Kansas
Medical Assistance
Program

May 2006 **Provider Bulletin Number 614**

Home Health Providers

Home Health Criteria

The *Home Health Provider Manual* has been updated with home health criteria information. This information can be found in Appendix III of the *Home Health Provider Manual.* The ACIL information, which used to be Appendix III, is now in Appendix IV. Other pages with changes are listed below.

Information about the Kansas Medical Assistance Program as well as provider manuals and other publications are on the KMAP Web site at https://www.kmap-state-ks.us. For the changes resulting from this provider bulletin, select the *Home Health Provider Manual*, pages 8-13, 8-20 through 8-23, AI-3, AIII-1 through AIII-15, and AIV-1 through AIV-4.

If you have any questions, please contact the KMAP Customer Service Center at 1-800-933-6593 (in-state providers) or (785) 274-5990 between 7:30 a.m. and 5:30 p.m., Monday through Friday.

Updated 5/06

Total Parenteral Nutrition (continued);

B4222 - SUPPLY KIT HOME MIX:

Containers	Heparin Flush
Gloves	Injection Caps
Alcohol Wipes	Micropore Tape
Iso. Alcohol	Plastic Tape
Acetone	Needles
Providone Iodine Scrub	Syringes
Providone Iodine Ointment	Ketodiastix
Providone Sticks	Destruclip
Gauze Sponges	

A4222, A4223 ADMIN KIT:

Admin Sets/Leur Lock &	Clamps
Micron Filter	Extension Sets
Pump Cassettes	2 or 3-way connectors

Family Planning:

Family planning is any medically approved treatment, counseling, drugs, supplies or devices which are prescribed or furnished by a provider to individuals of child-bearing age for purposes of enabling such individuals to freely determine the number and spacing of their children.

When a service provided in conjunction with a KAN Be Healthy screen relates to family planning, complete the family planning block (24H) on the claim form to ensure that federal funding is utilized appropriately.

Immunizations/Vaccines:

Reimbursement for covered immunizations is limited to the administration of the vaccine only. Vaccines are supplied at no cost to the provider through the Vaccines for Children Program.

Home Health Aide:

Home health aide services must be performed by a home health aide under the general supervision of a registered nurse. A nursing care plan outlining specific duties of the aide is required. Home health aide services need not be related to skilled nursing visits nor are they subject to time limitations. A supervisory visit of a home health aide is required at least every two weeks when the patient is under a skilled service plan of care.

Home health ~~aide~~ services must be prior authorized for home and community based services (HCBS) consumers. Beneficiaries not on an HCBS waiver may receive home health aide services and skilled nursing services on the same day without prior authorization as long as the limits for each service are not exceeded.

8400. Updated 5/06

Phototherapy:

Phototherapy is covered for newborns with a total bilirubin level above 12/dL. Use procedure code E0202RR for phototherapy (bilirubin) light or blanket with photometer. When billing E0202RR, one unit = one day and limited to 10 consecutive days per lifetime.

Services/Supplies for Medicare-Eligible Individuals:

Modifier GY is to be used to designate those services/supplies provided to a Medicare beneficiary when the service is reasonably believed by the provider to be non-covered by Medicare. Use modifier GY with the following procedure codes and codes listed in Appendix II when filing claims to Medicaid for Medicare eligible individuals:

G0154, G0156, S9128, S9129, S9131, T1002, T1003, T1004, T1021, 99601

Note: Medicare must be billed first if there is a possibility they will allow payment on a claim. **If Medicare does not allow payment, the claim may be submitted to Medicaid along with the Medicare denial.**

Skilled Nursing:

Skilled nursing services must be provided by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN). Skilled nursing services are those services requiring substantial and specialized nursing skill. **Skilled nursing services require a physician's order.** Skilled nursing services must be prior authorized for home and community based (HCBS) consumers.

Use procedure code G0154 for the first 15 minutes of a skilled nurse (RN or LPN) in a home health setting. Use procedure code T1002 for subsequent intervals of an RN visit, up to 15 minutes ~~intervals of an RN visit,~~ and procedure code T1003 for subsequent intervals of an LPN visit, up to15 minutes. ~~intervals of an LPN visit.~~ G0154 is limited to one unit per day. T1002 or T1003 are limited to a combined total of three units per day for non-HCBS waiver beneficiaries. Additional units must be prior authorized.

