

**Table of Contents**

1.0	Description of the Procedure, Product, or Service.....	1
1.1	Definitions .....	1
1.1.1	Skilled Nursing .....	1
1.1.2	Specialized Therapies .....	1
1.1.2.1	Physical Therapy.....	2
1.1.2.2	Speech Therapy.....	2
1.1.2.3	Occupational Therapy.....	3
1.1.3	Home Health Aide Services.....	3
1.1.4	Medical Supplies.....	3
2.0	Eligibility Requirements .....	4
2.1	Provisions.....	4
2.1.1	General.....	4
2.1.2	Specific .....	4
2.2	Special Provisions.....	4
2.2.1	EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age .....	4
2.2.2	EPSDT does not apply to NCHC beneficiaries .....	5
2.2.3	Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age .....	5
2.3	Managed Care Participation.....	5
3.0	When the Procedure, Product, or Service Is Covered.....	6
3.1	General Criteria Covered .....	6
3.2	Specific Criteria Covered.....	6
3.2.1	Specific criteria covered by both Medicaid and NCHC .....	6
3.2.1.1	Specific Criteria: All Home Health Visits .....	6
3.2.1.2	Specific Criteria: Skilled Nursing Services .....	7
3.2.1.3	Specific Criteria: Specialized Therapy Services.....	8
3.2.1.4	Specific Criteria: Home Health Aide Services .....	8
3.2.1.5	Specific Criteria: Medical Supplies .....	8
3.2.2	Medicaid Additional Criteria Covered.....	10
3.2.3	NCHC Additional Criteria Covered .....	10
4.0	When the Procedure, Product, or Service Is Not Covered.....	11
4.1	General Criteria Not Covered .....	11
4.2	Specific Criteria Not Covered.....	11
4.2.1	Specific Criteria Not Covered by both Medicaid and NCHC.....	11
4.2.2	Medicaid Additional Criteria Not Covered.....	11
4.2.3	NCHC Additional Criteria Not Covered.....	11
5.0	Requirements for and Limitations on Coverage .....	12
5.1	Prior Approval .....	12
5.2	Prior Approval Requirements .....	12
5.2.1	General.....	12
5.2.2	Specific .....	12

5.3	Limitations or Requirements.....	13
5.3.1	Physician’s Orders and Documenting the Plan of Care.....	13
5.3.1.1	Face to Face Encounter.....	13
5.3.1.2	Documenting the Plan of Care.....	14
5.3.1.3	Developing the Plan of Care.....	14
5.3.1.4	Components of the Plan of Care.....	14
5.3.1.5	Changing the Plan of Care.....	15
5.3.2	Location of Service.....	15
5.3.2.1	Primary Private Residence.....	15
5.3.2.2	Adult Care Homes and Group Homes.....	15
5.3.3	Amount, Frequency, and Duration of Service.....	15
5.3.3.1	Skilled Nursing.....	15
5.3.3.2	Home Health Aide Services.....	16
5.3.3.3	Specialized Therapies.....	16
5.3.3.4	Miscellaneous Supply Procedure Code.....	16
6.0	Provider(s) Eligible to Bill for the Procedure, Product, or Service.....	17
6.1	Provider Qualifications and Occupational Licensing Entity Regulations.....	17
6.1.1	Provision of Service.....	17
6.1.2	Home Health Aide Services.....	17
6.2	Provider Certifications.....	17
7.0	Additional Requirements.....	18
7.1	Compliance.....	18
7.2	DMA Compliance Reviews.....	18
7.3	Patient Self Determination Act.....	18
7.4	Post-Payment Validation Reviews.....	18
7.5	Coordination of Home Care Services.....	18
7.5.1	Coordination with Private Duty Nursing.....	19
7.5.2	Coordination with In-Home Drug Infusion Therapy.....	19
7.5.3	Coordination with In-Home Nutrition Therapy.....	19
7.5.4	Coordination with Hospice.....	19
7.5.5	Coordination with Community Alternatives Programs.....	19
7.6	Medical Record Documentation.....	20
7.6.1	Clinical or Progress Notes.....	20
7.6.2	Record Retention.....	20
8.0	Policy Implementation/Revision Information.....	21
Attachment A: Claims-Related Information.....		24
A.	Claim Type.....	24
B.	International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS).....	24
C.	Code(s).....	24
D.	Modifiers.....	25
E.	Billing Units.....	25
F.	Place of Service.....	26
G.	Co-payments.....	26
H.	Reimbursement.....	26

Attachment B: Skilled Nursing Service Billing Guide ..... 27

- A. Assessment and Evaluation..... 27
- B. Teaching and Training ..... 28
- C. Treatment ..... 28

Attachment C: Request for a HCPCS Code Addition..... 32

**Related Clinical Coverage Policies**

Refer to <http://www.ncdhhs.gov/dma/mp/> for the related coverage policies listed below:  
10A, Outpatient Specialized Therapies  
5A, Durable Medical Equipment.

## **1.0 Description of the Procedure, Product, or Service**

Home Health Services include medically necessary skilled nursing services, specialized therapies (physical therapy, speech-language pathology, and occupational therapy), home health aide services, and medical supplies provided to beneficiaries who live in primary private residences. Skilled nursing, specialized therapies, and medical supplies can also be provided if the beneficiary resides in an adult care home (such as a rest home or family care home).

The home health agency shall provide the services safely and effectively in the beneficiary's home in accordance with 10A NCAC 13J (The Licensing of Home Care Agencies) and the home health agency's policy. All services shall be provided by staff employed by or under contract to the home health agency.

### **1.1 Definitions**

Descriptions of the services available under the NC Medicaid (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*) and NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) home health programs are listed below.

#### **1.1.1 Skilled Nursing**

Skilled nursing components are the assessment, judgment, intervention, and evaluation of interventions by a licensed registered nurse (RN), or a licensed practical nurse (LPN) under the supervision of the RN, and in accordance with the plan of care (POC).

Skilled nursing services are covered when furnished by an RN or an LPN. An RN shall complete the initial assessment visit and shall appropriately supervise the LPN within the scope of the N.C. Board of Nursing (NCBON).

Services must be medically necessary and reasonable for the diagnoses and to the treatment of the beneficiary's illness or injury. The services include:

- a. Observation, assessment, and evaluation of the beneficiary's condition when only the specialized skills and training of a licensed nurse can determine the beneficiary's medical status;
- b. Management and evaluation of the beneficiary's POC to ensure that the care is achieving its purpose;
- c. Teaching and training the beneficiary, the beneficiary's family, or other caregivers about how to manage the beneficiary's treatment regimen; and
- d. Skilled nursing procedures medically necessary and reasonable for the treatment of the beneficiary's illness or injury.

#### **1.1.2 Specialized Therapies**

Refer to clinical coverage policy 10A, *Outpatient Specialized Therapies* on the Division of Medical Assistance (DMA)'s Web site at <http://www.ncdhhs.gov/dma/mp/>, for a complete description.

### 1.1.2.1 Physical Therapy

Physical therapy services are covered when provided by a licensed physical therapist (PT) or by a licensed physical therapy assistant (PTA) under the direction of a licensed PT. These services help relieve pain; restore maximum body function; and prevent disability following disease, injury, or loss to a part of the body.

