordinated in the most efficient manner. Multiple care member situations must be reported on each member's individual PA request. When one member of a home health agency provides care to multiple members during an encounter, only one overhead may be billed.

Home health care provider –RN, LPN, physical therapist (PT), occupational therapist (OT), ST, speech language pathologist (SLP), RT, or HHA.

Prior Authorization Requirements

Home Health Care

IHCP reimbursement is available to members medically confined to home for intermittent or part-time home health care services provided by home health care providers. In order for home health services to be approved, the services must be medically reasonable and necessary, and home care must be less expensive than alternative modes of care.

Home health services may consist of the following:

- Skilled nursing services provided by an RN or LPN
- Home health aide services
- Physical, occupational, and ST services
- RT services
- Renal dialysis
- Home tocolytic infusion therapy

Home health services require PA, except in the following circumstances:

- Services provided by an RN, LPN, or home health aide that have been ordered in writing by a physician prior to the member's discharge from a hospital and that do not exceed 120 hours within 30 days of discharge do not require PA. These services may not continue beyond 30 calendar days, unless PA is obtained.

- Any combination of therapy services ordered in writing by a physician prior to the member's hospital discharge that does not exceed 30 units in 30 calendar days does not require PA. These services may not continue beyond 30 days following discharge, unless PA is obtained.
- Home tocolytic infusion therapy does not require PA, effective April 4, 2002.

The PA request for home health services must contain information required for all PAs, as specified in *405 IAC 5-3-5*, including but not limited to:

- The appropriate diagnosis and related information
- Services or supplies requested with the appropriate codes
- Name of suggested provider of services and supplies
- Description of previous services or supplies
- Plan of treatment
- Rehabilitation potential

In addition, the following information must be submitted with the PA request form for home health services:

- An estimate of the costs for the services ordered by the physician and set out in the written plan of treatment. The cost estimate must be provided with the plan of treatment and signed by the attending physician. The estimate must reflect the cost of each service requested, plus the overhead rate for the time periods requested, as reflected on the plan of treatment.
- PA requests for home health services should provide documentation of all services – for example, Medicare, CHOICE, IHCP waiver programs, private insurance, and any other paid caregivers – received by the IHCP member. The number of hours per day and the number of days per week should be listed for each service.
- PA requests for home health services should indicate the number of non-paid caregivers (even if there are none) available to provide care for the member, including consideration of whether the caregiver works outside the home or attends school outside the home. A copy of the caregiver's work schedule from the employer or the class schedule from the school must be submitted with the PA request. The provider is responsible for coordinating home care services with the caregiver's work or school schedule to meet the member's needs, and should clearly document caregiver information on the PA request form.
- PA requests for home health services should document whether the member works or attends school outside the home, including what assistance is required.
- When there is a situation of multiple members, and more than one member is receiving home health services in a single household, care must be coordinated to provide service in the most efficient manner. Only one overhead component can be billed per encounter. Agencies are responsible for reporting this aspect of the case and should indicate this fact on the PA request submitted for each member of the household.

A copy of the current plan of treatment, developed by the attending physician, therapists, and agency personnel, and signed by the attending physician, must also be included with the PA request for home health services. The plan of treatment should include the date of onset of the medical problems and progress notes regarding the necessity, effectiveness, and goals of therapy services. The plan of treatment should detail the types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitation, activities permitted, nutritional requirements, medications and treatments, safety measures to protect against injury, and any other relevant items.

CMS Transmittal 59 allows for the acceptance of a physician's rubber stamp signature for clinical record documentation, provided it is permitted by federal, state, and local law, and authorized by the home health agency's or hospice agency's policy. This addresses the impact this change will have on the Medicaid PA process for home health and hospice services by referring providers to the appropriate regulations for Medicaid.

Chapter 6 of the *IHCP Provider Manual* and state regulations at *405 IAC 5-5-5* specify that the provider must approve the Indiana Prior Review and Authorization Request form by personal signature, or providers and their designees may use a signature stamp. Providers that are agencies, corporations, or business entities may authorize one or more representatives to sign requests for PA.