Skilled nursing responsibilities by an **RN** include but are not limited to the following:

- Initial and ongoing assessments
- Initiating and updating care plans
- Communication with physicians
- Supervision of aides
- Medication set-up
- IV/IM medication administration requiring the skill level of a nurse
- Invasive procedures requiring the skill level of a nurse
- Individualized teaching as outlined by the care plan
- Diabetic nail care
- Treatment and evaluation of wounds

Skilled nursing responsibilities by an **LPN** include but are not limited to the following:

- Ongoing assessments
- Updating care plans

8400. Updated 5/06

Skilled Nursing (continued)

- Communication with physicians
- Medication set-up.
- **Venipuncture for blood draws**
- Individual teaching as outlined by the care plan excluding teaching related to parenteral procedures (e.g., IVs, Hickman catheters).
- Diabetic nail care
- Treatment and evaluation of wounds
- **Medication administration requiring the skill level of a nurse, excluding IVs.***

***LPNs who have successfully completed an intravenous fluid therapy course may, under the supervision of a registered professional nurse, engage in a limited scope of intravenous fluid treatment, including the following: 1) Monitoring; 2) maintaining; 3)discontinuing intravenous flow and an intravenous access device not exceeding three inches in length in peripheral sites only; and 4) changing dressing for intravenous access devices not exceeding three inches in length in peripheral sites only.**

Combination of services:

- A skilled nursing visit and a supervisory visit when performed at the same time constitutes one visit
- An RN performing both aide and skilled nursing duties constitutes a skilled visit
- A non-skilled visit performed by an RN or LPN constitutes a home health aide visit

Note: Only one home health aide or restorative aide visit to the same individual may be reimbursed for the same date of service.

If services in excess of the following limitations on skilled nursing services are desired, documentation of medical necessity is required:

- Medication set-up - once a week
- Insulin syringes filling - once a week for a stable patient
- General assessment - every 60 days for a stable patient
- Supervisory visits
  - no more often than every two weeks if the patient is **also** receiving skilled services
  - at least every 60 days if the patient is receiving **non-skilled** services only

Tele-Medicine:

Tele-Medicine uses face-to-face video contact to monitor consumers in the home setting as opposed to a nurse going out to visit the home. This technology may be used to monitor consumers' medications, vital signs, and self-administered injections.

Tele-Medicine services must be provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN). **Agencies <u>may</u> bill skilled nursing services on the same date of service as tele-medicine services.**

8400. Updated 5/06

Therapy:

Therapy treatments are not covered for psychiatric diagnosis.

Habilitative - Therapy is covered for any birth defects/developmental delays only when approved and provided by an Early Childhood Intervention (ECI), Head Start or Local Education Agency (LEA) program. Therapy treatments performed in the Local Education Agency (LEA) settings may be habilitative or rehabilitative for disabilities due to birth defects or physical trauma/illness. Therapy of this type is covered only for participants age 0 to under the age of 21. Therapy **must** be medically necessary. The purpose of this therapy is to maintain maximum possible functioning for children.

Rehabilitative - All therapies must be physically rehabilitative. Therapies are covered only when rehabilitative in nature and provided following physical debilitation due to an acute physical trauma or physical illness and prescribed by the attending physician.

Therapy services are limited to 6 months for non-KAN Be Healthy participants (except the provision of therapy under HCBS), per injury, to begin at the discretion of the provider. There is no limitation for KAN Be Healthy participants.

All therapy services are limited to one unit per day. Therapy services provided by a home health agency for home and community based services (HCBS) consumers must be prior authorized.

Occupational:

Services must be prescribed by a physician and provided by a registered occupational therapist or by a Certified Occupational Therapy Assistant working under the supervision of a Registered Occupational Therapist. Supervision must be clearly documented. This may include, but is not limited to, the registered occupational therapist initializing each treatment note written by the certified occupational therapy assistant, or the registered occupational therapist writing "Treatment was supervised" followed by their signature.

Physical:

All physical therapy services must be initially prescribed by a physician and performed by either a registered physical therapist or by a Certified Physical Therapy Assistant working under the supervision of a Registered Physical Therapist. Supervision must be clearly documented. This may include, but is not limited to, the registered physical therapist initializing each treatment note written by the certified physical therapy assistant, or the registered physical therapist writing "Treatment was supervised" followed by their signature.

Restorative Aide:

Restorative aide service is only covered for physical therapy. Services must be restorative and rehabilitative physical therapy provided by a restorative aide under an outpatient physical therapy plan of care developed by a registered physical therapist. Services can not be billed on the same date of service as a home health aide service. Use T1021.

8400. Updated 5/06

Speech:
Services must be prescribed by a physician and provided by a certified speech pathologist.

Respiratory:
Respiratory therapy is covered for KAN Be Healthy participants only.

Urinary Equipment:

External catheters are limited to one per day.

External urethral clamps or compression devices are limited to one per month.

The following items (or combinations of these items) are limited to a combined total of two per month, regardless of provider. Medical necessity will not override this limitation.

- Indwelling catheters
- Intermittent urinary catheters

EXCEPTION: A4351 is limited to 4 per month.

The following items (or combinations of these items) are limited to a combined total of two per month, regardless of provider. Medical necessity will not override this limitation.

- Urinary drainage bags
- Urinary leg bag
- Bedside drainage bag

The following items (or combinations of these items) are limited to a combined total of two per month, regardless of provider. Medical necessity will not override this limitation.

