

**Government Business Division
Policies and Procedures**

Section (Primary Department) Health Care Management - Utilization Management		SUBJECT (Document Title) Home Health Services - LA	
Effective Date 03/09/2021	Date of Last Review 06/20/2025 01/13/2026	Date of Last Revision 06/20/2025	Dept. Approval Date 06/20/2025
Department Approval/Signature:			

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products	<input type="checkbox"/> Arkansas	<input type="checkbox"/> Iowa	<input type="checkbox"/> Nebraska	<input type="checkbox"/> South Carolina
<input checked="" type="checkbox"/> Medicaid/CHIP	<input type="checkbox"/> California	<input type="checkbox"/> Kansas	<input type="checkbox"/> Nevada	<input type="checkbox"/> Tennessee
<input type="checkbox"/> Medicare/DSNP	<input type="checkbox"/> Colorado	<input type="checkbox"/> Kentucky	<input type="checkbox"/> New Jersey	<input type="checkbox"/> Texas
	<input type="checkbox"/> District of Columbia	<input checked="" type="checkbox"/> Louisiana	<input type="checkbox"/> New York	<input type="checkbox"/> Virginia
	<input type="checkbox"/> Florida	<input type="checkbox"/> Maryland	<input type="checkbox"/> New York (WNY)	<input type="checkbox"/> Washington
	<input type="checkbox"/> Georgia	<input type="checkbox"/> Minnesota	<input type="checkbox"/> North Carolina	<input type="checkbox"/> West Virginia
	<input type="checkbox"/> Indiana	<input type="checkbox"/> Missouri	<input type="checkbox"/> Ohio	<input type="checkbox"/> Wisconsin

POLICY:

A home health agency (HHA) provides patient care services in the enrollee’s residential setting, under the order of an authorized healthcare provider (AHP), that are necessary for the diagnosis and treatment of the enrollee’s illness or injury. An AHP includes a physician, nurse practitioner, clinical nurse specialist, or physician assistant licensed, certified, registered, or otherwise authorized to order home healthcare services consistent with State law. Such services include part-time skilled nursing services, extended skilled nursing services (for enrollees under twenty-one (21) years of age), home health aide services, physical therapy (PT), speech-language therapy (ST), occupational therapy (OT), and medical supplies recommended by the AHP as required in the care of the enrollee and suitable for use in the enrollee’s place of residence.

During the home visit, the clinician should define a specific goal or reason for the appointment to substantiate the need for the visit (medical necessity) and the reason it is occurring in the enrollee’s place of residence.

Healthy Blue covers the following home health services:

- Skilled nursing (intermittent or part-time);
- Home health aide services, in accordance with the plan of care (POC) as recommended by the AHP
- Extended skilled nursing services (also referred to as extended home health), as part of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, is extended nursing care by a registered nurse or a licensed practical nurse (LPN) and may be provided to enrollees under age twenty-one (21) who are considered “medically fragile;”
- Rehabilitation services are physical, occupational and speech therapies, including audiology services; and

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- Medical supplies, equipment, and appliances, as recommended by the AHP, required in the POC for the enrollee and suitable for use in the place of residence are covered under the Durable Medical Equipment (DME) program and must be prior authorized.

Home health services are reimbursable only when ordered by a licensed AHP who certifies that the beneficiary meets the medical necessity criteria to receive services in a recipient's place of residence on an intermittent basis. Medicaid recipients do not have to be homebound in order to receive home health services. Home health services can be provided in a recipient's place of residence, which is any non-institutional setting in which a recipient's normal life activities take place or any setting in which payment is or could be made by Medicaid for inpatient services that include room and board. The enrollee cannot receive services in a hospital, nursing home, or intermediate care facility for individuals with intellectual disabilities (ICF-IID) (with limited exceptions). Beneficiaries in an ICF-IID may receive short-term home health care from a registered nurse (RN) during an acute illness to avoid the beneficiary being transferred to a nursing home. The AHP must certify that the recipient meets the medical criteria to receive the service in their place of residence and is in need of the home health service on an intermittent basis. This certification and AHP's plan of care must be maintained in the recipient's record and on file at the HHA. The AHP must review the POC every sixty (60) days.

A face-to-face encounter is required and it must be related to the primary reason the recipient requires home health services. A face-to-face encounter may be conducted by the recipient's AHP. Healthy Blue ensures that a face-to-face encounter between the patient and the AHP must occur no more than ninety (90) days prior to, or thirty (30) days after, admission to the HHA. The *Home Health Face-to-Face Encounter Form* must be included in the prior authorization request documentation sent from the HHA.

Electronic visit verification (EVV) is required for all home health services.

DEFINITIONS:

1915(c) Waiver – Refers to Medical Assistance Programs under Louisiana Medicaid approved by the Secretary of the United States Department of Health and Human Services that provide reimbursement for home or community-based services, other than room and board, pursuant to a written plan of care to individuals with respect to whom there has been a determination, but for the provision of such services, that the individual would require the level of care provided in a hospital, in a nursing facility, or in an intermediate care facility for the intellectually or developmentally disabled, the cost of which could be reimbursed under the Louisiana Medicaid State Plan. 1915(c) Waiver programs in Louisiana Medicaid include the Children's Choice (CC) Waiver, the New Opportunities Waiver (NOW), the Supports Waiver (SW), and the Residential Options Waiver (ROW).

