INDEX

768 HOME HEALTH SERVICES PAGE

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768 HOME HEALTH SERVICES

The New Mexico Medicaid program (Medicaid) pays for medically necessary health services furnished to eligible recipients, including home health services [42 CFR, Section 484 and 42 CFR, Section 440.70]. This section describes eligible providers, covered services, service limitations, and the general reimbursement methodology. [2-1-95]

768.1 Eligible Providers

Upon approval of New Mexico Medical Assistance Program Provider Participation Agreements by the New Mexico Medical Assistance Division (MAD), home health agencies that meet the following conditions are eligible to be reimbursed for furnishing services:

1. Meet the conditions of participation. See 42 CFR, Section 484 Subpart B;

2. Are licensed and certified by the Licensing and Certification Bureau of the New Mexico Department of Health to meet all standards for participation in a federal program established under Title XVIII (Medicare) of the Social Security Act. Any provider participating only in Medicaid must be licensed and certified to comply with the standards for Medicare participation; and

3. Are public agencies, private for-profit agencies, or private non-profit agencies primarily engaged in furnishing skilled nursing services and at least one other therapeutic service.

Once enrolled, providers receive a packet of information, including Medicaid program policies, billing instructions, utilization review instructions, and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

[2-1-95, 9-15-97]

768.2 Provider Responsibilities

Providers who furnish services to Medicaid recipients must comply with all specified Medicaid participation requirements. See Section MAD-701, GENERAL PROVIDERS POLICIES.

Providers must verify that individuals are eligible for Medicaid at the time services are furnished and determine if Medicaid recipients have other health insurance.

Providers shall have written policies concerning the acceptance of recipients and the feasibility of meeting the recipient's needs in the home care setting, which include, but are not limited to:

1. An evaluation visit in the recipient's residence to consider the physical facilities available, capabilities and attitudes of the recipient, family members or significant others, the availability of care givers, if any, to help in the care of the patient, and the appropriateness of home health care for meeting the recipient's needs in a safe environment.

2. The recipient's need to receive medical care at home.

3. Orders from the recipient's physician.

4. Documentation in the medical record of (1), (2) and (3).

Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See Section MAD-701, GENERAL PROVIDER POLICIES.

[2-1-95, 9-15-97]

768.3 Eligible Recipients

Recipients must have a medical need to receive care at home to be eligible for home health agency services and must be certified as such by their attending physicians. A medical need to receive care at home means that the recipient has a condition caused

by illness or injury which renders him/her unable to leave the home to obtain necessary medical care and treatment (i.e., is essentially homebound) or that the medical need for care at home is more appropriate and cost-effective and will prevent or delay institutionalization. Recipients do not need to be bedridden to be considered as having a medical need to receive care at home.

Recipients may be considered eligible to receive care at home if they meet one or more of the following criteria:

1. Recipients who cannot leave their residences without the use of wheelchairs, crutches, walkers or assistance from another individual;

2. Recipients who because of severe physical or mental illness or injury must comply with doctor's orders and avoid all stressful physical activity;

3. Recipients who cannot leave their residences because of danger caused by a mental condition;

4. Recipients who have just returned to their residence after hospital stays for severe illness or surgical procedures and whose activities are restricted by their physicians because of pain, suffering, medical limitation or danger of infection.

5. Recipients who are at high risk during pregnancy, infancy or childhood and for whom home health care is more appropriate to their needs.

Recipients are not eligible to receive care at home just because they (1) cannot drive, (2) have multiple medical problems or (3) live in an isolated area.

768.31 Infrequent Periods Away from Residence Recipients can leave their residences occasionally for medical treatment or personal errands and be eligible to receive home health care.

768.32 Determination of Medical Need to Receive Care At Home
MAD or its designee reviews information submitted by the provider and

determines whether recipients are considered eligible for home health service. Coverage is granted when the home health agency can demonstrate that care at home is appropriate to the medical needs of the recipient, the needed service is not otherwise available, and not receiving care would result in lack of access to health care services, institutionalization of the recipient and greater costs to the Medicaid program.

768.33 Documentation of Medical Need to Receive Care At Home
The home health agency is responsible for documenting on the written plan of care evidence of the recipient's medical need for home health care.

[2-1-95, 9-15-97]

768.4 Covered Services

Medicaid covers those home health services which are skilled, intermittent, and medically necessary. The focus of home health services shall be on the curative, restorative or preventive aspects of care. The goal of these services shall be to assist the recipient to return to an optimum level of functioning and to facilitate the timely discharge of the recipient to self-care or to care by his/her family, guardian or significant other. Services must be ordered by the recipient's attending physician and included in the plan of care established by the recipient's attending physician in consultation with home health agency staff. The plan of care must be reviewed, signed and dated by the attending physician.

The attending physician certifies that the recipient has a medical need to receive care at home at the initial certification, and as part of the plan of care review at recertification.

The attending physician certifies that the recipient requires the skilled services of a nurse, physical therapist, occupational therapist or speech therapist. If the recipient requires home health aide services, the physician shall certify the need for these services. The evaluation visit is covered whether or not the recipient is admitted to home health care.

