Home Health Services

20.1 Enrollment ........................................................................................................... 20-2
20.2 Benefits, Limitations, and Authorization Requirements ...................................... 20-2
    20.2.1 Prior Authorization Requirements for Home Health Services .................. 20-2
20.3 Home Health Aide (HHA) Visits ......................................................................... 20-3
    20.3.1 Supervision of Home Health Aides ................................................................. 20-3
    20.3.2 Prior Authorization for Home Health Aide (HHA) Visits .............................. 20-4
20.3.3 Skilled Nursing Services .................................................................................. 20-4
    20.3.3.1 Limitations for Skilled Nursing Services .................................................. 20-5
    20.3.3.2 Prior Authorization for Skilled Nursing Services .................................... 20-5
20.3.4 Occupational Therapy (OT) and Physical Therapy (PT) ................................ 20-5
    20.3.4.1 Limitations for Occupational Therapy (OT) and Physical Therapy (PT) .................................................. 20-6
    20.3.4.2 Prior Authorization for Occupational Therapy (OT) and Physical Therapy (PT) .................................................. 20-6
20.3.5 Speech-Language Pathology (SLP) ................................................................ 20-6
    20.3.5.1 Limitations for Speech-Language Pathology (SLP) .................................. 20-7
    20.3.5.2 Prior Authorization for Speech-Language Pathology (SLP) .................... 20-7
20.3.6 Medical Nutritional Counseling Services ...................................................... 20-7
    20.3.6.1 Prior Authorization for Medical Nutritional Counseling Services ........ 20-7
20.3.7 Social Work Services ...................................................................................... 20-7
    20.3.7.1 Prior Authorization for Social Work Services ......................................... 20-8
20.4 Claims Information ............................................................................................. 20-8
20.5 Reimbursement .................................................................................................. 20-9
20.6 TMHP-CSHCN Services Program Contact Center ............................................ 20-9
Chapter 20

20.1 Enrollment
To enroll in the CSHCN Services Program, home health agencies providing home health services must be actively enrolled in Texas Medicaid, have a valid provider agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, be a licensed and certified home and community services support agency (HCSSA), and comply with all applicable state laws and requirements. Out-of-state home health providers must meet all these conditions, be located in the United States, within 50 miles of the Texas state border, and be approved by the Department of State Health Services (DSHS).

Important: CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 25 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1617(6) for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 25 TAC §38.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

Refer to: Section 2.1, “Provider Enrollment,” on page 2-2 for more detailed information about CSHCN Services Program provider enrollment procedures.

20.2 Benefits, Limitations, and Authorization Requirements
Home health services are a benefit of the CSHCN Services Program for clients requiring services for an acute condition or an acute exacerbation of a chronic condition that can be met on an intermittent, part-time basis.

Home health services are considered medically necessary for a client who:
• Requires individualized, intermittent, and acute skilled care.
• Requires skilled assessment and treatment to improve health status, and if skilled intervention is delayed, it is expected to result in:
  • Deterioration of a chronic condition.
  • Loss of function.
  • Imminent risk to health status due to medical fragility or risk of death.

Providers must be a licensed and certified home health agency enrolled in the CSHCN Services Program and must comply with all applicable federal, state, and local laws and regulations and CSHCN Services Program policies and procedures.

20.2.1 Prior Authorization Requirements for Home Health Services
Home health services require prior authorization. Prior authorization requests must be submitted on the “CSHCN Services Program Authorization and Prior Authorization Request,” on page B-103.

A copy of the home health provider’s plan of care (POC) must be submitted for documentation of the required information. The POC must be signed by the physician who is ordering home health services and providing ongoing supervision. A copy of the POC with physician’s signature must be received within 30 days of the start of care.
All signatures must be current, unaltered, original, and handwritten; computerized or stamped signatures will not be accepted.

Requests must be submitted by fax or mail. Providers must obtain prior authorization within 3 business days of the start of care date for an initial authorization. The initial prior authorization period may not exceed 60 calendar days. For recertifications, providers must obtain prior authorization within 7 business days before the end of the authorization date.

During the prior authorization process, providers are required to deliver the requested services beginning on the start of care date. An updated POC signed by the physician must be submitted with the prior authorization request. The start of care must be documented on the POC.

Refer to: Chapter 4, “Prior Authorizations and Authorizations,” on page 4-1 for additional information about authorization and prior authorization requirements.

20.3 Home Health Aide (HHA) Visits

HHA visits (procedure code G0156) must be provided by a qualified HHA under the supervision of a qualified licensed individual (registered nurse [RN], physical therapist, occupational therapist) who is employed by the home health agency.