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Extended Home Health (EHH) – Refers to any Louisiana Medicaid service in which it is determined medically necessary for either a registered nurse (RN) or a licensed practical nurse (LPN) currently licensed to practice in Louisiana, to provide a minimum of three continuous hours per day of nursing services, as defined in the Louisiana Nurse Practice Act, pursuant to a written plan of care outside of an institutional setting. This term also refers to shift nursing care in the home and/or, as described in 42 United States Code (USC) §1396d(8) and 42 Code of Federal Regulations (CFR) §440.80, private duty nursing services for the purpose of caring for class members.

Home Health Care or Services – Patient care services provided in the patient’s residential setting or any setting in which normal life activities take place under the order of a physician that are necessary for the diagnosis and treatment of the patient’s illness or injury, including one (1) or more of the following services: (1) skilled nursing; (2) physical therapy (PT); (3) speech-language therapy (ST); (4) occupational therapy (OT); (5) home health aide services; or (6) medical supplies, equipment and appliances suitable for use in any setting in which normal life activities take place.

Intermittent Nursing (IN) – Refers to the Louisiana Medicaid State Plan service that allows for the provision of a daily nursing visit lasting less than three (3) continuous hours. This service does not require prior authorization.

Prior Authorization (PA) – Refers to the request for services submitted by a health care provider participating in Louisiana Medicaid on behalf of the participant to Louisiana Medicaid and determined to be medically necessary in accordance with generally accepted, evidence-based medical standards prior to the delivery of the particular service.

Rehabilitation Services and Devices* – Services ordered by the enrollee’s primary care provider (PCP) to help the enrollee recover from an illness or injury. These services are provided by nurses and physical, occupational, and speech therapists.

Skilled Nursing Care* – A level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse (RN) or a licensed practical nurse (LPN)).

Support Coordination (SC) Services – Refers to those services furnished by a support coordinator to assist participants in a 1915(c) Waiver under Louisiana Medicaid, who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, education, and other services in accordance with 42 CFR §§ 440.169 and 441.18. The assistance provided by support coordinators in assisting eligible participants is set forth in 42 CFR §440.169(d)-(e).

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PROCEDURE:

Skilled Nursing Services

Nursing services provided on a part-time or intermittent basis by an RN or LPN that are necessary for the diagnosis and treatment of a beneficiary's illness or injury. Examples of skilled nursing services include but are not limited to the following:

- Frequently monitoring blood pressure, fluid status, or blood glucose;
- More rigorous assessment of symptoms, including pain, dyspnea, or constipation;
- Management of complex wounds;
- Patient education around therapy (e.g., home glucose monitoring and insulin administration); and
- Assessment of medication adherence.

These services shall be consistent with:

- Established Medicaid policy;
- The nature and severity of the beneficiary's illness or injury;
- The particular medical needs of the patient; and
- The accepted standards of medical and nursing practice.

The requested services must meet all of the following:

- Be ordered and directed by a treating practitioner or specialist (MD, DO);
- Care must be delivered or supervised by a licensed professional in order to obtain a specific medical outcome;
- Services must be of skilled care in nature;
- Services must be part-time or intermittent; and
- Services must be clinically appropriate and not more costly than an alternative health service.

Psychiatric Services

Home health services provided to beneficiaries whose primary diagnosis is psychiatric must be provided in accordance with state requirements as published in the Minimum Standards for HHAs. One requirement stipulates that only RNs shall make psychiatric nurse visits. RN qualifications for psychiatric home health visits are taken from the Minimum Standards for Licensing Home Health Agencies (LAC 48:1. Chapter 91). Only RNs who have these credentials shall make psychiatric nurse visits.

Additionally, experience must have been within the last five years or documentation must show psychiatric re-training, classes, or continued education units (CEUs) to update psychiatric knowledge. RN requirements include the following:

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- RN with a master’s degree in psychiatric or mental health nursing;
- RN with a bachelor’s degree in nursing with one year of experience in an active treatment unit in a psychiatric or mental health hospital or outpatient clinic; or
- RN with a diploma or associate degree with two years of experience in an active treatment unit in a psychiatric or mental health hospital or outpatient clinic.

The services must be medically necessary and provided only to beneficiaries who meet Medicaid’s medical necessity criteria for home health services.

Home Health Aide Services

In some situations, a dually eligible beneficiary (one who has coverage from both Medicare and Medicaid) requires only home health aide visits. Medicare will not pay for this service unless skilled services (skilled nursing service, PT, OT or ST) are also required. However, Medicaid will reimburse for home health aide visits if only home health aide visits are required.

Periodic on-site supervision with the home health aide present is part of the Minimum Standards for HHAs. It is required that if the beneficiary is receiving a skilled service (nursing, physical therapy, occupational therapy, or speech-language therapy), the beneficiary shall have a RN or appropriate therapist supervisory visit made randomly every fourteen (14) days.