Medicaid and NCHC accept the medical necessity criteria for initiating, continuing, and terminating treatment as published by the American Physical Therapy Association in the most recent edition of *Physical Therapy: Guide to Physical Therapist Practice, Part Two: Preferred Practice Patterns*.

Exception: The basis for beginning treatment shall be the identification of a specific treatable functional physical impairment that impedes the beneficiary's ability to participate in activities of daily living (ADLs) and instrumental ADLs (IADLs). The impairment need not be *reversible*.

### 1.1.2.2 Speech Therapy

Speech-language pathology services are covered when provided by a licensed speech-language pathologist to treat speech and language disorders that result in communication disabilities. The services are also provided to treat swallowing disorders (dysphagia), regardless of the presence of a communication disability.

Medicaid and NCHC accept the medical necessity criteria for speech-language therapy treatment outlined in the following sources.

- a. Speech-language pathology services for the treatment of dysphagia. In Centers for Medicare & Medicaid Services (CMS) Publication 100-3, *Medicare National Coverage Determinations Manual* (Part 3, Section 170.3, Rev. 55: issued May 5, 2006; effective October 1, 2006; implementation October 2, 2006).
- b. Coverage of outpatient rehabilitation therapy services (physical therapy, occupational therapy, and speech-language pathology services) under medical insurance. In CMS Publication 100-2, *Medicare Benefit Policy Manual* (Chapter 15, Section 220, Rev. 36: issued June 24, 2005; effective June 6, 2005, implementation June 6, 2005).
- c. Practice of speech-language pathology. In CMS Publication 100-2, *Medicare Benefit Policy Manual* (Chapter 15, Section 230.3, Rev. 36: issued June 24, 2005; effective June 6, 2005; implementation June 6, 2005).
- d. **Note:** CMS publications can be found at <http://www.cms.hhs.gov/manuals/IOM/list.asp>.
- e. Position statement: Clinical management of communicatively handicapped minority language populations [American Speech-Hearing Association guidelines regarding bilingual services]. Available at <http://www.asha.org/docs/html/PS1985-00219.html>.

### 1.1.2.3 Occupational Therapy

Occupational therapy services are covered when provided by a licensed occupational therapist (OT) or by a licensed occupational therapy assistant under the direction and supervision of a licensed OT. Services help improve and restore functions impaired by illness or injury. When a beneficiary's functions are permanently lost or reduced, occupational therapy helps improve the beneficiary's ability to perform the tasks needed for independent living.

Medicaid and NCHC accepts the medical necessity criteria for beginning, continuing, and terminating treatment as published by the American Occupational Therapy Association in the most recent edition of Occupational Therapy Practice Guidelines Series.

Exception: The basis for beginning treatment shall be the identification of a specific *treatable* functional physical impairment that impedes the beneficiary's ability to participate in productive activities. The impairment need not be *reversible*.

### 1.1.3 Home Health Aide Services

Home health aide services are hands-on paraprofessional services provided by a Nurse Aide I or II (NA I or NA II) under the supervision of the RN. The services are provided in accordance with the established POC to support or assist the skilled service (skilled nursing and specialized therapies).

Home health aide services help maintain a beneficiary's health and facilitate treatment of the beneficiary's illness or injury. Typical tasks include:

- a. Assisting with activities such as bathing, caring for hair and teeth, eating, exercising, transferring, and eliminating.
- b. Assisting a beneficiary in taking self-administered medications that do not require the skills of a licensed nurse to be provided safely and effectively.
- c. Assisting with home maintenance that is incidental to a beneficiary's medical care needs, such as doing light cleaning, preparing meals, taking out trash, and shopping for groceries.
- d. Performing simple delegated tasks such as taking a beneficiary's temperature, pulse, respiration, and blood pressure; weighing the beneficiary; changing dressings that do not require the skills of a licensed nurse; and reporting changes in the beneficiary's condition and needs to an appropriate health care professional.

### 1.1.4 Medical Supplies

Medical supplies include those items listed on the Home Health Services Fee Schedule. This list is available on the DMA Web site at

<http://www.ncdhhs.gov/dma/fee/>.

## 2.0 Eligibility Requirements

### 2.1 Provisions

#### 2.1.1 General

*(The term “General” found throughout this policy applies to all Medicaid and NCHC policies)*

- a. An eligible beneficiary shall be enrolled in either:
  1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
  2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
- b. Provider(s) shall verify each Medicaid or NCHC beneficiary’s eligibility each time a service is rendered.
- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.
- d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

#### 2.1.2 Specific

*(The term “Specific” found throughout this policy only applies to this policy)*

- a. **Medicaid**  
None Apply.
- b. **NCHC**  
None Apply.

### 2.2 Special Provisions

#### 2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

- a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary’s physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the

needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**b. EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

*NCTracks Provider Claims and Billing Assistance Guide:*

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <http://www.ncdhhs.gov/dma/epsdt/>

**2.2.2 EPSDT does not apply to NCHC beneficiaries**

**2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age**

The Division of Medical Assistance (DMA) shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

**2.3 Managed Care Participation**

Beneficiaries participating in Community Care of North Carolina/Carolina ACCESS programs (CCNC/CA) shall gain access to home health services through their primary care physicians.

### 3.0 When the Procedure, Product, or Service Is Covered

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

#### 3.1 General Criteria Covered

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when medically necessary, and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

#### 3.2 Specific Criteria Covered

##### 3.2.1 Specific criteria covered by both Medicaid and NCHC

###### 3.2.1.1 Specific Criteria: All Home Health Visits

Nursing, home health aide, and specialized therapy services are provided on a per-visit basis. The primary private residence must be the most appropriate setting for the service. Services provided in the primary private residence are deemed appropriate when the service can be more effectively provided in that setting due to either the frequency of the service or the beneficiary's condition. The medical records must include documentation supporting one or more of the following reasons that the services must be provided in the beneficiary's primary private residence instead of the physician's office, clinic, or other outpatient setting.

- a. The beneficiary requires assistance in leaving the primary private residence, such as with opening doors and other routine activities, due to a physical impairment or a medical condition.
- b. The beneficiary is non-ambulatory or wheelchair bound with a medical condition that precludes leaving primary private residence on a regular basis.
- c. The beneficiary would require ambulance transportation.
- d. The beneficiary is medically fragile or unstable:
  1. Infants up to 6 weeks of age who have acute needs, who are at medical risk, or both.
  2. Post-surgery beneficiaries who are restricted from activity except for short periods of time.
  3. Beneficiaries with one or more medical conditions that would likely be exacerbated by leaving the primary private residence.
  4. Beneficiaries with one or more medical conditions that would make leaving primary private residence inadvisable or detrimental to the beneficiary's health.
  5. Beneficiaries who are experiencing severe pain.