The duties of an HHA during a visit include, but are not limited to, the following:
- Obtaining and recording the client’s vital signs
- Observation, reporting, and documentation of the client’s status and the care or service furnished
- Personal care including, but not limited to:
  - Sponge, tub, or shower bath
  - Shampoo, sink, tub, or bed bath
  - Nail and skin care
  - Oral hygiene
- Toileting and elimination care
- Ambulation
- Exercise
- Range of motion
- Safe transfer
- Positioning
- Assisting with nutrition and fluid intake
- Household services essential to the client’s health care at home
- Assistance with medications that are ordinarily self-administered
- Reporting changes in the client’s condition and needs
- Completing appropriate documentation

Typically HHA visits last no longer than 2 hours. Providers must submit documentation of medical necessity for services over 2 hours.

20.3.1 Supervision of Home Health Aides

Supervision, as defined by the Texas Nurse Practice Act, is the process of directing, guiding, and influencing the outcome of an individual’s performance of an activity.

An RN or physical or occupational therapist must provide the HHA with written instructions for all the tasks delegated to the HHA.
The requirements for HHA supervision are as follows:

- When skilled nursing, occupational therapy (OT), or physical therapy (PT) visits are provided in addition to an HHA visit, an RN must make a supervisory visit to the client’s residence at least once every two weeks. The supervisory visit must occur when the HHA is providing care to the client.
- When only OT or PT visits are provided in addition to HHA visits, the appropriate therapist may make the supervisory visit in place of an RN. The supervisory visit must occur when the HHA is providing care to the client.
- Documentation of HHA supervision must be maintained in the client’s medical record.

20.3.2 Prior Authorization for Home Health Aide (HHA) Visits

A provider requesting prior authorization for HHA services must submit the following documentation:

- A completed client assessment
- A completed POC that must be signed and dated by the assessing RN and signed and dated by the physician or submitted with the signed and dated physician’s orders

Requests must be based on the medical needs of the client. Documentation must support the quantity and frequency of intermittent or part-time HHA visits that will safely meet the client’s needs. The amount and duration of HHA visits requested will be evaluated by TMHP.

The home health agency must ensure that the requested services are supported by the client assessment, POC, and the physician’s orders.

20.3.3 Skilled Nursing Services

Skilled nursing visits (procedure code G0154) are limited to procedures performed by an RN or licensed vocational nurse (LVN) licensed to perform these services under the Texas Nursing Practice Act and 42 Code of Federal Regulations §§ 409.32, 409.33, and 409.44. These services include the following:

- Direct skilled nursing care, training, and education for parents, guardians, and caregivers
- Skilled nursing observation, assessment, and evaluation by an RN (if a physician specifically requests that a nurse visit the client for this purpose and the physician’s order reflects the medical necessity of the visit)

Determining whether a service requires the skill of an RN or LVN is based on the inherent complexity of the service, the condition of the client, and the accepted standards of medical and nursing practice.

If the service can be safely and effectively performed by an average nonclinician without the direct supervision of an RN or LVN, the service is not considered skilled nursing. A service that could be performed by an average nonclinician is not skilled nursing even if there is no competent person to perform it.

Some services are classified as skilled nursing on the basis of complexity alone (e.g., intravenous and intramuscular injections or insertion of catheters). If these services are reasonable and necessary to the treatment of the client’s illness or injury, they may be covered. In some cases, the client’s condition may require a service that is ordinarily considered unskilled and falls outside the scope of skilled nursing. This would occur when the client’s condition necessitates an RN or LVN to perform the service safely and effectively.

A service that, by its nature, requires the skills of a nurse to be provided safely and effectively continues to be considered skilled nursing even if it is taught to the client, the client’s family, or other caregivers. When the client needs the skilled nursing care and there is no one trained, able, and willing to provide it, the services of a nurse may be considered reasonable and necessary.

Skilled nursing must be reasonable and necessary to the diagnosis and treatment of the client’s illness or injury within the context of the client’s unique medical condition. To be considered reasonable and necessary for the diagnosis or treatment of the client’s illness or injury, the services must be consistent with the nature and severity of the illness or injury, the client’s particular
medical needs, and within accepted standards of medical and nursing practice. A client’s overall medical condition is a valid factor in deciding whether skilled nursing is needed. A client’s diagnosis should never be the sole factor in deciding whether the service the client needs is skilled nursing or not.

The determination of whether the services are reasonable and necessary should be made in consideration of the physician’s determination that the services ordered are reasonable and necessary. The services must, therefore, be viewed from the perspective of the condition of the client when the services were ordered, and what was, at that time, reasonably expected to be appropriate treatment for the illness or injury throughout the certification period.