Beneficiaries not receiving skilled services must have an RN supervisory visit at the beneficiary’s residential setting at least once every sixty-two (62) days while the home health aide is present and providing care. Supervisory visits are not billable services.

Extended Home Health (EHH)

EHH, also known as extended skilled nursing services (a minimum of three (3) or more hours of nursing services per day) may be provided to beneficiaries under the age of twenty-one (21) by the HHA if determined to be medically necessary, ordered by an AHP and prior authorized by Healthy Blue. The beneficiary must require skilled nursing care that exceeds the caregiver’s ability to care for the beneficiary without the EHH services.

Medical necessity for extended skilled nursing services exists when the beneficiary has a medically complex condition characterized by multiple, significant medical problems that require nursing care in accordance with the Louisiana Nurse Practice Act (La. RS 37:911, et seq).

When requesting prior authorization (PA) for EHH, all hours of care must be included with the PA request. In addition, the AHP’s prescription and a copy of the POC must be attached to the appropriate PA form. Cases approved for EHH should be billed using appropriate codes for RN and LPN in conjunction with the total number of hours provided, indicating the units as hours.

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Skilled nursing services are to be conducted in the beneficiary's residential setting. EHH services may be provided outside of the residential setting when the nurse accompanies the beneficiary for medical reasons such as doctor appointments, treatments or emergency room visit. Medicaid will not reimburse for skilled nursing services performed outside of state boundaries.

In order to provide continuity of care for beneficiaries, the following procedure will be used for beneficiaries requiring EHH care upon discharge from the hospital. Prior to hospital discharge, the PA process can begin. The following information must be submitted:

- A letter of medical necessity from the AHP;
- A signed prescription indicating the number of hours of EHH that are being requested;
- A copy of the admission assessment (history and physical);
- Progress notes;
- Discharge orders;
- A copy of the discharge summary, if available; and
- A copy of the unsigned POC. The unsigned POC will be accepted only if the beneficiary is being discharged from the hospital and is included with the above information. The POC assessment cannot be done in the hospital but must be done in the beneficiary's residential setting.

Rehabilitation Services

Physical, occupational and speech therapy services are covered when provided by the HHA. These services are covered with PA. All rehabilitation services (except for initial evaluations and wheelchair seating evaluations, which are restricted to one evaluation per discipline per beneficiary every one hundred eighty (180) days) require PA. All evaluations must have an AHP's prescription that must be kept in the beneficiary's file.

All initial PA requests must include a copy of the AHP's referral and the results of the evaluation of the beneficiary that documents the need for therapy. All renewal PA requests must include a copy of the AHP's referral and progress notes that document the need for the continuation of therapy.

Physical Therapy (PT) services are rehabilitative services necessary for the treatment of the beneficiary's illness or injury, or restoration and maintenance of function affected by the beneficiary's illness or injury. These services are provided with the expectation, based on the AHP's assessment of the beneficiary's rehabilitative potential, that:

- The beneficiary's condition will improve materially within a reasonable and generally predictable period of time; or
- The services are necessary for the establishment of a safe and effective maintenance program.

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Occupational Therapy (OT) is a medically prescribed treatment to improve or restore a function which has been impaired by illness, injury or, when the function has been permanently lost or reduced, to improve the beneficiary's ability to perform those tasks required for independent functioning.

Speech Therapy (ST) services are those services necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of a communication disability.

Home Health and Medical Supplies

Medical supplies recommended by the AHP, required in the care of the beneficiary and suitable for use in any setting in which normal life activities take place are covered under the DME program when approved.

Home health supplies are reimbursable under the DME Program. Approval of payment for covered supplies provided under the DME program must be obtained by the provider if prior authorization is required. Providers may either obtain these non-reimbursable supplies through a DME provider or provide the supplies through the DME program. Providers who opt to have the supplies provided by a DME provider must give the DME provider a copy of the AHP's orders for the supplies. The request must include the quantity and period of time the supplies are to cover. Home health providers who choose to provide these supplies can have their home health provider file updated to allow billing for these supplies. HHAs often train members or their caregivers to administer medications, or use certain equipment/supplies, in the provider's absence. DME covered IV, or other home health supplies, may be provided to the HHA for use in the member's residential setting when administration is monitored and home health services are provided.

When normal usage amounts are exceeded, a request for approval must be submitted with documentation of medical necessity to justify the greater quantity. Certain supplies for wound care and dressing will be covered under DME but will be authorized exclusively for the use of HHAs when delivering a home health service.