Covered services include the following:

1. Skilled nursing services;
2. Home health aide services;
3. Physical and occupational therapy services; and
4. Speech therapy services.

768.41 Skilled Nursing Services Medicaid covers skilled, intermittent and medically necessary skilled nursing services if the following conditions are met:

(A) Services must be ordered by the attending physician and included in the plan of care established by the recipient's attending physician in consultation with the home health agency staff. The plan of care must be reviewed, signed and dated by the attending physician.

(B) Skills of a registered nurse or licensed practical nurse must be required for direct care or supervision of home health aides.

(C) Services must be furnished by or under the supervision of a registered nurse licensed in New Mexico who is responsible for the initial evaluation, care planning and coordination of services.

(D) Services must be reasonable and necessary to the treatment of an illness or injury. To be considered reasonable and necessary, the services furnished shall be:

1. Consistent with the recipient's particular medical needs as determined by the recipient's attending physician.

2. Consistent with accepted standards of medical and nursing practice.

3. Consistent with provision of care in the safest, least restrictive setting for meeting the recipient's needs.

4. Consistent with the New Mexico MAD approved Medical Necessity Criteria for Home Health.

(E) Skilled nursing care includes, but is not limited to, the following:

1. Observation and evaluation of recipient's health needs

2. Teaching the recipient, family members or significant other caretaker to provide care such as, but not limited to:

   a. Giving an injection;

   b. Irrigating a catheter;

   c. Providing wound care, including applying dressings to wounds, positioning, and recognizing signs of infection and other complications;

   d. Using medications properly and safely, and understanding potential side effects;

   e. Using special equipment and adaptive devices; and

   f. Home safety.

3. Insertion and sterile irrigation of catheters;

4. Administering injections;

5. Administering intravenous antibiotics and enteral and intravenous total parenteral nutrition;

6. Treating decubitus ulcers and other skin disorders; and

7. Providing other health teaching according to recipient's needs.

768.42 Therapy Services Medicaid covers the therapy services furnished through the home health agency by licensed physical therapists, occupational therapists, or speech language pathologists.

(A) Services must be ordered by the recipient's attending physician and included in the plan of care established by the attending physician in consultation with the home health agency staff.

(B) All therapy services must conform with practice standards and licensing requirements as defined by state law.

(C) Services can be furnished by a public, private for-profit or private non-profit home health agency directly or under arrangement.

768.43 Home Health Aide Services Medicaid covers home health aide services if the following conditions are met:

1. Home health aides must complete training and/or a competency evaluation program that meets certain requirements. See 42 CFR, Section 484.36;

2. Services must be ordered by the attending physician and included in the plan of care established by the recipient's attending physician in consultation with the home health agency staff;

3. Written instructions for patient care are prepared by a registered nurse or therapist;

4. Assignment to a particular recipient is made by a registered nurse;

5. Duties of the home health aide include:

a. Performance of simple procedures as an extension of nursing and therapy services;

b. Personal care;

c. Walking and exercises;

d. Household services essential to health care at home;

e. Help with medications that are normally self-administered;

f. Reporting changes in the recipient's condition; and

g. Completing appropriate records.

6. Registered nurses or other appropriate professional staff members must make a supervisory visit to the recipient's residence at least every two (2) weeks to observe and decide whether goals are being met. The recipient's record must contain documentation that, at least every two (2) weeks or more often if necessary, there has been communication between the home health aide and the supervisory nurse or other appropriate professional staff member regarding the recipient's condition; and

7. Services must be furnished directly through the home health agency staff or by contractual arrangement.

768.44 Durable Medical Equipment and Medical Supplies Medicaid covers medically necessary durable medical equipment and medical supplies which are specified in the plan of care. See Section MAD-754, DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES.

Reimbursement is made to the home health agency and is limited to medical

supplies necessary during the course of the plan of care. The following durable medical equipment and medical supplies are covered as specified:

1. Medicaid does not cover stock or routine items, such as Band-Aids, cotton balls, thermometers, lotion, personal care items, tape, and alcohol.

2. Non-routine supplies, such as catheters, ostomy supplies, feeding tubes, intravenous supplies, dressing supplies, ointments, solutions, chux diapers, and home testing kits must be ordered as part of the plan of care.

Utilization review, including retrospective review, can be made by MAD or its designee to assess the medical necessity for durable medical equipment and medical supplies and program compliance. If MAD determines that the equipment and supplies that were billed were not medically necessary or a covered service for the care of that recipient, the MAD payments are recouped.

768.45 Maternal/child services Medicaid covers perinatal and pediatric home health services if the following conditions are met:

1. The service is prescribed by the recipient's attending physician and is included in the plan of care established by the recipient's physician in consultation with home health agency staff.

2. If the recipient has a medical need to receive care at home, in the sense that care in the home is more appropriate to the needs of the recipient, safe, cost-effective and will prevent or delay institutionalization.