20.3.3.1 Limitations for Skilled Nursing Services
Skilled nursing must be provided on a part-time or intermittent basis.
If medically necessary, a maximum combined total of three skilled nursing visits may be prior authorized per day. One visit may last up to a maximum of 2.5 hours. Skilled nursing visits may be provided on consecutive days.
Skilled nursing visits to obtain routine laboratory specimens may be reimbursed when the only alternative to obtain the specimen is to transport the client by ambulance. Collection of the laboratory specimen is considered part of the visit.
Skilled nursing visits requested primarily to provide the following services will not be prior authorized:
• Respite care
• Child care
• Activities of daily living for the client
• Housekeeping services
• Individualized, comprehensive case management beyond the service coordination required by the Texas Nursing Practice Act
A parent, guardian, primary caregiver, or alternate caregiver may not be reimbursed for skilled nursing, even if he or she is employed by an enrolled provider.
Total parenteral nutrition (TPN) is not a benefit through home health services.
Refer to: Section 25.5, “Total Parenteral Nutrition (TPN),” on page 25-14 for more detailed information.

20.3.3.2 Prior Authorization for Skilled Nursing Services
A provider requesting prior authorization for skilled nursing services must submit the following documentation:
• A completed client assessment
• A completed POC that must be signed and dated by the assessing RN and signed and dated by the physician or submitted with the signed and dated physician’s orders
Requests must be based on the medical needs of the client. Documentation must support the quantity and frequency of intermittent or part-time skilled nursing visits that will safely meet the client’s needs. The amount and duration of skilled nursing visits requested will be evaluated by TMHP.

20.3.4 Occupational Therapy (OT) and Physical Therapy (PT)
OT (procedure code G0152) and PT (procedure code G0151) are a benefit of the CSHCN Services Program when medically necessary. OT or PT must be prescribed by a physician and provided by a physical therapist or occupational therapist licensed by the state of Texas.
OT is limited to specific, goal-directed activities to achieve a functional level of mobility and communication. OT is intended to prevent further dysfunction within a reasonable length of time, based on the therapist’s evaluation and physician’s assessment and treatment plan.
PT is limited to the treatment of acute disorders of the musculoskeletal system or exacerbations of chronic disorders necessitating PT to restore function.

OT or PT are a benefit of the CSHCN Services Program under any of the following conditions:

- The client has a disability, has sustained a traumatic injury, or is experiencing the late effects of a traumatic injury and requires therapy to improve or maintain function, range of motion, strength, or to prevent or decrease the risk of deformity or osteoporosis.
- The client has an exacerbation of chronic illness or condition (e.g., juvenile rheumatoid arthritis, hemophilia, or sickle cell crisis).
- The client requires short-term therapy related to surgery or casting.
- The client or family requires training in the use of equipment, orthotics, or prosthetics.
- The client or family requires instruction in activities for daily living specific to their home environment.
- The client requires an assessment for appropriate equipment, seating braces, orthotics, or prosthetics.

### 20.3.4.1 Limitations for Occupational Therapy (OT) and Physical Therapy (PT)

The following outpatient OT or PT procedure codes will be denied if billed on the same date of service as procedure code G0151 or G0152, by any provider:

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<td>97001</td>
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Procedure codes 97545 and 97546 are not a benefit of the CSHCN Services Program.

### 20.3.4.2 Prior Authorization for Occupational Therapy (OT) and Physical Therapy (PT)

OT and PT evaluation visits do not require authorization. Treatment plans require prior authorization.

### 20.3.5 Speech-Language Pathology (SLP)

SLP (procedure code G0153) is a benefit of the CSHCN Services Program when it is medically necessary. SLP must be prescribed by a physician and provided by a speech-language pathologist licensed by the state of Texas.

SLP services are for acute or subacute pathological or traumatic conditions of the head or neck which affect speech production.

SLP services are a benefit of the CSHCN Services Program when provided to clients experiencing speech-language difficulty because of a disease or trauma, developmental delay, oral motor problem, or congenital anomaly.

SLP services are a benefit for dysphagia and swallowing disorders, cleft palate, or other craniofacial anomalies whether or not the client is school-age and in special education.

Children who have a condition other than cleft palate or craniofacial anomaly may be eligible to receive services if they have a voice articulation or expressive-receptive language disorder, and if they are expected to make measurable progress toward their individual SLP treatment goals.
Prior authorizations may be granted for:

- SLP evaluations—only one is allowed for payment per 6 months without authorization or written documentation of medical necessity. An evaluation will not be reimbursed on the same day as treatment.
- SLP reevaluations—reevaluations may only be reimbursed once per month.
- SLP evaluations of swallowing and oral function for feeding.
- Sessions that do not exceed 1 hour in length.
- Treatment plans (not to exceed 6 months) and extensions.