Routine supplies for which reimbursement is included as part of the reimbursement rate for the home health visit:

- Blood drawing supplies
- Sterile specimen containers
- Vacutainer used for drawing blood
- Tourniquet
- Tubex holder
- Alcohol preps-swabs
- Surgical masks

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- Bandage scissors
- Cultures
- Disposable gloves – non-sterile
- Adhesive tape
- Paper tape
- Emesis basins
- Oral swabs/toothettes
- Alcohol
- Tape measure, all types
- Non-sterile cotton balls, buds
- Disposable gowns (plastic, paper)
- Disposable masks
- Goggles
- Disposable wash clothes
- Water soluble lubricant
- Thermometer with holder
- Thermometer cover
- Sharps container
- Self-assistive devices (long handle tongs and shoehorn stocking aide)

Supplies covered only when provided in conjunction with a home health visit:

- Inflatable cushion (softcare mattress)
- Douche – betadine
- Enema – disposable enema administering kit
- Enema – fleets, mineral oil
- Fracture pan, plastic
- Bed pan, plastic
- Urinal, plastic, male
- Urinal, female
- Commode urinary disposable collection device (HAT)
- Toppers, sterile
- Steri-strips
- Reston
- Telfa
- Skin staple remover
- Sterile applicators (tongue blades, sterile q-tips)
- Suture removal kit
- Sitz bath, portable, disposable
- Elastoplast
- Foam tape

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- Pericare kit/supplies
- Bile bags
- Therabands/putty
- Sterile irrigation solutions (GU irrigant, acetic acid and normal saline)
- Lymphedema pumps

Service Limitations

Note: Medicaid prohibits multiple professional disciplines in a member's residential setting at the same time. This includes but is not limited to nurses, home health aides, and therapists. However, multiple professionals may provide services to multiple members in the same residential setting when it is medically necessary. Medical necessity will be determined by Healthy Blue.

Service limits for home health services are as follows:

- Birth through age twenty (20):
 - No annual service limits;
 - PA is required for multiple visits on the same day when medically necessary; and
 - PA is required for EHH services.
- Ages twenty-one (21) or older:
 - Medicaid will reimburse only one (1) visit per profession per day.
 - PA is required for all nursing and rehabilitation services in a residential setting:
 - Skilled Nursing and Home Health Aide Services;
 - Physical Therapy;
 - Occupational Therapy; and
 - Audiology Services.

Beneficiary Requirements and Medical Necessity Criteria

The Medicaid beneficiary must meet all eligibility requirements in order to qualify for home health services. The HHA providing the service is required to verify beneficiary eligibility, other insurance coverage, and living arrangements before providing services.

The beneficiary cannot be in a hospital, nursing facility, ICF-IID, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

Exception: In accordance with 42 CFR Part 483, Subpart I, there are situations in which a beneficiary residing in an ICF-IID may receive home health services. For example, short-term home health services may be provided to a beneficiary in an ICF-IID during an acute illness to avoid a beneficiary's transfer to a nursing facility.

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Medical necessity for home health services must be determined by medical documentation that supports the beneficiary's illness, injury and/or functional limitations. All home health services must be medically reasonable and appropriate. To be considered medically reasonable and appropriate, the care must be necessary to prevent further deterioration of a beneficiary's condition regardless of whether the illness/injury is acute, chronic, or terminal.

The services must be reasonably determined to:

- Diagnose, cure, correct, or ameliorate defects, physical and mental illnesses, and diagnosed conditions of the effects of such conditions;
- Prevent the worsening of conditions, or the effects of conditions, that endanger life or cause pain; results in illness or infirmity; or have caused, or threatened to cause a physical or mental dysfunctional impairment, disability or development delay;
- Effectively reduce the level of direct medical supervision required or reduce the level of medical care or services received in an inpatient or provided by the home health program;
- Restore or improve physical or mental functionality, including developmental functioning, lost or delayed as the result of an illness, injury, or other diagnosed condition or the effects of the illness, injury, or condition; or,
- Provide assistance in gaining access to needed medical, social, educational, and other services required to diagnose, treat, to support a diagnosed condition or the effects of the condition, in order that the beneficiary might attain or retain independence, self-care, dignity, self-determination, personal safety and integration into family, community, facility environments and activities.

Home health skilled nursing and aide services are considered medically reasonable and appropriate when the beneficiary's medical condition and records accurately justify the medical necessity for services to be provided by the home health program rather than in a physician's office, clinic, or other outpatient setting.

Home health services are appropriate when a beneficiary's illness, injury, or disability causes significant medical hardship and will interfere with the effectiveness of the treatment if the beneficiary has to go to a physician's office, clinic, or other outpatient setting for the needed service. Any statement on the plan of care (POC) regarding this medical hardship must be supported by the totality of the beneficiary's medical records.

The following circumstances are not considerations when determining medical necessity for home health services:

- Inconvenience to the beneficiary or the beneficiary's family;
- Lack of personal transportation; and,
- Failure or lack of cooperation by the beneficiary or the beneficiary's legal guardians or caretakers to obtain the required medical services in an outpatient setting.

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Plan of Care

The AHP must certify that the beneficiary meets the medical criteria to receive the service in the member's residential setting and is in need of the home health services on an intermittent basis. The AHP must order all home health services and sign a POC submitted by the HHA. If the HHA is not submitting a CMS-485 form then the POC must meet all the elements provided on the CMS-485 form. This certification and the AHP's POC must be maintained in the beneficiary's record and on file at the HHA. The AHP must reauthorize the POC every sixty (60) days.