- Catheter insertion tray

The following items (or combinations of these items) are limited to 15 per month, regardless of provider:

- Irrigation tray for bladder irrigation with bulb or piston syringe
- 3-way irrigation tubing set for a Foley catheter Irrigation syringe, ball or piston.

Updated 5/06

COV.	PROCEDURE CODE	NOMENCLATURE
		KAN BE HEALTHY SCREENING
		Refer to Section 2020 of the General Benefits Manual
		HOME HEALTH AIDE SERVICES
PA/HCBS	G0156	Services of home health aide in home health setting, ~~first~~ each 15 minutes
PA/HCBS	T1004	Services of a qualified nursing aide, ~~for subsequent intervals~~ up to 15 minutes ~~intervals~~
		SKILLED NURSING SERVICES
PA/HCBS	G0154	Services of a skilled nurse in home health setting, ~~first~~ each 15 minutes
PA/HCBS	T1002	RN services, ~~for subsequent intervals of an RN visit,~~ up to15 minutes ~~intervals of an RN visit~~
PA/HCBS	T1003	LPN/LVN services, ~~for subsequent intervals of an RN visit,~~ up to 15 minutes ~~intervals of an LPN visit~~
PA/HCBS	99601	Home Infusion/Specialty drug administration per visit (up to 2 hours)
		TELE-MEDICINE SERVICES
	99347	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family. Limit one visit per day
	99348	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family. May be billed on same date of service as 99347.
	99349	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family. Limit one visit per day, may not be billed on same date of service as 99347, may be billed on same date of service as 99348.

APPENDIX III

Updated 5/06 Criteria Revision Effective: March 16, 2006

Home Health Criteria

(Criteria dated May 2003, Updated January 2004, Revised May 2004, Revised October 2004, Revised March 16, 2006)

Provider Manual

The provider manual is located at:
https://www.kmap-state-ks.us
This on-line site also includes manuals for other issues addressed in Home Health, such as HCBS waivers.

Home Health Services

Skilled nursing, home health aide, and skilled therapy services provided on a part-time or intermittent basis at the beneficiary's place of residence are defined as the following:

- Part-time is less than eight hours each day and 28 or fewer hours each week
- Intermittent is skilled nursing care that is provided or needed fewer than seven days each week or fewer than eight hours per day for 21 days or less
- Residence is defined as where the person regularly makes his or her home, for example, a house or apartment. This does not include nursing facilities, hospitals, or intermediate care facility for mental retardation (ICF/MRs)
- Skilled services are those services requiring the substantial specialized knowledge and skill of a licensed professional nurse
- Unskilled services are those services not requiring the skill level of a licensed person

Goals of Home Health Services

The two main goals of Home Health Services are:

- Maximize independence of the beneficiary by teaching/training the beneficiary or other caregiver to provide medical care to maintain the beneficiary in the community
- Provide medically related services the beneficiary or caregiver is unable to perform

Updated 5/06
Prior Authorization Requirements

HCBS Waiver Beneficiaries

- All home health services provided to HCBS waiver beneficiaries require prior authorization.

- HCBS waiver beneficiaries are assigned one of the following level of care (LOC) codes. Most waivers include attendant care. This generally will cover the same types of service home health aides usually perform.
  - Mental retardation/developmental disabilities (MR/DD) waiver
  - Head injury (HI) waiver
  - Physically disabled (PD) waiver
  - Technology assisted (TA) waiver: This waiver is only used to access Medicaid services and does not provide any attendant or other nursing services through the waiver. All, or almost all, of the TA waiver beneficiaries receive ACIL nursing services, which should practically eliminate a need for home health nursing or aide services.
  - Frail elderly (FE) waiver
  - Severely emotionally disturbed **(**SED) waiver: The SED waiver only provides some mental health services.

- Skilled Services Limitations
  - Nursing services: RN or LPN level of care (home health aide is not skilled).
  - Occupational therapy (OT), physical therapy (PT), and speech therapy are limited to one unit per day.
    These services must be restorative and rehabilitative and may only be provided following physical debilitation due to acute physical trauma or physical illness. This is limited to 6 months in duration.
    Note: This limit may not be overridden with PA.
  - Respiratory therapy is limited to KBH eligible beneficiaries (beneficiary must be under the age of 21). Respiratory therapy is limited to one unit per day.
    Note: This limit may not be overridden with PA.

- Nonskilled Services Limitations:
  - Home Health Aide services are limited to one unit of G0156 (GY) and 3 units of T1004 (GY) per day.
    Note: This limit may not be overridden with PA.
  - Nonskilled (Home Health Aide) level services are rarely approved for persons on an HCBS waiver. Nonskilled level services should be provided as noted below:
    - FE waiver – Nonskilled services should be provided by FE Level II attendant.
    - PD waiver – Nonskilled services should be provided by PD personal services.
    - MR/DD waiver – Nonskilled services should be provided by attendants or family if the beneficiary is receiving supportive home care or family individual support, and through the facility if the beneficiary is receiving residential services.

