New Benefits for Home Health Services for the CSHCN Services Program
Information posted March 6, 2009

Effective for dates of service on or after May 1, 2009, the Children with Special Health Care Needs (CSHCN) Services Program will implement new benefit criteria for home health services.

Home health services are a benefit of the CSHCN Services Program for clients who require services for an acute condition or an acute exacerbation of a chronic condition and the service requirements can be met on an intermittent, part-time basis.

Home health services are considered medically necessary under the following conditions:

- A client requires individualized, intermittent, and acute skilled care.
- A client requires skilled assessment and treatment to improve health status
- A delay in skilled intervention is expected to result in:
  - Deterioration of a chronic condition.
  - Loss of function.
  - Imminent risk to health status due to medical fragility
  - Risk of death.

A home health provider 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 with all CSHCN Services Program policies and procedures.

Prior Authorization

Home health services require prior authorization. Documentation must be submitted with the prior authorization request.

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 provider who is ordering home health services and providing ongoing supervision. A copy of the POC with the provider’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 date of the existing authorization.

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 provider must be submitted with the prior authorization request. The start-of-care must be documented on the POC.
Skilled Nursing (SN)

SN visits (procedure code C-G0154) are limited to procedures that are performed by a registered nurse (RN) or licensed vocational nurse (LVN) who is 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 SN care, training, and education for parents, guardians, and caregivers
- SN observation, assessment, and evaluation by an RN (if a provider specifically requests that a nurse visit the client for this purpose and the provider's order reflects the medical necessity for 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 direct supervision of an RN or LVN, the service is not considered SN. A service that could be performed by an average nonclinician is not SN even if there is no competent person to perform it.

Some services are classified as SN 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 cause a service that would ordinarily be considered unskilled to be considered SN. 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 SN even if it is taught to the client, the client's family, or other caregivers. When the client needs the SN care and there is no one trained, able, and willing to provide it, the services of a nurse may be considered reasonable and necessary.

SN 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 and 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 SN is needed. A client's diagnosis should never be the sole factor in deciding whether the service the client needs is SN or not.

The determination of whether the services are reasonable and necessary should be made in consideration of the provider'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.

Prior Authorization

A provider requesting prior authorization for SN 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 provider or submitted with the signed and dated provider’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 SN visits that will safely meet the client’s needs. The amount and duration of SN visits requested will be evaluated by the Texas Medicaid & Healthcare Partnership (TMHP).

**Limitations**

SN must be provided on a part-time or intermittent basis.

SN visits provided by home health agencies enrolled in the CSHCN Services Program must be billed in 15-minute increments. If medically necessary, a maximum combined total of 3 SN visits may be prior authorized per day. One visit may last up to a maximum of 2.5 hours. SN visits may be provided on consecutive days.

One SN visit by a practicing registered nurse may be reimbursed every 30 days in addition to the prior authorized visits when SN visits have been authorized for the particular client.

SN visits to obtain routine laboratory specimens may be reimbursed when the only alternative is to transport the client by ambulance to obtain the specimen. Collection of the laboratory specimen is considered part of the visit.

**Exclusions**

SN provided in the day care or school setting will not be reimbursed.

SN 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 Nurse Practice Act

A parent, guardian, primary caregiver, or alternate caregiver may not be reimbursed for SN, even if he or she is employed by an enrolled provider.

**Home Health Aide (HHA) Visits**

HHA visits (procedure code C-G0156) must be provided by a qualified HHA under the supervision of a qualified, licensed individual (RN, physical therapist [PT], occupational therapist [OT]) 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
- Observing, reporting, and documenting 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.

**Supervision of HHAs**

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.

A RN or therapist (PT or OT) must provide the HHA written instructions for all the tasks delegated to the HHA.

The requirements for HHA supervision are as follows:

• When SN, PT, or OT visits are provided in addition to a HHA visit, an RN must make a supervisory visit to the client's residence at least once every 2 weeks. The supervisory visit must occur when the HHA is providing care to the client.

• When only PT or OT 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.

**Prior Authorization**

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
• Signed and dated by the provider or submitted with the signed and dated provider'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 the requested services are supported by the client assessment, POC, and the provider's orders.

**PT and OT**

PT is limited to the treatment of acute disorders of the musculoskeletal system or exacerbations of chronic disorders necessitating physical therapy to restore function.