An AHP's order must be submitted with the PA request. A POC will be accepted in lieu of a separate AHP's order if the frequency of visits are specified. If providers are unable to obtain a signed POC for a reconsideration request, an unsigned POC may be submitted for reconsideration requests for a thirty (30) day period only. The signed POC must be submitted with the new PA request in order for services to be approved.

Face-to-Face Encounter Requirements

For the initiation of home health services, a face-to-face encounter with the AHP and the beneficiary, must occur no sooner than ninety (90) days prior to the start of home health services, or no later than thirty (30) days after the start of home health services.

Evidence of the face-to-face encounter is required for routine skilled nursing and home health aide services for beneficiaries age twenty-one (21) and older. If providers do not have this documentation prior to the initiation of services then the initial PA request must be for thirty (30) days only. Providers must submit documentation of the face-to-face encounter with the new PA request in order for services to be approved.

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 (6) months prior to the start of services.

Any of the following will be accepted as evidence of a face-to-face encounter between an AHP and the beneficiary, or an allowed NPP and the beneficiary:

- A written statement on the certifying AHP's letterhead or prescription pad attesting to a face-to-face encounter between the AHP and the beneficiary or an allowed NPP and the beneficiary; or
- The HHA's face-to-face encounter form that the HHA requires the beneficiary's certifying AHP to complete as a routine business practice; or
- Medical notes or documentation from the AHP demonstrating evidence of a face-to-face encounter within the required timeframe.

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Documentation of a face-to-face encounter as detailed above must be kept in the beneficiary’s record for all home health service-related requests, including therapy services, medical equipment and supplies, and services for beneficiaries under the age of twenty-one (21).

The face-to-face encounter may be conducted by one of the following practitioners:

- The beneficiary’s AHP;
- A nurse practitioner or clinical nurse specialist, working in collaboration with the beneficiary’s AHP;
- A physician assistant under the supervision of the beneficiary’s AHP;
- A certified nurse-midwife, as defined in section 1861(gg) of the Social Security Act; or
- The attending acute or post-acute physician for beneficiaries admitted to home health immediately after an acute or post-acute stay.

Clinical findings must be incorporated into the beneficiary’s medical record. The AHP responsible for ordering the services must:

- Document that the face-to-face encounter which is related to the primary reason the beneficiary requires home health services, occurred within the required and specified timeframes above;
- Identify the practitioner who conducted the encounter; and
- Indicate the date of the face-to-face encounter.

Home Health Modifiers

Modifiers are available for routine home health and EHH (recipients age zero (0) through twenty (20)), to reflect specific scenarios as indicated in the chart below. All modifier requests must be submitted with the PA and approved in order to be reimbursed. Refer to the Louisiana Medicaid Home Health Revenue and Procedure Codes Fee Schedules.

Modifier	Modifier Name
U2	Second Daily Visit
U3	Third Daily Visit
TT	Multiple Beneficiaries in the Same Setting
TG	High Complexity
TN	Rural/Outside Area
TV	Weekends and Holidays
UH	Services Provided in the Evening
UJ	Services Provided at Night
TU	Overtime

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Multiple Same Day Visits

Multiple nursing visits on the same date of service may be provided to a beneficiary age birth through twenty (20) when the medical necessity criteria is met and these services cannot be provided during the course of one (1) visit. Multiple same day visits must be prior authorized before services begin.

Extended and multiple daily visits must be authorized in accordance with the certifying AHP's orders and home health POC. The AHP must issue orders detailing how many visits should be provided per day and the duration of time to provide the multiple visits, (i.e., 10 days, 2 weeks, 45 days, etc.). When the HHA receives the AHP's orders, the HHA must obtain documentation to support the medical need for multiple daily visits along with the POC signed by the AHP. Appropriate service code indicators, procedure codes and modifier codes, when applicable, must be used on PA requests and claims to designate additional visits on the same date. Modifier code U2 is to be used for second visits, and code U3 for third visits.

Visits for Multiple Beneficiaries in the Same Place of Residence on the Same Day

Multiple beneficiaries may be seen in the same residential setting by the same provider, on the same day when medically necessary. Medical necessity will be determined by review of the clinical documentation for each beneficiary receiving services. Each beneficiary must have a PA in order for services to be billed.

Services furnished by one nurse or home health aide to two or more beneficiaries within the same setting on the same day is reimbursed as follows:

- For the first beneficiary, Healthy Blue reimburses the service at the established Medicaid rate for the prior authorized CPT code/modifier combination; and
- For the second beneficiary, Healthy Blue reimburses the service at 50 percent of the established Medicaid rate.

The TT modifier must be added to the home health procedure code billed on the claim to identify the service provided to more than one beneficiary in the same setting. Providers are prohibited from billing for providing services to two beneficiaries concurrently without appending the TT modifier.

High Complexity Needs

The TG modifier may be authorized for recipients aged birth through twenty (20) with highly complex needs requiring EHH services. The HHA shall submit all necessary documentation to support the highly complex nature of the beneficiary. The TG modifier shall be attached to the relevant number of hours being requested.