Updated 5/06

- HI waiver – Nonskilled services should be provided through HI personal services.
- TA waiver – All TA waiver beneficiaries receive ACIL services.
- SED waiver – There may be rare requests for home health services for this waiver. Each request should be judged on its merits. Documentation must support the medical necessity for the requested service.

- Nonskilled Services Descriptions and Examples:

  Home Health Aide level services include, but are not limited to:

  - Administration of routine oral medications, eye drops, and topical ointments (assistance with medications ordinarily self-administered and do not require the skills of a licensed nurse to be provided safely and effectively)
  - General maintenance care of colostomy and ileostomy
  - Routine services to maintain satisfactory functioning of indwelling bladder catheters
  - Simple dressing changes for wounds, noninfected postoperative or chronic conditions
  - Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems
  - Routine care of the incontinent patient, including use of diapers and protective sheets
  - General maintenance care in connection with a plaster cast
  - Routine care in connection with braces and similar devices
  - Assistance in dressing, eating, and going to the toilet
  - Periodic turning and positioning in bed
  - Routine range of motion (ROM) activities
  - Gastrostomy and enteral feedings
  - Vital signs

- Restorative aide (T1021) services may not be approved on the same date of service as home health aide visits.

Nonwaiver Beneficiaries

Anytime a PA is created for a nonwaiver beneficiary, all units, including those within the established limits, must be included on the PA, not just the units that exceed the established limits.

- Limits:
  - Skilled Nursing Service: Beneficiaries not on an HCBS waiver may receive one G code and three T codes of skilled nursing service daily **without a PA.** One unit of G0154 and three units of **either** T1002 or T1003 or a combination of T1002 and T1003 as long as the total units of skilled nursing does not exceed one unit of G0154 and three units of T codes. If a beneficiary is not on a waiver and requires more units of service than one G code and three T codes daily, a PA is required.
    Note: If a PA is created for a nonwaiver beneficiary, all units, including those allowed within the limits, must be on the PA.

Updated 5/06

- Home Health Aide Service: Beneficiaries not on a waiver may receive one unit of G0156 and three units of T1004 (home health aide level of care) without a PA. There is no need to obtain a PA for this service for beneficiaries not on a waiver.

  Note: This limit may not be overridden by PA.

- Infusion Therapy: On and after January 1, 2004, code 99601 (GY) is used for IV Infusion Therapy. The code description states up to two hours of service. This code is a per visit code. An agency may use this code for each visit made to the home to provide infusion therapy. Agencies providing infusion services will be in the home longer and should use 99601, which is reimbursed at a higher rate. One unit of 99601 is expected to encompass both the initiation and disconnection of an infusion along with performance of other tasks in the home while the IV infuses. If an infusion is started and the nurse leaves while the IV infuses and returns to disconnect the IV, this is considered to be one visit. If a nurse performs an infusion in the morning and while the infusion is running does other tasks, such as a dressing change, and must return later in the day to perform another skilled nursing service, such as change the second dressing of the day, the second visit should be billed using G and T codes. Beneficiaries not on a waiver may receive up to three units of 99601 per day for 14 days without a PA. This limit may be overridden with a PA if the physician's order is for infusions beyond those limits.

  Note: Flushing ports or disconnecting a previously setup infusion are not considered infusion therapy and will not be reimbursed using 99601.

- Skilled Therapy Services: Speech, occupational, and physical therapy are limited to one unit per day. Respiratory therapy is limited to KBH eligible beneficiaries and is limited to one unit per day without a PA. There is no need to obtain a PA for this service for beneficiaries not on a waiver.

PRN Visits

- PRN visits may be requested and authorized by the PA unit nurse at the time a PA is requested for other services. For example, if the patient is unstable, has frequent medication changes, or has required PRN visits in the recent past, or if other situations or conditions exist such that the PA unit nurse believes PRN visits may be necessary during the authorized period, PRN visits may be approved.
- PRN visits may be requested any time prior to the visit or within two working days after a visit has been made. Calls made to the PA unit during nonworking hours shall be considered to be notification of the request. Agencies have 15 working days from the time of the call to submit a physician's order and completed PA request form to the PA unit. If the required documentation is not submitted within the time frame the request will be denied.

Updated 5/06

Paperwork Requirements

- Initial Request:
  - Completed Home Health Services PA Request Form
  - 485 or other completed care plan that includes physician's orders
  - Completed up-to-date OASIS

- Supporting documentation for reconsideration or renewal requests:
  - Completed Home Health Services PA Request Form
  - 485 or other completed care plan that includes physician's orders
  - 486 or documentation of the 60-day summary which includes beneficiary's response to treatment and supports continuance of home health services

- Call in Requests:
  - Providers may call in a PA request. The final authorization is based upon written information submitted within 15 days.
  - The paperwork can be mailed to Kansas Medical Assistance Program, Office of the Fiscal Agent, P.O. Box 3571, Topeka, KS, 66601-3571 or faxed to (785) 274-5956 or 1-800-913-2229. The Prior Authorization request form is also available at www.kmap-state-ks.us under the Publications tab (click Forms).