Providers should note that *Chapter 6* of the *IHCP Provider Manual* and state regulations address permissible signature requirements for the Indiana Prior Review and Authorization Request form, and must be differentiated from the signature requirements for physician orders and care plans. Under *405 IAC 5-5-5*, it is permissible for the agency to use a signature stamp for the Indiana Prior Review and Authorization Request form.

In conclusion, physician signature stamps may be used on the Indiana Prior Review and Authorization Request form when requesting Medicaid PA for home health services; however, any physician order or plan of treatment that is attached to the Indiana Prior Review and Authorization Request form must include an original signature by the physician.

Non-Covered Services

The following services are noncovered home health services, except as specified under the applicable IHCP Waiver Service programs:

- Transportation to and from grocery stores, drug stores, banks, etc.
- Homemaker services, including shopping, laundry, cleaning, meal preparation, etc.
- Companion or sitter services, including escort services, activity planning, etc.
- Chores, including picking up prescriptions, household supplies and/or groceries, etc.
- Respite care

Home Health Care Hourly Determination Guidelines

The following are guidelines for determining the appropriate number of hours reimbursable for general categories of home health care services. These are guidelines only and do not override medical decisions based on individual case review.

Factors for consideration when determining the hours of service to be approved include:

- Severity of illness and symptoms
- Stability of the condition and symptoms
- Change in medical condition that affects the type or units of service that can be authorized
- Intensity of care required to meet needs
- Complexity of needs
- Amount of time required to complete treatment tasks
- Treatment plan, including identified goals
- History of previous response to care
- Whether the member works or attends school outside the home, including what assistance is required
- Caregivers available to provide care for the member, including the following considerations:
  - Number of caregivers available
  - Physical limitations of available caregiver(s) that limit the ability of the caregiver(s) to provide care to the member
  - Number of hours requested, compared to availability of caregiver(s) available time
  - Whether the caregiver has additional child care responsibilities
  - Whether the caregiver works outside the home
- Other home care services currently being utilized including, but not limited to; Medicare, Medicaid Waiver Programs, CHOICE, vocational rehabilitation, and private insurance

12 to 16 Hours a Day of Home Health Care Services

Members requiring 24-hour monitoring may be authorized for up to 12 hours a day of skilled nursing or home health aide services to prevent deterioration in life sustaining systems. Examples of these conditions include, but are not limited to:

- Severe respiratory conditions resulting from pulmonary disorders, such as bronchopulmonary dysplasia, severe respiratory complications of cystic fibrosis, bronchitis, asthma; central nervous system disorders; cardiovascular disorders, such as cardiac anomalies; and neuromuscular disorders, such as muscular dystrophy and Guillain-Barré syndrome
- Dependency on mechanical ventilator assistance
- Tracheostomy

Special situations may occur where home health hours may be approved for up to 16 hours per day of skilled care on an ongoing basis, although each individual situation must be evaluated with a PA request. These special situations include but are not limited to:

- A single caregiver is available who also works full-time (or a significant number of part-time hours) outside the home. This also applies to situations where there may be two adults present, but one is unable to provide any, or a very limited amount, of care due to physical disability or severe physical limitations. The disabled caregiver's physician must substantiate this in writing.
- Significant additional child care responsibilities. Significant is defined as:
  - Three or more children under the age of six, or four or more children under the age of 10
  - One or more children in the home with special medical care needs requiring extensive medical and physical care above and beyond the needs of the average well child. If Medicaid is not providing services to this child at home also, the child's physician must provide a statement of the child's medical needs. The same caregivers must be caring for these children, as well as for the member for whom the PA request has been submitted.