Examples of high complexity may include but are not limited to:

- Repeated seizures requiring treatment, intervention or both;
- Frequent oropharyngeal or tracheostomy suctioning;

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- With or without nebulization treatments, repeated administration of percussion physiotherapy, high frequency chest wall oscillation physiotherapy, or use of a cough assist device;
- Ventilator, CPAP or BIPAP dependence during the nurse’s care hours;
- Continuous oxygen dependence with continuous oxygen saturation monitoring and frequent oxygen desaturations requiring intervention;
- Continuous or frequent tube feeding for a recipient with gastroesophageal reflux, recurrent aspiration, or recurrent nausea, vomiting or abdominal pain;
- Parenteral nutrition;
- Intravenous therapies; or
- Repeated or extensive care of complex wounds.

It is the responsibility of the provider and the RN or LPN to ensure they are working within their scope of practice and licensure.

This list does not guarantee authorization. Each request is considered on an individual basis and reviewed based on medical necessity and documentation provided.

Rural or Outside Area

The HHA may submit PA requests using the TN modifier to identify travel to EHH recipients who live in a rural area, or outside the providers’ usual service area. A geographical area will be considered rural as defined by the United States Department of Commerce, Census Bureau as non-urbanized. The HHA shall submit all necessary documentation to support the use of this modifier. The TN modifier can be requested for up to two units or hours per day, and can therefore be used in conjunction with other necessary modifiers.

Holiday and Weekend Visits

The HHA may submit PA requests using the TV modifier to identify hours for an EHH beneficiary that are required during a weekend (12 a.m. Saturday through midnight on Sunday) or on designated state holidays, as indicated in La. R.S 1:55. The TV modifier must be requested on the home health PA form which covers the certification period in which the state recognized holiday(s) occur.

The HHA shall submit all necessary documentation to support the use of this modifier. This shall include an explanation and documentation as to why services are required at those times. Services will not be provided in circumstances of inconvenience to the beneficiary or the beneficiary’s family. The TV modifier shall be attached to the relevant number of hours being requested.

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Evening and Night Visits

The HHA may submit PA requests using the UH or UJ modifier(s) to identify hours for an EHH beneficiary that are required during evening or night hours. The HHA shall submit all necessary documentation to support the use of this modifier. This shall include an explanation and documentation as to why services are required at those times. Services will not be provided in circumstances of inconvenience to the beneficiary or the beneficiary’s family.

Modifier Code	
UH	Evening (6 p.m. to 11:59 p.m.)
UJ	Night (12 a.m. to 5:59 a.m.)

Providers shall submit authorizations and claims using the modifier UH (evening) and/or UJ (night), for the hours that are required at these times. For example, if a beneficiary is requiring services between 5 p.m. and 5 a.m. (12 hours total), then six hours would be requested with the UH modifier and 5 hours requested with the UJ modifier.

Providers may request more than one modifier over the total number of hours, if the hours ordered are divided up and stipulate the appropriate modifier; however, only one modifier may be requested per line.

For example:

Description	Procedure Code	Modifier Code	Requested Units
Skilled Nursing Visit	S9124		45
Skilled Nursing Visit	S9124	TV	24
Skilled Nursing Visit	S9124	UH	15

For one week, this would be a total number of 84 hours; 24 of those hours are on a weekend and 15 hours are during the evening.

Electronic Visit Verification (EVV) for Home Health Services

Section 12006(a) of the 21st Century Cures Act has mandated that states implement an electronic visit verification (EVV) program for home health. EVV is a web-based system that electronically verifies service visit occurrences and documents the precise time services begin and end via smart devices. Agencies should use the EVV system designed by the Louisiana Department of Health (LDH), the Louisiana Service Reporting System (LaSRS), to electronically report begin and end times (i.e., clock-in and clock-out) for home health services. Providers

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will have access to this system at no cost and should schedule training for the EVV system by calling LDH’s EVV contractor ~~beginning October 2, 2023~~. Agencies that currently utilize a third party EVV vendor may be able to use that vendor in lieu of LaSRS. Home health claims may be denied reimbursement for services if a home health provider fails to use the EVV system.

~~Note: This program will go into effect for both managed care organization (MCO) and Fee for Service on January 1, 2024. Effective April 1, 2024, claims submitted by providers that are not utilizing the EVV system will be denied.~~

The home health agency shall use an electronic visit verification (EVV) system for time, attendance, and billing tracking. Home health agencies shall use the following:

- EVV system designated by the Department; or
- Alternate system that has successfully passed the data integration process to connect to the designated EVV system and is approved by the Department.

Reimbursement for services may be withheld or denied a home health agency who fails to use the EVV system or does not use the system in compliance with Medicaid’s EVV policies and procedures for.

Member Entry into LaSRS

Providers may enter member information into the EVV system as early as when a referral is received. This allows home health care providers to report services in the EVV system even if a prior authorization is not required or pending approval. The provider can use the Add Client functionality to add a recipient to their agency within the LaSRS system. Once the member data is submitted, it will be matched against Medicaid eligibility data. If there are no validation errors, the member will be available for the selected procedure codes in the EVV system within three hours. For providers using a third-party EVV system, the member information should be entered into the third-party EVV system and this data will be transmitted to LaSRS overnight.