- Physician's Orders:
  - All services require a signed physician's order. Either a physician's order or an RN-signed verbal order from a physician is acceptable to initiate treatment. If orders are never signed by the physician, services may be subject to recoupment on a postpay review.

GY Modifier

- The provider must either bill Medicare first to obtain a denial, or if Medicare does not usually pay for the service, the provider must use the GY modifier to bypass the denial requirement.
- Providers request Medicaid coverage because a beneficiary is not "homebound." Medicare has loosened their homebound criteria.

Updated 5/06
Procedure Codes and Nomenclature

Length of Prior Authorization

- PAs for chronic, ongoing services may be created for six month intervals; documentation must include beneficiary's response to treatment and progress toward discharge.
- PAs for wounds may only be created for 60 days. New information is required to extend the PA.
- PAs for teaching and training may be created for the length of time the teaching and training is authorized. New information is required to extend the PA.
- PAs may be created for the length of time requested by the provider if the request does not exceed the foregoing guidelines.

Adjusting Existing PA

- Adjustments may be made to existing PAs when RN level of care needs to be changed to LPN or vice versa. The total units should not be increased or decreased without specific documentation as to the need for the increased or decreased units. Requests for this type of adjustment should be accompanied by a completed home health request form.

PA Not Required

- A PA is not required for a beneficiary who is not on a waiver and the requested services do not exceed the limitations.
- The beneficiary is not on a waiver and the limits on the requested services cannot be overridden by a PA.

Guidelines

Time Allowed Per Visit

All services performed during the visit are to be considered concurrent. For instance, an RN doing a dressing change will not need another whole hour to do an assessment because the RN will be assessing while doing the dressing change. Consider which services can be combined in determining the total time required for each visit. Documentation provided for each visit must support the amount of time billed.

Updated 5/06

Licensed Professional Services Defined

Services generally considered to require the skill level of a licensed professional include, but are not limited to:

- Assessments
- Care plan development
- Catheter insertion and replacement
- Diabetic nail care
- Dressing changes/wound care – complicated
- Infusions
- Injections
- Medication setup
- Observation and assessment of an unstable beneficiary
- Parenteral feedings
- Prefilling insulin and other syringes
- Procedures requiring use of sterile technique
- Psychiatric nursing requiring RN level of care
- Supervision
- Teaching and training activities
- Tracheostomy tube changes
- Treatment of extensive decubitus ulcers or other widespread skin disorders
- Venipuncture requiring RN level of care

Aide Level (Nonskilled) Services defined

Services generally considered not to require the skill level of a licensed professional include, but are not limited to:

- Administration of routine oral medications, eye drops, and topical ointments
- Assistance with bathing, dressing, eating, and toileting
- Bowel and bladder procedures: bowel stimulation, obtaining specimens, performance of enemas, or impaction removal if:
  - Self directed (HCBS waivers only)
  - Ordered by the physician
  - No contraindications exist
  - Bowel condition is chronic
- Emptying of ostomy or urine bag
- Gastrostomy and enteral feedings
- General maintenance care of colostomy, ileostomy, and catheters
- Prophylactic and palliative skin care
- Routine ROM activities
- Simple, nonsterile dressing changes
- Treatment of minor skin problems
- Vital signs

Updated 5/06

Services generally considered not to require the skill level of a licensed professional may require a licensed professional if the beneficiary's condition is complicated or compromised, or if other extenuating circumstances exist. In these circumstances the documentation should support the use of a licensed professional. Reimbursement for services paid at a skill level higher than the skill level supported by the documentation will be recouped.

Time Frames

Providers who bill past the frequency and duration limits established in the guidelines (whether PA was required) may be subject to postpay recoupment if the documentation does not support the services provided.

All services that can be completed within the same visit should be completed within the same visit rather than scheduling multiple visits to perform different skilled tasks.

PA Guidelines

- Assessments/Evaluations/Reassessments: Up to 60 minutes if stand-alone service, 30 minutes if combined with another service. One initial assessment, if performed in the absence of any other skilled service, is reimbursable up to one hour every 60 days to determine the skilled service needs and to develop or revise the plan of care. A reassessment of up to one hour may be allowed if the beneficiary's needs change due to a change in condition. PA would not be required for nonwaiver beneficiaries for this level of service, unless another skilled nursing service was performed at the same visit causing the visit to exceed one hour of billable service. Both the initial assessment and reassessment require prior authorization for HCBS beneficiaries. (Up to one hour will be reimbursed for initial and ongoing assessments for care plan development and OASIS, and to update the care plan and OASIS every 60 days. Although assessments may exceed one hour, reimbursement will be allowed only up to one hour. Reassessments of up to one hour may be allowed if the beneficiary's needs change due to a change in condition.)