Special situations may occur where additional home health hours may be authorized on a short term or temporary basis. These situations are evaluated individually, on a case-by-case basis. Examples of these situations are as follows:

- Significant deterioration in the member's condition, particularly if additional hours will prevent an inpatient or extended inpatient hospital admission
- Major illness or injury of the caregiver with expectation of recovery, including, but not limited to:
  - Illness or injury that requires an inpatient acute-care stay
  - Chemotherapy or radiation treatments
  - A broken limb, which would impair the caregiver's ability to lift the member
- Temporary but significant change in the home situation, including but not limited to:
  - A caregiver's call to military duty
  - Temporary unavailability due to employment responsibilities

(These must be substantiated in writing by the commanding officer, other military representative, or by the employer.)

- Significant permanent change in the home situation, including, but not limited to, death or divorce with loss of a caregiver. Additional units of service may be authorized for a short period of time to assist in providing a transition.

8 Hours a Day Home Health Care Services

Members who require extensive care and daily monitoring of their medical/physical conditions, but who do not possess the same degree of potential to deteriorate quickly into life threatening situations as do members requiring 24-hour monitoring, may receive up to eight hours of care

daily. An additional hour or two may be allowed for transportation to and from work in situations where the caregivers work full time outside the home. Examples of these situations/conditions include, but are not limited to:

- Chronic, debilitating conditions, such as severe forms of cerebral palsy, muscular dystrophy, spina bifida, and other congenital anomalies; and quadriplegia.
- Conditions that require equipment or treatment needs with potential for serious complications – for example, central lines or Hickman catheters
- Frequent treatments, such as RT required (in the form of updrafts, chest PT, or CPT®, etc.)
- Nutrition provided by hyperalimentation or by gastrostomy tube feedings, in addition to one of the above
- Skilled nursing assistance required to attend school
- The member receives multiple medications that require monitoring for severe side effects or responses

Special situations may occur in which additional home health hours may be authorized on a short term or temporary basis. These will be evaluated individually on a case-by-case basis. Examples of these situations are:

- Significant deterioration in the condition of the member, particularly if additional hours will prevent an inpatient or extended inpatient hospital admission.
- Major illness or injury of the caregiver with expectation of recovery, including, but not limited to:
  - Illness or injury that requires an inpatient acute care stay
  - Chemotherapy or radiation treatments
  - A broken limb that impairs the caregiver's ability to lift the member
- Temporary but significant change in the home situation, including, but not limited to:
  - A caregiver's call to military duty
  - Temporary unavailability due to employment responsibilities

(These must be substantiated in writing by the commanding officer, other military representative, or by the employer.)

- Significant permanent change in the home situation, including, but not limited to, death or divorce, with loss of a caregiver. Additional units of service may be authorized for short periods of time to assist members with transitions.

Three to Seven Hours a Day of Home Health Care Services

Members without the severity of conditions noted above who require primarily heavy physical care, with some skilled nursing monitoring to avoid deterioration, may receive three to seven hours of care per day. These members are generally chronic but stable and may have conditions such as congenital anomalies, neuromuscular disorders, central nervous system disorders, or other disorders that severely disrupt the capacity to care for self.

Adults requiring care and assistance must be homebound, as certified by the attending primary physician. However, consideration may be given to paraplegics, quadriplegics, or other disabled members unable to provide self-care, such as bathing or dressing, who are able to drive mechanically altered vehicles to maintain meaningful employment and a relationship with the community. Such adults may be considered for assistance from a HHA for up to three to four hours per day. The agency may split the hours between morning and evening to attend to the bedtime needs of the member. This service is subject to medical necessity, and documentation must demonstrate the need.

Billing Requirements

The following is the computation of the total reimbursement rate:

- The overhead cost rate plus
- The staffing cost rate multiplied by the number of hours spent performing billable patient care activities

Each component of the total home health reimbursement rate is based on statewide weighted median costs calculated for each component. The statewide weighted median rate for each component is determined by calculating the per visit or per hour cost of each component for each home health agency. These costs are ranked from the highest to the lowest, calculating the cumulative number of Medicaid visits or hours, and locating the point on the array in which half the respective Medicaid visits or hours were provided by agencies with a higher cost and half were provided by agencies with a lower cost.