Emergency Preparedness Plan

The HHA must have an emergency preparedness plan that conforms to the current Louisiana Office of Emergency Preparedness (OEP) model plan. The plan is designed to manage the consequences of declared disasters or other emergencies that disrupt the HHAs ability to provide care and treatment or threaten the lives or safety of its clients. The HHA is responsible for obtaining a copy of the current Home Health Emergency Preparedness Model Plan from OEP and must submit the plan to the parish OEP for review.

Additionally, per The Centers for Medicare and Medicaid (CMS), the HHA must comply with the reporting requirements of the At-Risk Registry. The HHA shall update the “Louisiana At-Risk Registry” or other current state-required reporting mechanism as needed or as required.

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At a minimum, the HHA must have a written plan that includes:

- The evacuation procedures for agency clients who require community assistance as well as for those with available caregivers to evacuate to another location;
- The delivery of essential care and services to agency clients whether they are in a shelter or other locations;
- The provisions for the management of staff, including distribution and assignment of responsibilities and functions;
- A plan for coordinating transportation services required for evacuating agency clients to another location; and
- A declaration that the agency will notify the client’s family or caregiver if the client is evacuated to another location.

AJ v. LDH

This section explains the class-action lawsuit titled AJ, a minor child by and through his mother, Donnell Creppel, et al., versus the Louisiana Department of Health (LDH), et al., 3:19-CV-00324 (hereinafter, “AJ v. LDH”) and the implementation and operation of key provisions of the settlement agreement in that litigation.

Class members in AJ v. LDH are defined as follows: All current and future Medicaid beneficiaries under the age of twenty-one (21) in Louisiana who are certified in the Children’s Choice Waiver, the New Opportunities Waiver, the Supports Waiver, or the Residential Options Waiver who are also prior authorized to receive EHH or intermittent nursing (IN) services which do not require PA but are not receiving some or all of the hours of EHH or IN services as authorized by Louisiana Medicaid.

AJ v. LDH, filed on May 22, 2019, seeks to enforce rights under the EPSDT and reasonable promptness mandates of Title XIX of the Social Security Act, the Americans with Disabilities Act [42 USC §12131, et seq.], and Section 504 of the Rehabilitation Act [29 USC §794] by compelling the Department to arrange for the in-home skilled nursing care prior authorized for Medicaid-enrolled, medically fragile children. Because of their medical needs, class members have been prior authorized to receive EHH services to be able to live in the community. Data reflect gaps between the EHH service amounts prior authorized and the EHH service amounts actually delivered to class members. Potential service gaps in medically necessary IN services to class members also fall under the scope of the litigation. The suit has been settled, and the corresponding settlement agreement was approved by the court on March 31, 2020.

Managed Care Organizations (MCOs) are prohibited from reducing prior approved EHH service amounts for class members to increase the percentage of prior approved EHH services actually delivered. Such reduction in the amount of services that have been prior approved is contrary to federal Medicaid law and would constitute a due process violation under the United States Constitution.

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Implementation of the settlement by MCOs is discussed more fully below:

- Crisis Response Team (CRT)
 - Louisiana Medicaid has established a CRT, the primary responsibility of which is arranging for in-home nursing services for class members when such services are unavailable through existing Medicaid home health agencies within the class member's LDH region. Healthy Blue is responsible for accepting referrals from the CRT and arranging service fulfillment. Healthy Blue shall respond to the CRT within two business days of receipt of any communication, not limited to referrals. Responses to a referral shall, at a minimum, include the following:
 - A plan of action to resolve the obstruction to the member receiving care; and
 - Confirmation that any outreach to any interested party has been completed.
 - Support coordinators or case managers have the obligation promptly to make referrals to the CRT for any class member who, after making reasonable efforts to receive EHH or IN services:
 - Has received less than ninety percent (90%) of his or her prior approved EHH or medically necessary IN services for at least two (2) consecutive weeks; or
 - Has been unable to locate a home health provider in his or her LDH Region or has been denied enrollment by all home health providers in his or her LDH Region; or
 - Is otherwise facing a serious risk of institutionalization due to lack of EHH or IN services.
 - In addition, when a member is being terminated from existing EHH services where the class member's LDH region does not have a provider for IN services on the date that the notice of denial has been sent, the class member must be immediately referred to the CRT via an email to crisisresponseteam@la.gov. In such situations, a reasonable effort includes a reevaluation of whether or not the class member should have been found eligible for EHH services.
 - The CRT operates in addition to, and does not replace, the responsibilities of a class member's existing support coordinator or case manager.
 - Healthy Blue is responsible for submitting a monthly report to LDH documenting the actions taken to ensure service provision and fulfillment for CRT referral members. Healthy Blue is also responsible for submitting a monthly report detailing the hours and service provision for class members.
- Class Member Denial Notices
 - Notices to class members denying EHH services must contain contact information for the CRT when there is an identified need for IN services, i.e., for

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in-home skilled nursing services of visits with a duration shorter than three (3) contiguous hours per day.