3. The services are reasonable and medically necessary to treat a high risk pregnancy, at-risk infant, illness, injury and to prevent infection. To be considered reasonable and medically necessary, the services furnished shall be:

a. Consistent with the recipient's particular medical needs as determined by the recipient's attending physician;

b. Consistent with accepted standards of medical and nursing practice;

c. Consistent with the New Mexico MAD approved Medical Necessity Criteria for Home Health.

[2-1-95, 9-15-97]

768.5 Noncovered Services

Home health services are subject to the limitations and coverage restrictions of other Medicaid services. See Section MAD-602, GENERAL NONCOVERED SERVICES. Medicaid does not cover the following home health agency services:

1. Services beyond the initial evaluation which are furnished without prior approval;

2. Home health services which are not skilled, intermittent and medically necessary;

3. Services furnished to recipients who do not meet the eligibility criteria for home health services;

4. Services furnished to recipients in places other than their place of residence;

5. Services furnished to recipients who reside in intermediate care facilities for the mentally retarded or nursing facility (NF) residents who require a high NF level of service;

   Physical, occupational, and speech therapy can be furnished to residents of nursing facilities who require a low level of service.

6. Skilled nursing services which are not supervised by registered nurses; and

7. Services not included in written plans of care established by physicians in consultation with the home health agency staff.

[2-1-95, 9-15-97]

768.6 Prior Approval and Utilization Review

All Medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See Section MAD-705, PRIOR APPROVAL AND UTILIZATION REVIEW. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

768.61 Prior Approval All home health services beyond initial visits for evaluation purposes, require prior approval from MAD or its designee. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process. Prior approval does not guarantee payment, if upon utilization review after payment has occurred, recipients are determined to be ineligible or medical necessity is not found.

768.62 Eligibility Determination Prior approval of services does not guarantee that individuals are eligible for Medicaid. Providers must verify that individuals are eligible for Medicaid at the time services are furnished and determine if Medicaid recipients have other health insurance.

768.63 Reconsideration Providers who disagree with prior approval can request a re-review and a reconsideration. See Section MAD- 953, RECONSIDERATION OF UTILIZATION REVIEW DECISIONS.

768.64 Effect of Hospitalization If a recipient is hospitalized during the certification period and a significant change in condition or course of treatment occurs, the home health agency must treat the recipient as a new patient and

submit a new prior approval request and new plan of care.

If there is no significant change in the recipient's condition or course of treatment, an agency can resume care under the existing plan of care.

[2-1-95, 9-15-97]

768.7 Treatment Plan Reserved [2-1-95; R, 9-15-97]

768.8 Reimbursement

Home health agencies assume responsibility for any and all claims submitted on behalf of the provider and under the provider's number. Home health agencies must submit claims for reimbursement on the UB-92 claim form or its successor. See Section MAD-702, BILLING FOR MEDICAID SERVICES. Once enrolled, providers receive instructions on documentation, billing, and claims processing. Reimbursement is made based on the Title XVIII (Medicare) cost-finding procedures and reimbursement methodology. Charges are paid at an interim rate basis established under the Medicaid guidelines by the Medicare audit agent, subject to retroactive settlement when the cost report is final.

Cost reports on appropriate forms must be submitted to the audit agent within ninety (90) days of the close of the provider's fiscal accounting period. Failure to provide timely cost reports results in suspension of payments.

[2-1-95, 9-15-97]

768.9 Reimbursement Limitations

The following limitations apply to reimbursement made to home health agencies:

1. Allowable costs are determined according to Medicare and Title XIX (Medicaid) reimbursement regulations;

2. The established percentage relationship of the agency's cost to charges per unity of services includes all services;

3. Out-of-state providers are reimbursed at seventy percent (70%) of billed charges. Out-of-state home health services are approved only in very unusual circumstances, since home health services are furnished in the recipient's residence and that residence must be in New Mexico; and

4. Claims for approved home health services must include the types of visits, dates of visits, and number of visits.

[2-1-95]

768.10 Plan of Care

The plan of care, established by the physician in consultation with the home health agency staff, and the request for prior approval must be received or postmarked within five (5) working days of the proposed start of services or recertification period by MAD or its designee. Plans of care must be signed and dated by the physician, and prior approval must be received from MAD or its designee before claims are submitted to the MAD claims processing contractor. The plan of care must include the following:

1. All principle diagnoses, surgical procedures, and other pertinent diagnoses;

2. Medications and dosages;

3. Types of services, equipment and non-routine supplies required;

4. Frequency of visits;

5. Safety measures to protect against injury;

6. Nutritional/fluid balance requirements;

7. Allergies;

8. Functional limitations, activities permitted, and documentation of homebound status;

9. Mental status;

10. Prognosis;

11. Goals and measurable objectives, including rehabilitation potential, long range projection of likely changes in the recipient's condition and plans for timely discharge to self-care or to care by family, guardian or significant other; and

12. Clinical findings and updates.

(A) The plan of care for home health services is certified by MAD or its designee for specific time periods, not to exceed sixty-two (62) working days.

(B) The attending physician and home health agency professional personnel must review the total plan of care prior to a request for recertification and submit the revised plan, including a report on the patient's response to care provided under the previous plan of care and specifying changes in services required.

[9-15-97]