- Care Plan Development: Care Plan Development is not a separate billable service. (It is included in the assessment/evaluation reimbursement rate.)

- Catheters (insertion and replacement):
    - Foley: Up to one hour per month plus up to two one-hour PRN visits if ordered by the physician. (Up to 30 minutes once per month plus up to two PRN visits if the beneficiary has newly acquired the catheter or has history of complications.)
    - Straight Catheter: Up to 30 minutes up to four times daily. Document the efforts to train the beneficiary or caregiver to perform the catheterization. (Up to 30 minutes)

Updated 5/06

- Chronic Illness Monitoring: Up to 60 minutes twice monthly. Skilled nursing services may be provided on a limited basis to chronically ill beneficiaries with the potential for exacerbation or instability. One-hour visits up to twice monthly for six months may be approved if the documentation supports a history of frequent hospital admissions, exacerbations to acute stages of the chronic disease, or overall debility which puts the beneficiary at risk of instability. (Up to two 30-minute visits per month).

- Dressing changes/wound care non MRSA: Up to two hours per day; this may be one hour twice a day (BID) for 10 days and up to one hour per day for an additional four days when supported by the physician's order and plan of care. (30 minutes BID up to ten days and up to 30 minutes daily for up to four days.)

- Dressing changes/wound care MRSA or VRE: Up to two 90-minute visits daily for a total of up to three hours daily, for a maximum of 60 days. (Up to 60 minutes BID up to 60 days)

- Decubitus ulcers: Treatment of extensive decubitus ulcers will vary depending upon the services needed and the extent of the problem. Documentation must support the time billed.

- Diabetic Nail Care: 30 minutes monthly. This service should usually be done in conjunction with some other service and rarely be a stand-alone service. (20-30 minutes monthly)

- Eye Drops: 15 minutes per visit. Documentation must support the need for a licensed nurse visit for the purpose of instilling eye drops, such as new postsurgery or newly diagnosed acute medical condition. (Up to four visits daily, up to 10 minutes)

- Glucose Monitoring: Up to four 15-minute visits per day. Generally this is not a skilled service and is usually performed by the beneficiary or caregiver but may be allowed as a skilled nursing service if the documentation demonstrates the beneficiary or caregiver is unable to perform glucose monitoring. A skilled visit may also be allowed if the beneficiary is unstable and the documentation supports a clinical need for assessment, management, and reporting to the physician of specific conditions and/or symptoms which are unstable or unresolved. (Five minutes up to four times per day for up to two weeks if stand-alone service. If provided with insulin administration, five to ten minutes are allowed.)

- Injections: Up to five minutes for injections, up to 30 minutes for observation for allergy injections. (Allergy injections should not be provided in the home to a person who routinely goes out of the home and could obtain the injection from his or her physician's office or a clinic.)

Updated 5/06

- Insulin injections/diabetes management: Up to 15 minutes up to four times per day, depending upon the physician's orders. (Five to ten minutes up to four times a day (QID) for two weeks during the unstable phase. Five to ten minutes up to QID up to two weeks to teach and train once stable.)
  - Insulin injections may be allowed if the beneficiary is unable to self inject, there is no other person available to give the injection, and attempts to use other technology or to teach the patient to self inject have failed. Documentation must demonstrate the beneficiary and/or caregiver is unable to administer the injections.
  - Documentation must support the need for diabetes management and reporting specific conditions or symptoms which are unstable or unresolved.

- Medication Administration: Routine oral medication administration is a home health aide level service and should not require skilled nursing services. Exceptions may exist when the beneficiary is compromised or requiring assessment prior to medication administration, or when medications must be crushed or administered through a G-tube. Inhalers should be administered by the waiver attendants or beneficiary should be taught to self administer inhalers. In rare cases, a beneficiary may not be able to self administer an inhaler and home health services may be authorized.

  Note: If a patient is on a waiver, medication administration is content of the waiver service and should not require home health services.

- Medication Setup: Medications should be obtained setup from the pharmacy or in unit dose packs to aid in the proper administration of routine oral medications by the beneficiary, caregiver, attendants, or aides.
  - When a nurse must set up medications in a beneficiary's home, the nurse performs the medication setup in conjunction with other skilled activities. Rarely should it be necessary for a nurse to perform a skilled visit solely for the purpose of medication setup.

  Note: Other community resources should be considered in these instances such as use of a Community Mental Health Center (CMHC), a local health department, or pharmacy.

  - When possible, medications should be setup for more than a one-week period of time.
  - Time allowed to set up medication could be up to 20 minutes, depending on the number and complexity of the medications and the number of weeks being set up.
  - Prefilling insulin syringes should be included as part of medication setup. If this is the only medication required by the beneficiary to be set up, prefilled syringes should be obtained from the pharmacy, if possible.