Clients may receive SLP from both the CSHCN Services Program and other sources (such as school districts) only when the therapy provided by the CSHCN Services Program addresses different client needs. Therapy provided by the CSHCN Services Program is not intended to duplicate, supplement, or replace services that are the legal responsibility of other entities or institutions. The CSHCN Services Program encourages the private therapist to coordinate with other therapy providers to avoid treatment plans that might compromise the client’s ability to progress.

### 20.3.5.1 Limitations for Speech-Language Pathology (SLP)

The following outpatient speech and language therapy procedure codes will be denied if billed on the same date of service as procedure code G0153, by any provider:

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### 20.3.5.2 Prior Authorization for Speech-Language Pathology (SLP)

The initial SLP evaluation does not require prior authorization. Treatment plans require prior authorization.

### 20.3.6 Medical Nutritional Counseling Services

Medical nutritional counseling services (procedure codes 97802, 97803, and S9470) are a benefit of the CSHCN Services Program when provided in the home by a licensed dietician.

Refer to: Section 25.3.2, “Benefits, Limitations, and Authorization Requirements,” on page 25-5 for additional information about medical nutritional counseling services.

### 20.3.6.1 Prior Authorization for Medical Nutritional Counseling Services

Prior authorization is required for medical nutritional counseling services.

Providers are responsible for maintaining documentation to support medical necessity of nutritional counseling services in the clinical record.

### 20.3.7 Social Work Services

Social work services (procedure code G0155) that are provided by a qualified medical social worker or a social work assistant under the supervision of a qualified medical social worker are a benefit when the client meets the qualifying criteria:

- The services of these professionals are necessary to resolve social or emotional problems that are expected to be an impediment to the effective treatment of the client’s medical condition or rate of recovery.
• The POC indicates why the required services need the skills of a qualified social worker to be performed safely and effectively.

The services provided by the social worker may include, but are not limited to, the following:
• Assessment of the social and emotional factors related to the client’s illness, need for care, response to treatment, and adjustment to care
• Assessment of the relationship of the client’s medical and nursing requirements to the client’s home situation, financial resources, and availability of community resources
• Appropriate action to obtain available community resources to assist in resolving the client’s problem
• Counseling services that are required by the client
• Medical social services furnished to the client’s family member or caregiver on a short-term basis when the HHA can demonstrate that a brief intervention (i.e., two or three visits) by a medical social worker is necessary to remove a clear and direct impediment to the effective treatment of the client’s medical condition or to the client’s rate of recovery (to be considered “clear and direct,” the behavior or actions of the family member or caregiver must plainly obstruct, contravene, or prevent the client’s medical treatment or rate of recovery)

20.3.7.1 Prior Authorization for Social Work Services
Prior authorization is required for social work services.
The following services are not benefits:
• Medical social services to address general problems that do not clearly and directly impede treatment or recovery
• Long-term social services furnished to family members, such as ongoing alcohol counseling

20.4 Claims Information
Home health services claims must be submitted to TMHP in an approved electronic format or on a UB-04 CMS-1450 paper claim form. Providers may purchase UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a UB-04 CMS-1450 paper claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills or itemized statements are not accepted as claim supplements.

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the Centers for Medicare & Medicaid Services (CMS) NCCI web page at www.cms.gov/MedicaidNCCICoding/ for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

Refer to: Chapter 37, “TMHP Electronic Data Interchange (EDI),” on page 37-1 for information about electronic claims submissions.
Section 5.7.2.8, “Instructions for Completing the UB-04 CMS-1450 Paper Claim Form,” on page 5-31 for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Services and supplies that exceed the 28-items-per-page limitation must be submitted on separate UB-04 CMS-1450 paper claim forms.
20.5 Reimbursement

Skilled nursing visits provided by home health agencies enrolled in the CSHCN Services Program must be billed in 15-minute increments.

One practicing registered nurse skilled nursing visit may be reimbursed every 30 days outside of the prior authorized visits when skilled nursing visits have been authorized for the particular client. Skilled nursing provided in the day care or school setting will not be reimbursed.

Two medical nutritional counseling visits (procedure code S9470) may be reimbursed per rolling calendar year.

Reimbursement for mileage is not a benefit of the CSHCN Services Program.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at www.tmhp.com.

20.6 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.