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 provider's assessment and treatment plan.

PT and OT (procedure codes C-G0151 and C-G0152) 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 on 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.

**Prior Authorization**

PT and OT evaluation visits do not require prior authorization. Treatment plans require prior authorization. If the client is school-aged, one of the following must be submitted with the prior authorization request:

• A copy of the individualized education plan (IEP)
• A statement from the client’s school that the client is not eligible for therapy services from the school district

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

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**Exclusions**

Procedure codes 1-97545 and 1-97546 are not a benefit of the CSHCN Services Program.

**Speech-Language Pathology (SLP)**

SLP (procedure code C-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 benefits 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.

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. 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. 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.

Prior authorizations may be granted for:

- SLP evaluation. Only one is allowed for reimbursement per 6 months, without authorization or written documentation of medical necessity. An evaluation will not be reimbursed on the same day as treatment.
- SLP reevaluation. Reevaluations may only be reimbursed once per month.
- SLP evaluation 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.
- Treatment of new conditions, including, but not limited to, the following:
  - Traumatic brain injury
  - Brain tumor
• Stroke
• Brain embolism
• Other new conditions that affect voice, articulation, and expressive or receptive language

• Equipment assessment for augmentative communication devices (ACDs) or other communication technology.
• Training sessions in the use of technology (such as ACDs), including their required adjustments and modifications.
• Treatment of developmental conditions including, but not limited to, the following:
  • Cleft palate
  • Cerebral palsy
  • Significant hearing loss when there is a voice, articulation, or expressive or receptive language disorder, or with swallowing dysfunction or oral dysfunction for feeding

• Rehabilitation after implantation of a cochlear implant.

Exceptions to the limitations listed may be made when appropriate and after medical review.

Prior Authorization
SLP must be prior authorized. The initial SLP evaluation does not require prior authorization.

If the client is school-aged, one of the following must be submitted with the prior authorization request:
• A copy of the IEP
• A statement from the client’s school that the client is not eligible for the same service through the school district

Limitations
Speech-language pathology services may be prior authorized for the following conditions:
• Cleft lip/palate or other craniofacial anomaly
• Dysphagia/swallowing disorder

SLP may be reimbursed for dysphagia/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.
The following outpatient speech and language therapy procedure codes will be denied if billed on the same date of service as procedure code C-G0153, by any provider:

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**Medical Nutritional Counseling**

Medical nutrition counseling (procedure codes C-97802, C-97803, and C-S9470) is a benefit of the CSHCN Services Program when provided in the home by a licensed dietician.

Medical nutrition therapy and nutrition counseling services may be considered beneficial for disease states in which dietary adjustment has a therapeutic role. This includes, but is not limited to, the following conditions:

- Cardiovascular disease
- Diabetes or alterations in blood glucose
- Hypertension
- Kidney disease
- Eating disorders
- Abnormal weight gain
- Gastrointestinal disorders
- Lack of normal weight gain
- Nutritional deficiencies
- Inherited metabolic disorders

Nutrition intervention for chronic fatigue syndrome, attention-deficit hyperactivity disorder, idiopathic environmental intolerances, and multiple food and chemical sensitivities is considered experimental and investigational and is not a benefit of the CSHCN Services Program.

Medical nutrition counseling services for the diagnosis of obesity without a comorbid condition will not be considered for coverage.

Nutrition counseling with a dietitian visit is a less comprehensive service and does not include an assessment or reassessment. This is limited to 1 service per day with a maximum of 2 per rolling year.

**Prior Authorization**

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.

**Limitations**

Two nutrition counseling visits may be reimbursed per rolling calendar year.

Procedure code C-S9470 will be denied as part of another service when billed for the same date of service as either procedure code C-97802 or C-97803 by any provider. Procedure code C-97803 will be denied as part of another service when billed for the same date of service as procedure code C-97802 by any provider.

**Social Work**

Social work services (procedure code C-G1055) 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 following criteria:

- The services of these professionals are necessary to resolve social or emotional problems that are or are expected to be an impediment to the effective treatment of the client's medical condition or rate of recovery.
- The POC indicates how the services that are required necessitate 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.)

**Prior Authorization**

Prior authorization is required for social work services.

**Exclusions**

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

Noncovered Services

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

For more information, call the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413.