6. Beneficiaries with shortness of breath that significantly hinders travel.
  7. Beneficiaries who, because of their medical condition, must be protected from exposure to infections.
  8. Beneficiaries who have just had major surgery.
- e. Leaving the primary private residence would interfere with the effectiveness of the services:
1. Beneficiaries, especially young children, with an extreme fear of the hospital or physician's office.
  2. Beneficiaries living in an area where travel time to outpatient services would require 1 hour or more of driving time.
  3. Beneficiaries who need a service repeated at frequencies that would be difficult to accommodate in the physician's office, clinic, or other outpatient setting.
  4. Beneficiaries requiring regular and PRN (as needed) catheter changes.
  5. Beneficiaries who have a) demonstrated a failure to comply with medical appointments at a physician's office, clinic, or other outpatient facility due to a medical condition or cognitive impairment and b) suffered adverse consequences as a result.
  6. Beneficiaries requiring complex wound care, such as irrigation and packing, twice a day or more often.
- f. The beneficiary requires in-home training for the use of assistive devices specifically customized for his or her primary private residence environment (such as bath chairs and shower grab bars).

**Note:** Medicaid and NCHC coverage of services in an alternate setting (other than in the primary private residence) for beneficiaries under 21 years of age must be submitted to DMA as a request for a non-covered state plan service under EPSDT. The service must meet all EPSDT criteria for coverage. The procedure for requesting EPSDT coverage is located on the DMA Web site, <http://www.ncdhhs.gov/dma/epsdt/>.

### 3.2.1.2 Specific Criteria: Skilled Nursing Services

A Medicaid or NCHC-eligible beneficiary qualifies for in-home skilled nursing services when he or she meets the criteria listed in **Subsections 3.1** and **3.2** and all the following requirements are met.

- a. The services are ordered by the beneficiary's attending physician and provided according to an approved POC.
- b. The beneficiary requires medically necessary skilled nursing care that can be provided only by an RN or LPN.
- c. The beneficiary requires repeated skilled nursing assessments and ongoing monitoring that can be provided on an intermittent or part-time basis (refer to **Subsection 5.3.3, Amount, Frequency, and Duration of Service**, for more details).
- d. The beneficiary lives in a primary private residence, an adult care home, or a group home.

### 3.2.1.3 Specific Criteria: Specialized Therapy Services

A Medicaid or NCHC-eligible beneficiary qualifies for in-home specialized therapy (physical therapy, occupational therapy, and speech-language therapy) assessment, evaluation, and treatment services when the criteria listed in **Subsections 3.1** and **3.2** are met. The beneficiary may live in a primary private residence, an adult care home, or a group home.

Medical necessity for outpatient specialized therapies is defined by the policy guidelines recommended by the authoritative bodies for each discipline. Refer to **Subsection 1.1.2, Specialized Therapies**, for resources. A comprehensive explanation of outpatient specialized therapy coverage can be found in Clinical Coverage Policy 10A, *Outpatient Specialized Therapies*, (on DMA's website at <http://www.ncdhhs.gov/dma/mp/>).

Refer to **Attachment A, Claims-Related Information**, for billing information on home health–provided specialized therapies.

### 3.2.1.4 Specific Criteria: Home Health Aide Services

Home health aide services are ordered by the beneficiary's attending physician and delivered according to a POC that is established by the RN or licensed therapist and authorized by the attending physician. An eligible Medicaid beneficiary qualifies for home health aide services when the criteria listed in **Subsections 3.1** and **3.2** are met and *all* of the following requirements apply.

- a. The beneficiary requires help with personal care, ADLs, or other non-skilled health care as designated in the POC.
- b. The service is provided under the professional supervision of an RN or licensed therapist in accordance with the federal conditions of participation (42 CFR 484.36).
- c. The beneficiary lives in a primary private residence.
- d. The beneficiary is receiving a skilled service (skilled nursing or specialized therapies).
- e. The tasks performed by the home health aide are those specified in the POC. The tasks must be within the scope of home care licensure rules as set forth by the NCBON.

### 3.2.1.5 Specific Criteria: Medical Supplies

Medical supplies are covered when they are:

- a. ordered by a physician,
- b. documented in the beneficiary's POC,
- c. medically necessary as part of the beneficiary's home health care,
- d. reasonable for use in the primary private residence, and
- e. listed on the Home Health Services Fee Schedule.
- f. medically necessary and reasonable for treatment of a beneficiary's illness or injury.
- g. for a therapeutic or diagnostic purpose for a specific beneficiary and is not a convenience or comfort item (items that are often used by persons who are not ill or injured, such as soaps, shampoos, lotions and skin conditioners, and pantliners or pads).

- h. specifically ordered by the physician and included in the POC. The physician's order in itself does not make an item "medically necessary" for the purposes of Medicaid or NCHC coverage. The order authorizes the agency to provide the item, but the agency should bill Medicaid or NCHC for the item only if it meets Medicaid or NCHC criteria.
- i. not items routinely furnished as part of beneficiary care (minor medical and surgical supplies routinely used in beneficiary care, such as alcohol wipes, applicators, lubricants, lemon-glycerin mouth swabs, thermometers, nonsterile gloves, and thermometer covers). These items are considered part of an agency's overhead costs and cannot be billed and reimbursed as separate items.
- j. items that Medicaid or NCHC considers to be a home health medical supply item. Items such as drugs and biologicals, medical equipment (i.e. Blood pressure cuffs, glucometers, etc.), orthotics and prosthetics, and nutritional supplements are examples of items not considered home health medical supplies.
- k. assessed for need and appropriateness every 60 calendar days by an in-home assessment in the beneficiary's primary private residence. (When incontinence supplies are being provided and the only service being rendered is physical or occupational therapy, the assessment for incontinence supplies may be conducted by the therapist.)
- l. documented by the agency and the documentation supports the medical necessity and quantity of supplies for the beneficiary's need.

**Note:** The Home Health Services Fee Schedule lists the covered medical supplies with the applicable national HCPCS codes, as mandated under the Health Insurance Portability and Accountability Act (HIPAA). The fee schedule is posted on DMA's Website at <http://www.ncdhhs.gov/dma/fee/>. Periodic updates are made to the fee schedule to accommodate coding changes made by CMS. The supplies may be furnished to any eligible Medicaid or NCHC beneficiary as long as these criteria are met, even if no other skilled services are rendered.

**Note:** Nonsterile gloves for agency staff use are considered an overhead cost to the agency and cannot be billed for Medicaid or NCHC reimbursement. Gloves for use by the beneficiary or caregiver can be billed but must meet medical necessity criteria to be covered. There must be a need for immediate contact with the beneficiary's bodily fluids or infectious waste to meet this criterion. Incontinence supplies for children under age 3 are considered age appropriate and not medically necessary and are, therefore, not covered.

#### Use of the Miscellaneous Supply Procedure Code

Every effort is made to include on the fee schedule the items that are medically necessary and reasonable to treat the illnesses, diseases, and injuries common to the Medicaid or NCHC home care population.

Items that are medically necessary for treatment but not included on the fee schedule may be billed and reimbursed with the miscellaneous supply procedure code. The supply must meet Medicaid's and NCHC's coverage criteria.

When considering the use of the miscellaneous supply procedure code, do the following.