The overhead cost rate per visit for each home health provider is based on total patient-related costs, less the direct staffing and employee benefit costs, less the semi-variable costs, divided by the total number of home health agency visits during the Traditional Medicaid reporting period for that provider. The result of this calculation is the overhead cost per visit for each home health provider that was included in the statewide overhead array. The semi-variable cost was removed from the overhead cost rate calculated, and included in the staffing cost rates.

The staffing cost rate per hour for each discipline in the home health agency is based on the total patient-related direct staffing and employee benefit costs, plus the semi-variable cost, divided by the total number of home health agency hours worked. The result of this calculation is the staffing cost rate per hour, per discipline for each home health agency.

Occurrence Codes

Providers use the *UB-04* occurrence code, occurrence date, and occurrence span for fields 31-34, a–b, on the *UB-04* to indicate the appropriate overhead fees. Use the following occurrence code to identify the overhead rate.

- **Code 61** indicates that one encounter with the member occurred on the date shown.

All home health visits must be documented on any PA request submitted on behalf of members.

If the dates of service billed are not consecutive, the provider should enter the correct occurrence code corresponding to each DOS billed on the UB-04 in the Occurrence Code and Occurrence Date fields, Locators 32–35 a–b, on the UB-04. If the dates of service billed are consecutive, and one encounter was provided per day, then Occurrence Code 61 and the dates

of service being billed are entered in the Occurrence Span Code field, locator 36 a-b. Providers that submit more than one UB-04 claim form in a multiple member care situation should submit only one of the forms with the overhead attached. As long as the overhead is attached to only one member, it does not matter to which member it is attached.

Multiple Visit Billing

When multiple visits for the same prior authorized service are made to a member in one day, providers should bill all visits on the same claim form. Billing these same-day services on one claim form allows the system to bypass duplicate editing. If these services are billed on separate claim forms, one or more of the services will be denied as a duplicate service. It is not appropriate for HHA providers to rotate personnel in the home merely to increase billing.

Partial Units of Service

Partial units of service must be rounded to the closest whole unit when calculating reimbursement. A partial unit of service of 30 minutes or more should be rounded up to the next highest unit. A partial unit of service of 29 minutes or less should be rounded down to the next lowest unit. One unit of service equals 60 minutes.

- Example 1:85 minutes spent on billable patient care activities is rounded down to one unit.
- Example 2:95 minutes spent on billable patient care activities is rounded up to two units.

Home Health Services – General Guidelines

Table 27.1 – CPT®/HCPCS Codes Home Health Services

Code	Description
99600 TD	Unlisted home visit service or procedure; RN
99600	Unlisted home visit service or procedure ; some health aide
99600 TE	Unlisted home visit service or procedure ; skilled nurse, LPN/licensed vocational nurse (LVN)
S9349	Home infusion therapy, tocolytic infusion therapy, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
G0151	Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes

Table 27.2 – Tocolytic Therapy

Code	Description

99601	Home infusion/specialty drug administration, per visit (up to 2 hours);
99602	Home infusion/specialty drug administration, per visit (up to 2 hours); each additional hour (List separately in addition to code for primary procedure)

Indicators for Home Health Services

One of the following indicators from each category must be present for a member to be eligible for home health services:

Category I: Member

- The member is at risk of respiratory failure, severe deterioration, or hospitalization without constant monitoring.
- The member requires total care – monitoring 24 hours per day.
- The member desires to stay in the home, rather than in a LTC facility.
- The medical condition of the member has deteriorated, creating the need for more intense short-term care (physician’s statement required).
- The member does not have a primary caregiver or access to other care.

Category II: Caregiver

- Primary caregiver is employed and absent from the home, or is unable to provide the necessary care.
- Primary caregiver has additional child care responsibilities, disallowing the time needed to care for the member (three or more children under six years of age, or four or more children under the age of 10).
- Primary caregiver also has additional children with special needs to care for (one or more children with special healthcare needs requiring extensive medical and physical care).
- Major illness or injury of caregivers, with expectation of recovery (physician’s statement required)
- Temporary but significant change in the availability of caregiver – for example, military service (commanding officer, other military representative, or employer’s statement required).
- Significant permanent change in caregiver’s status – for example, death or divorce with loss of one caregiver (physician’s statement required).