- Additionally, in situations when a class member is being referred to the CRT due to the unavailability of a provider for IN services concurrent with a termination from existing EHH services, the notice of denial to the class member of the EHH services termination must also notify the class member of the referral to the CRT.
- Support Coordination
 - Support coordinators must document in the progress notes for each class member all prior approved EHH or medically necessary IN services and whether those EHH or IN services are provided, as reported by the family, including whether the family has refused the offered services and, if so, the basis for the refusal.

Contact information for the CRT is as follows:

- Email: crisisresponseteam@la.gov
- Telephone: (866) 729-0017

The settlement period for AJ v. LDH is scheduled to terminate on March 31, 2025, unless otherwise ordered by the court.

REFERENCES:

- Health Plan Advisory 20-16 (definitions; Retired)
- Louisiana Medicaid Home Health Provider Manual
- Louisiana Medicaid Managed Care Organization (MCO) Manual
- Managed Care Organization (MCO) Manual-LA
- Utilization Management-LA

Form(s):

- Home Health Face-to-Face Encounter Form

RESPONSIBLE DEPARTMENTS:

Primary Department: Health Care Management – Utilization Management

Secondary Department(s): Health Care Management – Case Management
Medicaid Quality and Accreditation
Operations-Claims
Provider Network and Relations

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EXCEPTIONS:

Routine skilled nursing and home health aide services for beneficiaries who are age twenty-one (21) and older require PA. There is no benefit coverage for EHH services or multiple daily nursing visits for persons age twenty-one (21) and older.

All EHH services for beneficiaries under the age of twenty-one (21) require PA. PA is required for routine home health visits for beneficiaries under the age of twenty-one (21). Routine home health services for beneficiaries under the age of twenty-one (21) must be prescribed by an AHP for only one (1) skilled nursing visit per day. A request for PA of services is required whenever the prescription of the AHP includes multiple daily visits for a beneficiary under the age of twenty-one (21). Multiple visits in the same day are usually associated with IV therapy.

All home health rehabilitation services (PT, OT, and ST) require PA.

A face-to-face encounter form is not required for beneficiaries under the age of twenty-one (21), for rehabilitation services, or medical equipment and supplies provided through the DME program; however, documentation of the face-to-face encounter for these groups of services is required to be kept in the recipient’s record.

All home health services must be provided by staff employed by or under contract with the HHA (see LAC 48:I, Chapter 91. Also, refer to 42 CFR 417.416 and Sec 2194 of the State Operations Manual CMS Pub. 7 for specific requirements). All staff must meet all required licensure requirements in accordance with Medicaid policies, federal, state and other applicable laws. All nursing services shall be provided in accordance with the Louisiana Nurse Practice (La. R.S. 37:911, et seq).

REVISION HISTORY:

Review Date	Changes
03/09/2021	<ul style="list-style-type: none"> New; policy entirety comprised of state-specific language and requirements
02/01/2022	<ul style="list-style-type: none"> Annual Review; no changes
04/27/2022	<ul style="list-style-type: none"> Off-Cycle Review Procedure updated to comply with LDH MCO Manual Update #40036: Communications Related to AJ v. LDH
10/26/2022	<ul style="list-style-type: none"> Off Cycle Review Revised for Contract Readiness Review Updated policy, definitions, procedure, and exceptions Updated references and added forms

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Review Date	Changes
	<ul style="list-style-type: none"> Removed Claims as a secondary department; Added Operations-Claims and Provider Network and Relations as secondary departments
01/18/2023	<ul style="list-style-type: none"> Annual Review Updated procedure to comply with LDH Home Health Provider Manual
04/04/2023	<ul style="list-style-type: none"> Off-Cycle Review Updated procedure Home Health/Medical Supplies to align with LDH Home Health Provider Manual Updated Exceptions
08/29/2023	<ul style="list-style-type: none"> Off-Cycle Review Updated Policy and Procedure sections to align with LDH Home Health Provider Manual revisions Updated Exceptions to align with current business process Added language from LDH Alert #48729 Informational Bulletin 23-14 regarding Electronic Visit Verification
01/26/2024	<ul style="list-style-type: none"> Annual Review Edits made to Policy and Procedure sections Updated language from LDH Alerts #50343 and #50471 Informational Bulletin 23-14 Revision regarding Electronic Visit Verification Added EVV criteria from LDH Home Health Provider Manual update Medicaid Quality and Accreditation department added as a secondary department
11/19/2024	<ul style="list-style-type: none"> Annual Review Updated Procedure section to align with LDH Home Health Provider Manual revisions issued 10/14/24
06/20/2025	<ul style="list-style-type: none"> Annual Review Updated Procedure section to align with LDH Home Health Provider Manual revisions
<u>01/13/2026</u>	<ul style="list-style-type: none"> <u>Off Cycle Review</u> <u>Updated language regarding EVV to align with LDH Alerts #61142 and #61254</u>