- a. Determine whether the item is classified as a home health medical supply. Medical supplies are defined as consumable non-durable supplies that:
  1. are usually disposable in nature;
  2. cannot withstand repeated use by more than one beneficiary;
  3. are primarily and customarily used to serve a medical purpose;
  4. are not useful to a beneficiary in the absence of illness or injury; or
  5. are ordered or prescribed by a physician.
- b. If the supply is on the Durable Medical Equipment (DME) fee schedule or the Home Infusion Therapy (HIT) fee schedule, but is not listed on the Home Health Services Fee Schedule, the item is not covered as a home health medical supply.
- c. Determine whether the item meets the medical necessity criteria outlined in **Subsection 3.6.1**.
- d. Document the medical reason for using this item instead of one listed on the fee schedule. Retain this information in the beneficiary's medical records.

**Note:** If the medical supply item is not listed on the fee schedule but will need to be used continually, a request to add the item should be submitted to DMA. The request must be submitted on the Request for HCPCS Code Addition form (DMA-3400) with supporting documentation on cost, usage, and efficacy. Refer to **Attachment C, Request for HCPCS Code Addition**, for additional information and an illustration of the form. The form may be downloaded from <http://www.ncdhhs.gov/dma/provider/forms.htm> (under Home Health).

### **3.2.2 Medicaid Additional Criteria Covered**

None Apply.

### **3.2.3 NCHC Additional Criteria Covered**

None Apply.

## 4.0 When the Procedure, Product, or Service Is Not Covered

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

### 4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

- a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;
- b. the beneficiary does not meet the criteria listed in **Section 3.0**;
- c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

### 4.2 Specific Criteria Not Covered

#### 4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

Medicaid and NCHC shall not cover the following home health services:

- a. Any services that were not ordered by a physician and included on the authorized POC or verbal order.
- b. Home health aide services for beneficiaries residing in an adult care or group home.
- c. Home health aide services when no skilled service is being provided.
- d. Home health aide services provided on the same day as In-Home Care Services Physical therapy, occupational therapy, or speech pathology service for maintenance only.
- e. Medical supply items routinely furnished as part of beneficiary care, such as alcohol wipes, applicators, lubricants, mouth swabs, nonsterile gloves, or thermometers.
- f. Medical supplies considered convenience items (items that are often used by persons who are not ill or injured) such as soaps, shampoos, lotions and skin conditioners, and disposable pantliners or pads.
- g. Any services when there is no evidence that the primary private residence is the most appropriate place to provide the service (refer to **Subsection 3.2**).
- h. Provision of any service without documentation (in clinical or progress notes) to support that the service was provided in accordance with policy guidelines. All documentation must be signed and dated in accordance with accepted professional standards. The service provision must be supported by the POC.
- i. Any services related to the terminal illness when the beneficiary has elected Medicare or Medicaid hospice benefits (home health services may be provided when they are unrelated to the terminal illness).

#### 4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

#### 4.2.3 NCHC Additional Criteria Not Covered

- a. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent

to coverage provided for dependents under North Carolina Medicaid Program except for the following:

1. No services for long-term care.
2. No nonemergency medical transportation.
3. No EPSDT.
4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.”

## 5.0 Requirements for and Limitations on Coverage

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

### 5.1 Prior Approval

Prior approval for home health services is required for the following:

- a. Beneficiaries with Medicaid for Pregnant Women coverage. Submit prior approval requests to the Department of Health and Human Services (DHHS) fiscal contractor on a Request for Prior Approval form (372-118).
- b. Refer to Clinical Coverage Policy 10A, *Outpatient Specialized Therapies*, (on DMA’s website at <http://www.ncdhhs.gov/dma/mp/>) for specific instructions.

**Note:** Prior approval is granted on the basis of medical necessity only. It does not guarantee payment or ensure beneficiary eligibility on the date of service. All service requirements must be met for the provider to receive payment.

### 5.2 Prior Approval Requirements

#### 5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

- a. the prior approval request; and
- b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.

#### 5.2.2 Specific

None Apply.

### 5.3 Limitations or Requirements

#### 5.3.1 Physician's Orders and Documenting the Plan of Care

An order from the attending physician's is required for all home health services as a condition for Medicaid and NCHC reimbursement. The physician shall certify in writing that primary private residence is the most appropriate place for the care and provide a statement supporting the certification. Refer to specific criteria in **Subsection 3.2** of this policy.

With verbal authorization from the physician, the home health agency can begin services prior to receiving written orders. Verbal orders must be documented and signed by the physician according to home care licensure rules within 60 calendar days.

##### 5.3.1.1 Face to Face Encounter

The physician shall provide a written attestation statement that face-to-face contact was made with the beneficiary within the last 90 days in accordance with Section 6407 of the Patient Protection and Affordable Care Act. The attestation should be a brief narrative describing the patient's clinical condition and how the patient's condition supports the needs for skilled services. The required contact must be with the physician or an allowed non-physician practitioner (NPP). The encounter must occur within the 90 days prior to the start of care or within the 30 days after the start of care. A copy of the statement must be kept in the beneficiary's records. Home health agencies shall established internal processes to comply with the face-to-face encounter requirement mandated by the Patient Protection and Affordable Care Act for purposes of certification of a beneficiary's eligibility for Medicaid and NCHC covered home health services.

##### 1. Qualified Non-Physician Practitioner

The NPP allowed to perform the face to face encounter must be one of the following, as defined by the Social Security Act and accepted by Medicaid and NCHC:

- a. a nurse practitioner or clinical nurse specialist as defined in section 1861(aa)(5) of the Social Security Act , who is working in collaboration with a physician in accordance with state law;
- b. a certified nurse mid-wife as defined in section 1861(gg) of the Social Security Act; or
- c. a physician's assistant as defined in section 1861(aa)(5) of the Social Security Act, working under the supervision of a physician.

##### 2. Documenting the Face to Face Encounter

Documentation of the face to face encounter must include the following:

- a. the date of the face to face encounter with the physician or the appropriate NPP;
- b. a brief narrative composed by the certifying physician who describes how the patient's clinical condition as seen during that encounter supports the patient's need for skilled services

If the certifying physician or NPP has not seen the beneficiary within 90 calendar days of the start of care, a face to face encounter is required within 30 calendar days after the start of services.

#### **5.3.1.2 Documenting the Plan of Care**

The physician shall authorize a POC by signing a completed Form CMS-485 submitted by the home health agency. The POC must be re-certified every 60 calendar days if the services continue to be medically necessary.

Home Health Agencies shall provide beneficiaries with a generalized version of the POC. This copy must include service types, frequencies, and tasks that will be provided to the individual receiving the service. A copy of this POC must be maintained in the beneficiary's primary private residence at all times.

The legal signature may be handwritten or electronic (faxed copy) and shall comply with Division of Health Service Regulation (DHSR) and CMS regulations. The ordering physician is responsible for the authenticity of the signature.

**Note:** The use of a signature stamp is not acceptable.

#### **5.3.1.3 Developing the Plan of Care**

The POC is developed by the home health nurse or therapist in collaboration with the physician and according to home care licensure rules and federal conditions of participation. The documentation must indicate that all ordered services are medically necessary and that the beneficiary's primary private residence is the most appropriate setting for the care.