Home Health Care for Central Nervous System Disorders

Table 27.3 – CPT®/HCPCS Codes Home Health Services

Code	Description
99600 TD	Unlisted home visit service or procedure; RN
99600	Unlisted home visit service or procedure; home health aide
99600 TE	Unlisted home visit service or procedure; skilled nurse, LPN/LVN
S9349	Home infusion therapy, tocolytic infusion therapy, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
G0151	Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes

Indicators for Central Nervous System (CNS) Disorders

One of the following indicators must be present for a member to receive home health care for CNS disorders:

- Altered level of consciousness
- Respiratory distress
- Potential for increased intracranial pressure
- Body temperature fluctuations (hypothalamus involvement)
- Posturing (decerebrate/decorticate)
- Seizure activity (current)
- Spasticity (severe)
- Pain
- Impaired motor/sensory function to include:
  - Paresis
  - Paralysis
  - Vision impairment
  - Hearing impairment
  - Impaired gag reflex
  - Decreased tactile sensation
- Potential for self-injury
- Need for constant supervision

One of the following services must also be necessary to receive either skilled or non-skilled nursing care for CNS disorders.

Services Requiring Skilled Care	Services Requiring Nonskilled Care
1. Vital signs 2. Ventilator operation/maintenance 3. Central line maintenance/dressings 4. Complex treatment modalities (sterile dressings, soaks, packing, etc.) 5. Parenteral/enteral nutrition 6. Oxygen therapy 7. Respiratory treatments 8. Tracheostomy maintenance/change 9. Suctioning (frequency/secretion type) 10. Stimulation (verbal/tactile) 11. Tube feedings/maintenance of tube 12. IV medication administration 13. Urinary catheter maintenance/change 14. Exercise (active/passive)	1. Bathing/linen change/dressing 2. Catheter care 3. Skin care 4. Minor treatment modalities 5. Oral care 6. Stimulation 7. Continue plan of OT/PT 8. Assist with transfers/ambulation 9. Positioning 10. I&O records 11. Assist with oral feedings 12. Splint or brace application 13. Exercise (active/passive) 14. Ensure safety measures (seizure precautions) 15. Vital signs

Home Health Care for Gastrointestinal Disorders

Table 27.4 – CPT®/HCPCS Codes Home Health Services

Code	Description
99600 TD	Unlisted home visit service or procedure; RN
99600	Unlisted home visit service or procedure; home health aide
99600 TE	Unlisted home visit service or procedure; skilled nurse, LPN/LVN
S9349	Home infusion therapy, tocolytic infusion therapy, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
G0151	Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes
G1053	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes

Indicators for Gastrointestinal Disorders

One of the following indicators must be present for a member to receive home health care for GI disorders:

- Nutritional impairment

- Malabsorption
- Mechanical cause

- Stomatitis, pharyngitis, esophagitis
- Swallowing disorders
- Gastric reflux
- Vomiting
- Anorexia
- Pain
- Orthostatic blood pressure (B/P)
- Significant rapid weight loss
- Morbid obesity >200% optimal weight
- Periorbital/perirectal lesions
- Unhealed wound(s)
  - Surgical
  - Fistula, abscess, fissures
- Bacterial/parasitic infections
- Diarrhea
- Constipation
- Subtotal/total gastrectomy
- Ostomies
- Anemia
- Weakness and fatigue

One of the following services must also be necessary to receive either skilled or non-skilled nursing care for GI disorders:

Services Requiring Skilled Care	Services Requiring Nonskilled Care
1. Vital signs	1. Bathing/linens/dressing
2. IV medication administration	2. Oral care
3. Parenteral/enteral nutrition	3. Skin care
4. Administration/maintenance	4. Feedings (oral)
5. Central line maintenance	5. Force fluid
6. Oral medication administration	6. Assist with ambulation
7. Gastric tube medication administration	7. Exercise active/passive
8. Placement of nasogastric tubes	8. Reinforce teaching of OT/PT/ST
9. Complex treatment/wound care, sterile dressings/wound packing/medicated soaks,	9. I&O
	10. Weight

etc. 10. Ostomy care/irrigation 11. Oxygen therapy 12. Bowel training 13. Weight 14. I&O	

Home Health Care for Musculoskeletal Disorders

Table 27.5 – CPT®/HCPCS Codes Home Health Services

Code	Description
99600 TD	Unlisted home visit service or procedure; RN
99600	Unlisted home visit service or procedure; home health aide
99600 TE	Unlisted home visit service or procedure; skilled nurse, LPN/LVN
S9349	Home infusion therapy, tocolytic infusion therapy, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
G0151	Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes

Indicators for Musculoskeletal Disorders

One of the following indicators must be present for a member to receive home health care for musculoskeletal disorders:

- Pain
- Loss of locomotor ability
- Decreased muscle strength
- Stiffness
- Joint pain, swelling, redness, tenderness
- Muscle wasting
- Paralysis
- Postamputation
- Multiple fractures
- Muscle spasms
- Potential for injury to self

One of the following services must also be necessary to receive either skilled or non-skilled nursing care for musculoskeletal disorders:

Services Requiring Skilled Care	Services Requiring Non-Skilled Care
1. Assistance with prostheses, braces, splints 2. Treatments requiring sterile procedures 3. Assistance with transfers/ambulation 4. Assistance with prostheses, braces, splints 5. Exercise – active or passive 6. Position changes 7. Non-invasive treatments, comfort measures	1. Bathing/linen/dressing 2. Assistance with activities of daily living (ADLs)

Home Health Care for Respiratory Disorders

Table 27.6 – CPT®/HCPCS Codes Home Health Services

Code	Description
99600 TD	Unlisted home visit service or procedure; RN
99600	Unlisted home visit service or procedure; home health aide
99600 TE	Unlisted home visit service or procedure; skilled nurse, LPN/LVN
S9349	Home infusion therapy, tocolytic infusion therapy, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
G0151	Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes

Indicators

One of the following indicators must be present for a member to receive home health care for respiratory disorders:

- Dyspnea
- Quality of respiration (shallow, air hunger, etc.)
  - ➢ Rate of respiration
  - ➢ Dyspnea at rest
  - ➢ Dyspnea with exertion
  - ➢ Cyanosis
  - ➢ Use of accessory muscles

- Apnea/bradycardia

- Abnormal breath sounds
- Splinting respirations
- Strenuous coughing
- Excessive, tenacious secretions
- Ineffective airway clearance
- Abnormal arterial blood gases (ABGs)
- Decreased ability to be mobile due to dyspnea
- Irritability/depression
- Fatigue/weakness
- Anxiety

One of the following services must also be necessary to receive either skilled or non-skilled nursing care for respiratory disorders.

Services Requiring Skilled Care	Services Requiring Non-Skilled Care
1. Oral medication administration 2. IV medication administration 3. Parenteral/enteral nutrition 4. Vital signs 5. Ventilator operation/maintenance 6. Tracheostomy maintenance/change 7. Suctioning 8. Complex treatment modalities (sterile dressing, wound care) 9. Respiratory treatments	1. Assist with bathing, dressing, ADLs (total care may be required) 2. Skin care 3. Oral care 4. Force fluids as instructed 5. Assist with ambulation 6. Exercise active/passive 7. Assist with meals (oral feeding) 8. Vital signs

Home Tocolytic Infusion Therapy

Table 27.7 – Tocolytic Therapy Code

Code	Description
S9349	Home infusion therapy, tocolytic infusion therapy, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
99601	Home infusion/specialty drug administration, per visit (up to 2 hours);
99602	Home infusion/specialty drug administration, per visit (up to 2 hours); each additional hour (List separately in addition to code for primary procedure)

Indicators

All of the following indicators must be present for a member to receive home health care for home tocolytic infusion therapy.