Updated 5/06

- Ostomy Care:
  - Rarely should ostomy care require a licensed professional, such as acute post operative period or in the presence of complications. Ostomy care should occur in conjunction with other services, such as teaching or training rather than as a stand-alone service.
  - Documentation must support the need for the licensed professional.
  - Insertion/replacement of a gastrostomy or urostomy tube may be approved up to one hour every month with a maximum of two additional one-hour PRN visits per month.

- Psychiatric Nursing:
  - Documentation should support the time spent. Assessments, AIMS tests, mental status exams, and other therapeutic interventions designed to relieve psychiatric symptoms are considered psychiatric nursing.
  - Psychiatric nursing services provided by home health agencies are not limited to the homebound. Nonhomebound patients should be encouraged to use community mental health centers.
  - Psychiatric nursing services must be provided by an RN.

- Supervision:
  - Nursing visits for the purpose of supervising aides are not a separate billable service. Supervisory visits should occur during visits scheduled for other skilled services such as medication setup, assessment, catheter change, and so forth.
  - Supervision of home health aides is required every two weeks only if the patient is receiving skilled nursing services. If the patient is receiving only home health aide level of care, supervision is only required every 60 days.

- Teaching and training:
  - Teaching and training activities requiring skilled nursing personnel to teach a beneficiary, the beneficiary's family, or caregivers how to manage the beneficiary's treatment regimen constitutes skilled nursing services as long as the services are appropriate to the beneficiary's functional loss, illness, or injury.
  - All teaching and training should be associated with the performance of an actual service, such as wound care, ostomy care, or glucose monitoring.
  - Three types of teaching and training are recognized:
    - Initial teaching of a new skill
    - Reinforcement of teaching or training previously provided in an institutional setting
    - Reteaching when there is a change in the beneficiary's condition or the task is being carried out incorrectly.
  - Documentation must support the need for teaching and training.

Updated 5/06

- Occupational Therapy: Occupational therapy must be restorative and rehabilitative and provided by a registered occupational therapist. It may only be provided following physical debilitation due to acute physical trauma or physical illness and is limited to six months duration for nonKAN Be Healthy participants. This service is limited to one unit per day. This limit may not be overridden by PA.

- Physical Therapy: Physical therapy must be restorative and rehabilitative and provided by a registered physical therapist. Physical therapy may only be provided following physical debilitation due to acute physical trauma or physical illness and is limited to six months duration for nonKAN Be Healthy participants. This service is limited to one unit per day. This limit may not be overridden by PA.

- Respiratory Therapy: Respiratory therapy is limited to KAN Be Healthy participants. The limit is one unit per day. This limit may not be overridden by PA.

- Speech Therapy: Speech therapy must be restorative and rehabilitative and provided by a licensed speech-language pathologist. Speech therapy may only be provided following physical debilitation due to acute physical trauma or physical illness and is limited to six months duration for nonKAN Be Healthy participants. This service is limited to one unit per day. This limit may not be overridden by PA.

- Restorative Aide: Restorative aide may only provide restorative and rehabilitative physical therapy services under the physical therapy plan of care developed by a registered physical therapist. Restorative aide services may not be billed on the same date of service as a home health aide service. Restorative aide services may only be provided following physical debilitation due to acute physical trauma or physical illness and is limited to six months duration for nonKAN Be Healthy participants. One unit of restorative aide service is allowed per day. This limit may not be overridden by PA.

- Venipuncture: Venipuncture service should rarely, if ever, be provided as a stand-alone service and will generally be included with other services during a home visit.

APPENDIX IV

ACIL PROGRAM

Updated 5/06

Program Purpose:

Attendant Care for Independent Living (ACIL) is a medical service. ACIL provides long-term maintenance or supportive care for KAN Be Healthy (KBH) children who are both technology dependent and chronically ill. Without ACIL services, the beneficiary would be institutionalized. ACIL services are provided in the beneficiary's own home.

Program Description

Services: All ACIL services require a HealthConnect referral.

ACIL Target Case Management

ACIL Targeted Case Management (G9012) is limited to 480 units (15 minutes per unit) per calendar year. Case management must be provided by a pediatric ARNP or general ARNP. Prior authorization (PA) is required when a beneficiary requires more than 480 units per year of Targeted Case Management. PA requests must be directed to the ACIL Program Manager at (785) 296-3561.

ATTN: ACIL Program Manager
Division of Healthcare Policy
Docking State Office Building
915 SW Harrison, 10th Floor
Topeka, KS 66612-1570

ACIL Nursing Services

- ACIL Nursing Services must be prescribed by a physician in accordance with a plan of care. The plan of care must include the beneficiary's physical, psychosocial, emotional, and personal care needs. The plan of care must also include documentation indicating ACIL services are the most appropriate services to best meet the child's needs.

- ACIL Nursing services must be provided by a qualified person (attendant) under the supervision of a Registered Nurse (RN) employed by a licensed home health agency. ACIL nursing services are medically necessary, medically oriented tasks requiring the caregiver to have a higher skill level such as those performed by persons with professional training (e.g. LPNs, home health aides).