#### **5.3.1.4 Components of the Plan of Care**

The POC must include:

- a. All pertinent diagnoses, including the beneficiary's mental status;
- b. The type of services, supplies, and equipment ordered;
- c. The frequency and duration of visits for skilled nursing, therapy, and home health aide services;
- d. The beneficiary's prognosis, rehabilitation potential, functional limitations, permitted activities, nutritional requirements, medications, treatments, goals, allergies, and teaching requirements;
- e. A statement that the beneficiary's primary private residence is the most appropriate setting for the required services;
- f. Safety measures to protect against injury; and
- g. Discharge plans.

**Note:** For skilled nursing or therapy services, the POC must additionally include defined goals for each therapeutic discipline; specific content, duration, and intensity of service for each therapeutic discipline; and a delineation of whether the visit is for evaluation or treatment.

### **5.3.1.5 Changing the Plan of Care**

The physician shall authorize any change in the amount, type, or frequency of home health services provided.

- a. The physician's orders may be verbal or written. Verbal orders shall be transcribed and signed by the physician in accordance with 10A NCAC 13J.
- b. A face to face encounter is recommended for a significant change in the beneficiary's condition.

## **5.3.2 Location of Service**

### **5.3.2.1 Primary Private Residence**

Skilled nursing services, medical supplies, specialized therapy services, and home health aide services can be provided to beneficiaries in a primary private residence.

### **5.3.2.2 Adult Care Homes and Group Homes**

Skilled nursing services, medical supplies, and specialized therapy services can also be provided in the adult care and group home setting.

**Note:** Home health aide services are not covered for beneficiaries residing in adult care or group homes.

## **5.3.3 Amount, Frequency, and Duration of Service**

Home health services are provided through visits made to the beneficiary's primary private residence by the skilled staff or a home health aide.

A visit is a personal contact in a beneficiary's primary private residence by the employee of a certified home health agency for providing home health services. A visit begins when a service is initiated and does not end until the delivery of the service is completed.

If multiple services are required and can be performed during the same visit, then all the services shall be completed in only one visit.

Skilled nursing and home health aide visits are provided on a part-time or intermittent basis. For purposes of this policy, part-time or intermittent is defined as skilled nursing or home health aide services combined to total less than 8 hours per day and 28 or fewer hours each week. Based on the need for care, on a case-by-case basis, the weekly total may be increased to up to 35 hours.

### **5.3.3.1 Skilled Nursing**

Skilled nursing is provided under the Medicaid and NCHC programs on a per-visit basis. Skilled nursing visits are limited to the amount, frequency, and duration of service authorized by the attending physician and documented in the beneficiary's POC. The visits must be provided on a part-time or intermittent basis.

Skilled nursing shall comply with the physician-approved POC; 10A NCAC 13J; 21 NCAC 36; and NCGS 90, Article 9.

Skilled nursing visits are limited according to the purpose of the visit. Refer to chart on **Attachment A (C)-Revenue Codes**.

Limitations on skilled nursing visits include the following:

- a. Pre-filling insulin syringes/Medi-Planner visits must be limited to a maximum of every two (2) weeks with one (1) PRN visit allowed each month.
- b. **75** total maximum skilled nursing visits per year per beneficiary

Refer to **Attachment B, Medicare–Medicaid Skilled Nursing Services Billing Guide**, for information on billing skilled nursing services.

#### **5.3.3.2 Home Health Aide Services**

Home health aide services are limited to the amount, frequency, and duration of service ordered by the physician and documented in the POC.

Home health aide services must be limited to 100 total visits per year per beneficiary.

**Note:** Home health aide services are covered only when provided in the beneficiary’s primary private residence.

#### **5.3.3.3 Specialized Therapies**

The type, amount, frequency, and duration of specialized therapy treatment visits are limited to what is ordered by the physician and documented in the POC. Specialized therapy treatment is subject to the limits and requirements and prior approval process listed in **Subsection 5.1, Prior Approval**, and in clinical coverage policy 10A, *Outpatient Specialized Therapies* (refer to <http://www.ncdhhs.gov/dma/mp/>).

#### **5.3.3.4 Miscellaneous Supply Procedure Code**

Limits and prior approval of requirements on the T1999 code for miscellaneous billing include the following:

- a. Total maximum miscellaneous billing limit of **\$250** per patient per year without prior approval required.
- b. Prior approval required for total miscellaneous billing greater than **\$250**.
- c. Total maximum miscellaneous billing limit of **\$1500** per patient per year.

**Note:** Providers shall complete a **General Request for Prior Approval form 372-118** and return to DMA via fax to 919-715-9025 or via mail to:

Division of Medical Assistance  
Clinical Policy and Programs  
Home Health Consultant  
2501 Mail Services Center  
Raleigh, NC 27699-2501

for prior approval.

## **6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service**

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

- a. meet Medicaid or NCHC qualifications for participation;
- b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

### **6.1 Provider Qualifications and Occupational Licensing Entity Regulations**

#### **6.1.1 Provision of Service**

Skilled nursing care must be provided by an RN or an LPN. The RN shall supervise the skilled nursing care. The services must be provided within the scope of practice, as defined by the NCBON Nurse Practice Act and Home Care Licensure Rules.

All services provided by a home health aide must be supervised by an RN or a licensed therapist. Supervisory visits must be made at least once every two weeks in accordance with the federal conditions of participation (42 CFR 484.36).

Specialized therapy services must be provided by the appropriate licensed therapist or a qualified therapy assistant under the direction and supervision of a licensed therapist.

#### **6.1.2 Home Health Aide Services**

NA I and II training, qualifications, and tasks must comply with the administrative rules for the NCBON.

The aide shall be listed as either a Nurse Aide I on the NA Registry at the N.C. Department of Health and Human Services, DHSR, or as a Nurse Aide II on the NA registry and on the NCBON registry.

### **6.2 Provider Certifications**

To qualify for enrollment as a Medicaid home health provider, the agency shall be Medicare certified and licensed by DHSR to provide home health services. All services must be provided by staff employed by or under contract to the home health agency.

## 7.0 Additional Requirements

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

### 7.1 Compliance

- Provider(s) shall comply with the following in effect at the time the service is rendered:
- All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
  - All DMA's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

### 7.2 DMA Compliance Reviews

The Home Health Provider Organization shall:

- Cooperate with and participate fully in all desktop and on-site quality, compliance, post-payment audits that may be conducted by DMA or its designee;
- Meet DMA requirements for addressing identified program deficiencies, discrepancies, and quality issues through the DMA corrective action process and any overpayment recovery or sanctioning process imposed by DMA's Program Integrity Section; and
- Maintain all clinical records and billing documentation in an accessible location in a manner that will facilitate regulatory reviews and post payment audits.

### 7.3 Patient Self Determination Act

The Patient Self Determination Act of 1990, Sections 4206 and 4751 of the Omnibus Budget Reconciliation Act of 1990, P.L.101-508 requires that Medicaid-certified hospitals and other health care providers and organizations, give patients information about their right to make their own health decisions, including the right to accept or refuse medical treatment. Providers shall comply with these guidelines. Refer to *NCTracks Provider Claims and Billing Assistance Guide*:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>.