- The member must be at least 24 to 34 weeks gestation
- The member must be in current preterm labor (preterm labor being defined as greater than or equal to six contractions per hour)
- The member must have a cervical dilation of greater than or equal to 1 cm, or an effacement of greater than or equal to 75 percent
- The member must have experienced secondary failure to wean from infused tocolytics, or have failed oral therapy and requires continued infusion therapy
- The member must have direct home telephone access to providers

Agency guidelines for home tocolytic infusion therapy

Home health care agencies must meet the following minimum guidelines to be reimbursed for home tocolytic infusion therapy:

- Provide home health care to the pregnant member 24 hours a day, seven days a week
- Provide the member with a tocolytic infusion pump and a uterine monitoring device (including setup and delivery); provide member education regarding equipment use and be available for trouble shooting for the equipment 24 hours a day, seven days a week
- Provide pharmacological consultation regarding the use of tocolytics and individualized member dosing 24 hours a day, seven days a week
- Provide member education regarding uterine contractions and other subtle symptoms of preterm labor
- Contact the member’s physician at least weekly for updates on the member’s condition/compliance

Home Health Care For Urinary/Renal Disorders

Table 27.8 – CPT®/HCPCS Codes Home Health Services

Code	Description
99600 TD	Unlisted home visit service or procedure; RN
99600	Unlisted home visit service or procedure; home health aide
99600 TE	Unlisted home visit service or procedure; skilled nurse, LPN/LVN
S9349	Home infusion therapy, tocolytic infusion therapy, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
G0151	Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes

G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes

Indicators for Urinary/Renal Disorders

One of the following indicators must be present for a member to receive home health care for urinary/renal disorders:

- Anemia
- Dyspnea
- Increased blood urea nitrogen (BUN)/creatinine
- Decreased mental acuity
- Increased B/P
- Abnormal electrolytes
- Oliguria
- Weakness/fatigue
- Decreased mobility
- Neuropathies
- New diagnosis of renal failure
- Vascular access
- Newly initiated hemodialysis
- Recent admission for renal failure
- Recent admission for UT surgery
- Peritoneal dialysis
- Pain
- Edema
- Potential for self injury

- One of the following services must also be necessary to receive either skilled or non-skilled nursing care for urinary/renal disorders.

Services Requiring Skilled Care	Services Requiring Non-Skilled Care

1. Complex treatment modalities • Sterile dressings • Special catheter care (ureteral catheters, irrigation, etc.) 2. Urinary, suprapubic catheter care 3. Input and Output (I&O) 4. Weight 5. Vital Signs	1. Assist bathing/linens/dressing 2. Skin care 3. Oral care 4. Assist with exercise and ambulation 5. Reinforce nutritional teaching 6. Weight 7. I&O 8. Vital signs 9. Safety measures

Rules, Citations and Sources

42 CFR 441.15, Subpart A – General Provisions

42 CFR 440.70, Subpart A – Definitions

IC 16-41-6 – Communicable disease

405 IAC 5-16 – Home health agency and clinic services

405 IAC 5-16-2 – Home health agency services

405 IAC 5-16-3 – Home health agency services; limitations

405 IAC 5-3-13 – Prior authorization – services requiring prior authorization

405 IAC 5-19-6 – Durable medical equipment subject to prior authorization

405 IAC 5-19-12 – Home hemodialysis equipment

405 IAC 5-22 – Nursing and therapy services

405 IAC 5-34 – Hospice services

IHCP Bulletins

BT201227 - Home Health Rates for State Fiscal Year 2013 Are Effective July 1, 2012

BT200353 – HIPAA-Mandated Elimination of Local Codes and Local Code Modifiers

BT200237 – Required Documentation for Prior Authorization Requests for Home Health Services

IHCP Provider Manual

> *Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.*

Related Medical Topics

Not applicable.