  ACIL nursing services must be provided by Home Health Agencies licensed by the Kansas Department of Health and Environment. Medicare certification as a Home Health Agency is not required.

  ACIL beneficiaries may receive Hospice services, however ACIL services cannot duplicate Hospice services. PA requirements apply, see Section 4300 of the General Special Requirements Provider Manual.

Updated 5/06

Admission into the ACIL Program:

Admission to ACIL services requires program manager approval. Approval for admission into the ACIL program is obtained in the following manner:

- Approved ACIL Targeted Case Management (TCM) providers evaluate beneficiaries for eligibility for ACIL services.

- If the ACIL Case Manager (CM) determines the beneficiary meets eligibility criteria, the ACIL CM submits the following documentation to the ACIL Program Manager at the following address:

    - Case Management Provider's Worksheet
    - Assessment Instrument

    ATTN: ACIL Program Manager
    Division of Healthcare Policy
    Docking State Office Building
    915 SW Harrison, 10th Floor
    Topeka, Kansas 66612-1570

- The ACIL Program Manager reviews the submitted documentation, and notifies the ACIL TCM provider in writing whether the beneficiary has been approved or not approved for admission into the ACIL program.

Approval for ACIL Nursing Services and Changes to ACIL Nursing Services:

- The ACIL Program Manager must approve requested ACIL Nursing Services or changes to ACIL services prior to the start or change of those services for all beneficiaries. This includes, but is not limited to:

    - The initiation of ACIL nursing services
    - Changes in the number of approved ACIL nursing hours
    - Changes in the approved skill level of ACIL nursing services provider
    - Changes in ACIL nursing provider
    - Changes in the reimbursement rate for ACIL nursing services

    To support the ACIL Nursing Services request, the ACIL CM submits the following documentation to the ACIL Program Manager. Documentation must support the proposed ACIL Nursing Services request.

    ATTN: ACIL Program Manager
    Division of Healthcare Policy
    Docking State Office Building
    915 SW Harrison, 10th Floor
    Topeka, Kansas 66612-1570

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Approval for ACIL Nursing Services and Changes to ACIL Nursing Services: (continued)

- Rate Sheet - initial plan and any changes to the plan
- Justification from CM for the proposed changes to the plan
- Updated Case Management Provider's Worksheet - changes to the plan
- Updated Assessment Instrument - changes to the plan

- The ACIL Program Manager reviews the submitted documentation and notifies the ACIL TCM provider in writing whether the proposed initiation or changes in ACIL services have or have not been approved.

Note: Babies born to mothers assigned to FirstGuard (HealthWave 19) are excluded from ACIL eligibility. FirstGuard provides intensive medical care needed for these babies.

Note: Any services not provided in accordance with these processes are subject to recoupment.

Registered Nurse Supervision:

Supervisory visits must be provided in the presence of the attendant. Supervisory visits provided when the attendant is not present are subject to recoupment.

The supervising nurse provides written instructions to the attendant in a plan of care regarding the various services required by the child. The supervising nurse instructs the attendant about essential observations for each child's health and about any condition which should be brought to the attention of the attending physician.

The supervising nurse visits the child a minimum of every 60 days to assess the child's health and quality of care received. The nurse reviews written documentation, the plan of care, the attendant's observations and notes. The supervising nurse assesses the child's health and assesses the interaction and relationship between the patient and attendant, and updates the plan of care as needed.

Record Keeping:

Each agency is responsible for maintaining their own records in accordance with Medicaid requirements. All written instructions regarding the services performed by the attendant are kept and reviewed by the supervising nurse at each assessment. The instructions are updated if needed, and signed by the supervising nurse. At each visit the attendant documents the tasks performed, the child's condition and beginning and ending time worked. All records are retained as documentation the services were provided and are subject to review.

Technology Assisted Children Waiver

The technology assisted (TA) children's waiver provides special waiver services for TA children who would, in the absence of home care services, require a hospital level of care.

Updated 5/06

Technology Assisted Children Waiver: (continued)

Medical respite care is defined as a temporary service provided on an intermittent basis for the purpose of relieving the family of the care of a dependent child for short, specified periods of time. Respite care must be provided by skilled nursing staff (e.g., R.N., L.P.N., or Attendant), under the direct supervision of a home health agency licensed by the Kansas Department of Health and Environment and enrolled as a Child-ACIL provider.

A maximum of seven days or 168 hours per calendar year of respite care may be provided in the home per beneficiary. Procedure code T1005, respite care should be indicated on the HCFA-1500 claim form when billing for this service.

Limitations:

- Children must be under the age of 18
- Are ventilator dependent, or require total parenteral nutrition, or similar conditions
- Children must be KAN Be Healthy participants
- Are approved as waiver eligible by Health Care Policy of SRS
- Services delivered to the child must be contained in a plan of care approved by Medical Services
- Other insurance is primary and must be billed first