### 7.4 Post-Payment Validation Reviews

Medicaid, NCHC, or agents acting on behalf of Medicaid or NCHC will perform reviews for monitoring utilization, quality, and appropriateness of all services rendered. Post-payment validation reviews will be conducted using a statistically valid random sample from paid claims. Overpayments will be determined using monthly paid claims data. Written notice of the finding(s) will be sent to the provider who is the subject of the review and will state the basis of the finding(s), the amount of the overpayment, and the provider's appeal rights. Case reviews may also show the need for an educational notification to the provider.

### 7.5 Coordination of Home Care Services

The home health agency is responsible for determining what other services the beneficiary is receiving and for coordinating care to ensure there is no duplication of service.

### **7.5.1 Coordination with Private Duty Nursing**

Home health skilled nursing services are not covered on the same day as private duty nursing (PDN) services. The PDN nurse shall provide all of the nursing care needed in the home for the PDN beneficiary. The PDN provider shall assume the responsibility for providing medical supplies, when medical supplies are the only home health service needed, and shall bill Medicaid and NCHC for the supplies as part of the PDN service.

Specialized therapies may be provided during the same time period that a beneficiary is receiving PDN services.

Home health aide services are not covered on the same day as PDN services.

### **7.5.2 Coordination with In-Home Drug Infusion Therapy**

Home health skilled nursing services are not covered for the provision of drug infusion therapy when the beneficiary is receiving services from a Medicaid HIT provider. Nursing services related to the drug infusion are provided by the HIT provider and covered in the HIT per diem payment. Home Health skilled nursing may be covered for medical needs not related to the provision of drug therapy. Home health must be coordinated with other home care service providers to avoid more than one person working with the beneficiary at the same time.

**Note:** HIT services cannot be provided for beneficiaries receiving Medicare-covered home health nursing services. HIT services include a nursing component billed at an all-inclusive rate, which would result in a duplication of service if billed concurrently with home health nursing services.

### **7.5.3 Coordination with In-Home Nutrition Therapy**

Home health skilled nursing care may be provided to beneficiaries who need enteral or parenteral nutrition therapy. DME suppliers and HIT providers may furnish the equipment, supplies, and formulae needed for enteral nutrition. However, only HIT providers may provide these items for parenteral nutrition.

### **7.5.4 Coordination with Hospice**

Hospice provides all skilled nursing care related to the terminal illness. Home health agencies may provide only those services that are not related to the terminal illness.

### **7.5.5 Coordination with Community Alternatives Programs**

If a beneficiary is eligible under one of the Community Alternatives Programs (CAP), including CAP for Disabled Adults (CAP/DA), CAP for Children (CAP/C), CAP for Individuals with Intellectual/Developmental Disabilities (CAP- I/DD), or CAP/Choice, the home health agency shall coordinate services with the responsible CAP case manager.

CAP case managers are responsible for keeping the cost of home care services within the limits of the CAP program in which the beneficiary is enrolled.

**Note:** In order to receive home health services, CAP beneficiaries shall meet all home health guidelines for coverage.

## **7.6 Medical Record Documentation**

The home health agency is responsible for maintaining all financial and medical records and documents necessary to disclose the nature and extent of services billed to Medicaid.

### **7.6.1 Clinical or Progress Notes**

Services rendered to the beneficiary must be documented in the medical record, in the form of clinical notes or progress notes. The clinical notes or progress notes must adhere to the definitions outlined in 42 CFR 484.2. Each entry must include the following:

- a. A full description of the nature and extent of the service provided;
- b. The employee's signature, initial of first name, full last name, and abbreviation of licensure (such as RN, LPN, PT, OT) or job title (NA, personal care technician (PCT), PTA).
- c. The date (month/day/year) and the time the entry is made; and
- d. The beneficiary's name and identification (medical record number or history number) written or stamped on each page or report at the time it becomes a part of the medical record.
- e. A copy of the completed CMS-485 or similar POC form signed and dated by the physician supporting the services documented; and
- f. A copy of physician written certification of face-to-face encounter.

### **7.6.2 Record Retention**

These records must be maintained:

- a. at the home health agency office responsible for providing services to the beneficiary—except for financial records, which may be maintained in a central location and made available to DMA upon request; and
- b. in an accessible location and in a manner that will facilitate regulatory review.

Upon request, the home health agency will provide to DMA all financial and medical records and other documents for beneficiaries whose care and treatment has been billed in whole or in part to DMA.

## **8.0 Policy Implementation/Revision Information**

**Original Effective Date:** February 1, 1980

**Revision Information:**

<b>Date</b>	<b>Section Revised</b>	<b>Change</b>
09/01/2005	Subsection 2.2	A special provision related to EPSDT was added.
12/01/2005	Subsection 2.2	The Web address for DMA's EDPST policy instructions was added to this section.
12/01/2006	Sections 2 through 5	A special provision related to EPSDT was added.
05/01/2007	Sections 2.2, 3.0, 4.0, and 5.0	EPSDT information was revised to clarify exceptions to policy limitations for beneficiaries under 21 years of age
05/01/2007	Attachment A	Added UB-04 as an accepted claim form.
08/01/2007	Sections 3.2, 5.1, 6.0, and 6.2	Changed the name of Division of Facility Services (DFS) to Division of Health Service Regulation (DHSR).
08/01/2007	Subsection 3.6.2; Attachment D	Updated the form number and illustration of the DMA-3400 form.
08/01/2007	Subsections 5.3.2 and 7.1; Attachment B	Changed Medical Review of North Carolina (MRNC) to The Carolinas Center for Medical Excellence (CCME); updated Web site address, telephone, and fax information.
08/01/2007	Subsection 5.3.2 and Attachment B	Updated prior approval instructions to include electronic submission; added CCME URL for further instructions.
08/01/2007	Subsection 5.4.1	Added "medical supplies" to the list of items that may be provided in a private residence.
08/01/2007	Subsection 7.2.5	Deleted CAP/AIDS and added CAP/Choice.
08/01/2007	Attachment C	Clarified the requirements for a PRN skilled nursing visit.
02/01/2008	Attachment D	Updated form DMA3400 and corrected a reference to its former designation (A001).
12/01/2009	Subsection 1.2	Added sources for standards of care for outpatient specialized therapies (moved from former Att. B).
12/01/2009	Subsection 2.3	Deleted references to colors of Medicaid ID cards.
12/01/2009	Subsection 2.5	Moved information on transfer of assets policy to this section from Section 4.2.
12/01/2009	Subsection 3.6.2, former Attachment D	Moved description of the Home Health Services Fee Schedule to the body of the policy from former Attachment D.
12/01/2009	Subsection 4.2	Deleted "any services that do not justify provision of care in the home" and its examples; added items b through h in the list.
12/01/2009	Subsection 7.3.1	Clarified requirements for coordination with private duty nursing.
12/01/2009	Former Att. B	Deleted "Home Health Outpatient Specialized Therapy Guidelines" and condensed information into body of policy.
12/01/2009	All sections and attachment(s)	Revised wording and added sections to match DMA's current standards for documentation.
05/11/2010	Attachment B	Code for Venipuncture corrected from 551 to 580
12/01/2011	Subsections 3.6.1	Added language to descriptions of non-covered supplies prompted by questions received on T1999 billing
12/01/2011	Subsection 3.6.2.a	Added information to clarify the definition of a medical supply.

