

KMAP GENERAL BULLETIN 17111

Home Health Services

Effective with dates of service on and after July 1, 2017, the following federal regulatory changes for Medicaid home health services as documented in CMS 2348 Final Rule will be implemented in accordance with revisions to 42 Code of Federal Regulation 440.70.

1. Coverage of home health services cannot be contingent upon the beneficiary needing nursing or therapy services.
2. Home health services may be provided in any setting in which normal life activities take place, other than a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. Home health services cannot be limited to services furnished to beneficiaries who are homebound.
3. Medical supplies, equipment, and appliances are suitable for use in any setting in which normal life activities take place.
4. Supplies are defined as health care-related items that are consumable or disposable, or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness, or injury.
5. Equipment and appliances are defined as items that are primarily and customarily used to serve a medical purpose; generally are not useful to an individual in the absence of a disability, illness, or injury; can withstand repeated use; and can be reusable or removable. State Medicaid coverage of equipment and appliances is not restricted to the items covered as durable medical equipment (DME) in the Medicare program.
6. States can have a list of preapproved medical equipment supplies and appliances for administrative ease but States are prohibited from having absolute exclusions of coverage on medical equipment, supplies, or appliances. States must have processes and criteria for requesting medical equipment that is made available to beneficiaries to request items not on the State's list. The procedure must use reasonable and specific criteria to assess items for coverage. When denying a request, the State must inform the beneficiary of the right to a fair hearing.

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7. Additional services or service hours may, at the State's option, be authorized to account for medical needs that arise in the settings where home health services are provided.
8. Payment may not be made for the services listed below unless the physician or allowed nonphysician practitioner, with the exception of a certified nurse midwife, documents that there was a face-to-face encounter with the beneficiary that meets the requirements of 42 CFR 440.70.
 - Nursing services
 - Home health aide services
 - Medical supplies, equipment, and appliances
 - Physical therapy, occupational therapy, or speech pathology and audiology services
9. For the initiation of home health services, the face-to-face encounter must be related to the primary reason the beneficiary requires home health services and must occur within the 90 days before or within the 30 days after the start of the services.
10. For the initiation of medical equipment, the face-to-face encounter must be related to the primary reason the beneficiary requires medical equipment and must occur no more than six months prior to the start of services.
11. The face-to-face encounter may be conducted by one of the following practitioners:
 - Physician
 - Nurse practitioner or clinical nurse specialist (working in collaboration with the physician and in accordance with state law)
 - Certified nurse midwife
 - Physician assistant (under the supervision of the physician)
 - Attending acute or postacute physician (for beneficiaries admitted to home health immediately after an acute or postacute stay)
12. The allowed nonphysician practitioner performing the face-to-face encounter must communicate the clinical findings of the face-to-face encounter to the ordering physician. Those clinical findings must be incorporated into a written or electronic document included in the beneficiary's medical record.
13. To ensure clinical correlation between the face-to-face encounter and the associated home health services, the physician responsible for ordering the services must:

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- Document that the face-to-face encounter which is related to the primary reason the patient requires home health services occurred within the required timeframes prior to the start of home health services.
 - Indicate the practitioner who conducted the encounter and the date of the encounter.
14. The documentation requirement of the face-to-face encounter will be monitored through the home health program prior authorization (PA) process. All home health services require PA. The home health provider must submit documentation of the face-to-face encounter in addition to the PA request form, Outcome and Assessment Information Set (OASIS), and CMS-485 (home health plan of care) which includes the physician's or nonphysician practitioner's orders and certification for care. A specific form for the face-to-face encounter is not required, but the documentation must contain all of the key information. **Note:** Copies of the PA and face-to-face encounter documentation must be retained on file in the beneficiary's medical record at the home health agency.
15. The face-to-face encounter may occur through telehealth, as implemented by the State.
16. Payment may not be made for medical equipment, supplies, appliances, or DME if the face-to-face encounter is performed by a certified nurse midwife.
17. The face-to-face encounter for medical equipment, supplies, or appliances may be performed by any of the practitioners described above, with the exception of the certified nurse midwife.
18. A beneficiary's need for medical supplies, equipment, and appliances must be reviewed by a physician annually.

This policy will expand coverage of specified incontinence supplies for beneficiaries 21 years of age and older. Reference the provider manual for a list of covered incontinence supplies and a list of acceptable incontinence diagnosis codes. The coverage criteria for incontinence supplies for KAN Be Healthy - Early and Periodic Screening, Diagnostic, and Treatment (KBH-EPSDT) beneficiaries (ages 5 to 20) remains the same.

Note: All home health initial start of care dates on and after July 1, 2017, will require a face-to-face visit performed by a physician or an allowed nonphysician practitioner. Supporting documentation must be included as specified above. Existing home health prior authorizations and plans of care will not require a face-to-face encounter.

For the changes resulting from this provider bulletin, view the updated *Home Health Agency Fee-for-Service Provider Manual*. Updates to other provider manuals will be published as well.

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