12/01/2011	Section 5.0	Added Face-to-Face and MD orders
12/01/2011	Subsection 5.4.1	Added nursing visit limitation
12/01/2011	Subsection 7.2	Added Patient Self Determination Act
12/01/2011	Subsection 7.4.1	Clarified HIT and HH services
12/01/2011	Subsection 7.5.1	Changed numbering to separate clinical notes instruction from requiring a 485. Added F2F statement as requirement for record keeping
12/01/2011	Attachment A	Changed reference section to 7.5.1 to match renumbered section
07/01/2013	All sections and attachment(s)	Technical changes to merge Medicaid and NCHC current coverage into one policy.
07/01/2013	Subsection 5.5.4	Added prior approval requirements and limitations on use of T1999
07/01/2013	Subsections 5.5.1, 5.5.2	Added limitations on nurse and nurse aide visits.
07/01/2013	All sections and attachment(s)	Replaced "recipient" with "beneficiary."
07/01/2013	All sections and attachment(s)	Replaced "residence, private residence or home" with "primary private residence."
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.

## Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, DMA’s clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

**A. Claim Type**

Institutional (UB-04/837I transaction)

**B. International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)**

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

**C. Code(s)**

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

The revenue codes used for billing skilled visits, home health aide visits, and specialized therapies are listed in the table below.

For specialized therapies, it is essential to distinguish between therapy visits for the purpose of evaluation (or re-evaluation) and therapy visits for treatment. Document the distinction in the physician’s orders and keep the documentation in the beneficiary’s record. Bill with the appropriate revenue code. Refer to codes 420, 424, 430, 434, 440, and 444 in the table below. Additional information on specialized therapies can be found in Clinical Coverage Policy 10A, *Outpatient Specialized Therapies*. Refer to <http://www.ncdhhs.gov/dma/mp/>.

Revenue Code	Use	Unit of Service
<b>THERAPIES</b>		
420	Physical therapy	1 visit
424	Physical therapy evaluation	1 visit
430	Occupational therapy	1 visit
434	Occupational therapy evaluation	1 visit
440	Speech-language pathology services	1 visit
444	Speech-language pathology services evaluation	1 visit

SKILLED NURSING VISITS		
550	Skilled nursing: Initial assessment/re-assessment (Initial assessment of a new patient or 60-calendar-day re-assessment)	1 visit
551	Skilled nursing: Treatment, teaching/training, observation/evaluation	1 visit
559	Skilled nursing: For a dually eligible beneficiary when the visit does not meet Medicare criteria (for example, the beneficiary is not homebound)	1 visit
580	Skilled nursing: venipuncture	1 visit
581	Skilled nursing: Pre-filling insulin syringes/Medi-Planners	1 visit
589	Supply only visit; no other skilled service provided	1 visit
HOME HEALTH AIDE		
570	Home Health Aide	1 visit

Home health medical supplies are billed using revenue code 270, along with the applicable HCPCS code for the individual supply.

**Unlisted Procedure or Service**

**CPT:** The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

**HCPCS:** The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

**D. Modifiers**

Not applicable

**E. Billing Units**

Provider(s) shall report the appropriate code(s) used, which determines the billing unit(s).

The home health agency furnishing the service shall bill for services with its individual NPI.

Providers may bill only for those services ordered by a physician and documented in the beneficiary's individual POC.

The scope, duration, and date of the service shall be documented in the clinical notes or progress notes to support the billing. (Refer to **Subsection 7.6.1 Clinical or Progress Notes** for documentation in the clinical record.)

Individual home health services shall be billed in accordance with the *NCTracks Provider Claims and Billing Assistance Guide*: <https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>.

Supervisory visits are considered administrative costs and may not be billed as skilled nursing services.

A five calendar day window is allowed for the sixty calendar day assessment visits to accommodate the scheduling of staff. This means that the 60 calendar day assessment for ongoing services or the 60 calendar day supply assessment visit may be provided within a 55 to 60 calendar day range.

The appropriate procedure code(s) used determines the billing unit(s). Each of the aforementioned billing codes has a unit of service of one (1) visit.

**F. Place of Service**

Skilled nursing services, medical supplies, specialized therapy services, and home health aide services can be provided to beneficiaries in a primary private residence.

Skilled nursing services, medical supplies, and specialized therapy services can also be provided in the adult care and group home setting. Home health aide services are not covered for beneficiaries residing in adult care or group homes.

**G. Co-payments**

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at <http://www.ncdhhs.gov/dma/plan/sp.pdf>.

For NCHC refer to G.S. 108A-70.21(d), located at [http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter\\_108A/GS\\_108A-70.21.html](http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html)

**H. Reimbursement**

Provider(s) shall bill their usual and customary charges.

For a schedule of rates, see: <http://www.ncdhhs.gov/dma/fee/>

## Attachment B: Skilled Nursing Service Billing Guide

The information in the following charts is not an all-inclusive list of covered home health skilled nursing visit types and reasons; instead, it gives examples to be used for guidance for billing the Medicaid program. Medicare should be billed for services for dually eligible beneficiaries when Medicare criteria are met and payment is available from Medicare. Condition codes D7 and D9 should be entered on the UB-04 to override Medicare, when applicable.

### A. Assessment and Evaluation

Examples of Skilled Nursing Visits for Assessment & Evaluation	Medicaid Eligibility Only	Medicare/Medicaid Dually Eligible (Service Not Meeting Medicare Criteria)
Initial assessment required to admit a new beneficiary, or 60-calendar-day reassessment.	550	559
Evaluation of a new condition or illness or exacerbation of current condition, causing the care to become more complex or requiring changes to the POC for an <i>established</i> patient.	551	559
Observation and evaluation after a period with no significant changes in intervention. The beneficiary's illness has reached a plateau. There is a chronic condition that is considered "stable"—no recent exacerbations, no recent changes in the medication or treatment regimen—yet there continues to be a documented medical necessity for intermittent nursing visits. Visits would be limited to no more than one visit per calendar month. One PRN visit may also be billed per calendar month when it is ordered by the physician and can be documented as a medical necessity.	551	559
<b>60-calendar-day assessment for need of supplies (supply-only assessment visit)</b>	<b>589</b>	<b>589</b>

**B. Teaching and Training**

Examples of Skilled Nursing Visits for Teaching & Training	Medicaid Eligibility Only	Medicare/Medicaid Dually Eligible (Service Not Meeting Medicare Criteria)
<p>Teaching or training activities required for a beneficiary or the family/caregiver to manage the treatment regimen. The teaching or training is reasonable and medically necessary for the beneficiary's illness or injury.</p> <p>Examples:</p> <ul style="list-style-type: none"> <li>• Teaching self-administration and self-management of a specific condition such as diabetes.</li> <li>• Reinforcement of teaching that had been provided in a controlled institutional setting.</li> <li>• Retraining a beneficiary when there has been a change in procedure or in the beneficiary's condition that requires re-teaching; or when the beneficiary or the family/caregiver is not properly carrying out the task.</li> <li>• Training a new caregiver.</li> </ul>	551	559

**C. Treatment**

Examples of Skilled Nursing Visits for Treatment	Medicaid Eligibility Only	Medicare/Medicaid Dually Eligible (Service Not Meeting Medicare Criteria)
Administration of intravenous, intramuscular, or subcutaneous injections and infusions when the medication being administered is accepted as the safe and effective treatment of a beneficiary's illness or injury, and there is a medical reason that the medication cannot be taken orally.	551	559
Ostomy care during the post-operative period and in the presence of associated complications.	551	559
Changing or replacing tubes such as indwelling Foley catheters, gastrostomy tubes, supra-pubic tubes, and nasogastric tubes.	551	559

Examples of Skilled Nursing Visits for Treatment	Medicaid Eligibility Only	Medicare/Medicaid Dually Eligible (Service Not Meeting Medicare Criteria)
<p>B-12 injections for the following conditions only:</p> <ul style="list-style-type: none"> <li>• Pernicious anemia, megaloblastic anemias, macrocytic anemias, fish tapeworm anemia.</li> <li>• Gastrectomy; malabsorption syndromes such as sprue and idiopathic steatorrhea; surgical and mechanical disorders such as resection of the small intestine, strictures, anastomosis, and blind loop syndrome.</li> <li>• Postlateral sclerosis and other neuropathies associated with pernicious anemia, during the acute phase or acute exacerbation of neuropathy due to malnutrition and alcoholism.</li> </ul>	551	559
<p>Pre-filling insulin syringes. <b>Note:</b> Visits are limited to no more than one every two calendar weeks with one PRN visit per calendar month.</p>	581	581
<p>Pre-filling medication dispensers (“Medi-Planners”) and monitoring medication compliance after a period of time when the beneficiary or caregiver has not been able to comprehend teaching and there is not a caregiver willing and able to do so. <b>Note:</b> Visits are limited to no more than one every two calendar weeks with one PRN visit per calendar month.</p>	581	581
<p>Administering prescribed oral medications, or providing skilled observation and monitoring the administration of eye drops when the complexity of the beneficiary’s condition, the nature of the drugs prescribed, and the number of drugs prescribed require the skills of a nurse to detect and evaluate side effects or reactions. <b>Note:</b> Neither Medicare nor Medicaid covers routine administration.</p>	551	559
<p>One-time visits to provide a skilled service such as suture removal in the absence of another qualifying skilled service.</p>	551	559

Examples of Skilled Nursing Visits for Treatment	Medicaid Eligibility Only	Medicare/Medicaid Dually Eligible (Service Not Meeting Medicare Criteria)
<p>Venipuncture when collection of a specimen is necessary for diagnosis and treatment of a beneficiary's illness or injury; and when venipuncture cannot be performed in the course of regularly scheduled absences from the primary private residence to acquire medical treatment.</p> <ul style="list-style-type: none"> <li>• The physician's order for the venipuncture for a laboratory test shall be associated with a specific symptom or diagnosis, and the treatment shall be recognized in the <i>Physicians' Desk Reference</i> or other authoritative source as being reasonable and necessary for the treatment of the illness or injury.</li> <li>• The frequency of testing shall be consistent with accepted standards of medical practice for continued monitoring of a diagnosis, medical problem, or treatment regimen. Even when the laboratory results are consistently stable, periodic venipuncture may be reasonable and necessary because of the nature of the treatment.</li> </ul> <p><b>Note:</b> Supplies used for venipuncture are included in the visit charge.</p>	580	580
<p>Examples of reasonable and medically necessary venipuncture for stabilized beneficiaries include the following.</p> <ul style="list-style-type: none"> <li>• Venipuncture to monitor white blood cell count and differential count every 3 months for beneficiaries taking Captopril when the results are stable and the beneficiary is asymptomatic</li> <li>• Venipuncture for phenytoin (Dilantin) levels every 3 months when the results are stable and the beneficiary is asymptomatic</li> <li>• Venipuncture to monitor complete blood count as ordered by a physician for beneficiaries taking chemotherapy at home</li> <li>• Venipuncture for fasting blood sugar (FBS) once every 2–3 months for a stable diabetic</li> <li>• Venipuncture for prothrombin time (PT test) monthly when the results are stable within the therapeutic range</li> </ul> <p>The medical necessity for venipuncture visits that do not meet the guidelines above must be fully substantiated in the medical records.</p> <p><b>Note:</b> Medicaid may not be billed for venipuncture if the test is covered under Medicare.</p>		

<b>Examples of Skilled Nursing Visits for Treatment</b>	<b>Medicaid Eligibility Only</b>	<b>Medicare/Medicaid Dually Eligible (Service Not Meeting Medicare Criteria)</b>
<b>Wound care when the skills of a licensed nurse are needed to provide the care safely and effectively. The care may include direct, hands-on treatment; teaching of care; skilled observation and assessment; or any combination of these.</b>	<b>551</b>	<b>559</b>

### Attachment C: Request for a HCPCS Code Addition

Refer to **Subsection 3.2.1.5** for details.

**REQUEST FOR HCPCS CODE ADDITION**  
**MEDICAID HOME HEALTH FEE SCHEDULE**

*North Carolina*  
*Department of Health and Human Services*  
DIVISION OF MEDICAL ASSISTANCE

<b>PROVIDER NAME/ADDRESS:</b>	<b>Contact Person</b>		
	<b>Phone Number</b>		
	<b>Provider Number</b>		<b>Date Submitted</b>
1.	<b>Name of item or supply</b>	<b>Manufacturer</b>	
	Provide a brief description		
	Procedure (CPT or HCPCS) code. <i>(Indicate if there is no HCPCS code for the item)</i>		
2.	Can an existing HCPCS code from the fee schedule cover this item? (circle) YES NO		
	Explain		
3.	Did this item replace another supply previously used for the medical condition? (circle) YES NO		
	If yes, explain reason for change (examples: Is it less expensive to use the packaged item? Is there potential to alleviate an exacerbation of the patient's condition?, etc.)		
4.	a. Diagnostic indication(s).		
	b. Duration and frequency of use.		
	c. Proposed advantages of the new care, service, or supply.		
5.	a. Estimates of charges for the requested coverage <i>(charge billed to Medicaid by your agency)</i>	b. Actual cost and source	
6.	Does Medicare and/or another insurance company cover this? (circle) YES NO <b>(Attach verification, if available)</b>		
7.	Extent to which the requested coverage is currently in use in North Carolina (if known)		
8.	Attach any supporting data from research studies, peer-reviewed journals, etc. Attachments? (circle) YES NO		

Submit completed form with attachments to Hospice/Home Health Program Consultant, DMA Clinical Policy and Programs, 2501 Mail Service Center, Raleigh, NC 27699-2501

Form DMA3400  
Revised 11/07