

10-144 Chapter 101
 MAINECARE BENEFITS MANUAL
 CHAPTER II

SECTION 40	HOME HEALTH SERVICES	ESTABLISHED 10/1/79 UPDATED 01/20/06 Updated 9/1/11
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CHAPTER II

SECTION 40

HOME HEALTH SERVICES

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40.01 DEFINITIONS

40.01-1 **Authorized Agent** shall mean the organization authorized by the Department to perform functions pursuant to a contract or which are specified in a written agreement. The Authorized Agent will perform authorizations of plans of care as required.

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40.01-2 **Certification Period** shall mean the months, days, years, which identify the period covered by the physician's plan of care. The "From" date for the initial certification must match the start of care date. The "To" date can be up to, but never exceed, two (2) calendar months and mathematically never exceed sixty (60) days. Recertifications shall follow the same length of time requirements.

40.01-3 **Contraindicated** shall mean the member's condition renders some particular line of treatment improper or undesirable.

40.01-4 **Duration** shall mean the length of time the services are to be rendered and may be expressed in days, weeks, or months. This must be specified on the physician certified plan of care.

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40.01-5 **Eligibility Period** shall mean the period of time, designated by a start and end date established by the Department or its Authorized Agent, approved for coverage of home health services, in accordance with Section 40.08.

40.01-6 **Extensive Assistance** means although the individual performed part of the activity over the last seven (7) days, or twenty-four (24) to forty-eight (48) hours if in a hospital setting, help of the following type(s) was provided:

- Weight-bearing support three (3) or more times, or
- Full staff performance during part (but not all) of the last seven (7) days.

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40.01-7 **Face to Face Encounter** means an encounter between the member and the certifying physician, or a nurse practitioner or clinical nurse specialist who is working in collaboration with the physician, or a certified nurse midwife as authorized by State law or physician assistant under the supervision of the physician. The encounter may be through telehealth, consistent with Section 1834(m) of the Social Security Act and 42 CFR 424.22. The face-to-face encounter must be related to the primary reason the patient requires home health services. The face-to-face encounter shall be documented by the physician responsible for performing the certification for the Home Health service as indicated in 40.08-4.15 and 40.08-1.D.4. The face-to-face encounter must occur within the time frame set out in section 40.08-4.15,

40.01-8 **Frequency** shall mean the number of visits per discipline to be rendered, stated in days, weeks, or months. This must be specified on the physician certified plan of care.

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HOME HEALTH SERVICES

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Major Substantive Rules

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40.01 **DEFINITIONS** (Cont)

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40.01-9 **Functionally Significant Improvement** is the demonstrable, measurable increase in the individual's ability to perform specific tasks or motions that contribute to independence outside the therapeutic environment.

40.01-10 **Home Health Agency (HHA)** means a voluntary, public or private organization, or a part of such organization, that is certified under Title XVIII of the Social Security Act for reimbursement for the delivery of home health services.

40.01-11 **Home Health Aide Services** are those in-home services that are provided by a certified home health aide and which are delegated and supervised by a registered nurse. A certified home health aide must have satisfactorily completed a training program for certified nurse assistants, consistent with the rules and regulations of the Maine State Board of Nursing. Home health aides employed by a home health agency must also have completed an agency orientation as defined by the regulations Governing the Licensing and Functioning of Home Health Care Services.

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40.01-12 **Home Health Services** are those skilled nursing and home health aide services, physical and occupational therapy services, speech-language pathology services, medical social services, and the provision of certain medical supplies, needed on a "part-time" or "intermittent" basis. Services are delivered by a Medicare certified home health agency to a member in his or her home or in other particular settings with limitations as described in Section 40.06. Services are delivered according to the orders of a licensed physician and an authorized plan of care that certify the need for the Home Health Services. Certification for Home Health Services shall occur as a result of a documented face- to-face encounter as defined in 40.01-7 that meets the requirements of 40.08-4.15 and 40.08-1.D.4

In a nursing facility (NF) setting, only physical therapy, occupational therapy and/or speech-language pathology services may be delivered by a home health agency if the NF's MaineCare reimbursement rate does not include these services.

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40.01-13 **Intermittent**, in general, shall mean skilled nursing care needed on fewer than seven (7) days each week or less than eight (8) hours each day for periods of up to twenty-one (21) days (or longer in exceptional circumstances when the need for care is finite and predictable); but as defined in CMS Publication 11 "Medicare Home Health Agency Manual," and the regulations issued pursuant thereto as are most currently in effect. This manual is available on line at http://www.cms.hhs.gov/manuals/11_hha/HH00.asp .

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40.01-14 **Medical Social Services** are assessment, counseling, and assistance services that are needed by a member to resolve social or emotional problems that are or are expected to be an impediment to the effective treatment of the member's medical condition or

40.01 **DEFINITIONS** (Cont)

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40.01-14 **Medical Social Services** (cont)

to affect his or her rate of recovery. Services are provided by a social worker who is functioning within the scope of the license granted by the state or province in which the services are performed and who has had at least one (1) year of social work experience in a health care setting. Medical social services must be required in conjunction with a skilled nursing service, physical therapy, occupational therapy or speech-language pathology services.

A licensed social worker shall receive consultation in accordance with State of Maine Board of Social Work Registration and the Rules and Regulations of the Board of Social Work. The licensed social worker with more than two (2) years experience shall receive consultation from a licensed master social worker, a licensed clinical social worker, or a certified social worker on a quarterly basis.

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40.01-15 **Non-Routine Medical Supplies** are supplies that are necessary for a particular procedure ordered by a physician to be provided by Home Health Services. Non-Routine medical supplies meet the following criteria;

- A. The non routine medical supply must be medically necessary and reasonable for the Home Health Agency provider to use in performance of the specific service for the individual Member as ordered by the physician in the order for service.
- B. The non routine medical supply must be an item that is consumable, in that its use is of limited duration and it will be discarded after use. The use of the supply is confined to the one member for the particular procedure ordered by the physician.
- C. The non routine medical supply is appropriate for use in the member's place of residence as defined in 40.02-3.
- D. The covered non routine medical supply must be outside the scope of usual supplies generally utilized as part of the services the Home Health Agency provides. Examples of routine supplies include cotton swabs, alcohol wipes and latex gloves. Routine supplies are not separately reimbursed and are considered part of the rate for the Home Health Service.

40.01-16 **Nursing Services** are those services that are provided by a registered nurse (RN) and/or a licensed practical nurse, which holds a current license issued by the state or province in which services are performed.

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DEFINITIONS (Cont)

- 40.01-17 **Occupational Therapy Services** are those restorative services provided in accordance with physician orders, by an Occupational Therapist Registered (OTR) or by a Certified Occupational Therapist Assistant (COTA) under the direct supervision of an OTR, licensed by the state or province in which services are provided and acting within the scope of that license.
- 40.01-18 **One-person Physical Assist** requires one (1) person to provide either weight-bearing or non-weight-bearing assistance for an individual who cannot perform the activity independently over the last seven (7) days, or twenty-four (24) to forty-eight (48) hours if in a hospital setting. This does not include cueing.
- 40.01-19 **Part-time**, in general, shall mean less than eight (8) hours a day or twenty-eight (28) hours a week; but as defined in CMS Publication 11 “Medicare Home Health Agency Manual and the regulations issued pursuant thereto as are most currently in effect. This manual is available on line at http://www.cms.hhs.gov/manuals/11_hha/HH00.asp .
- 40.01-20 **Physical Therapy Services** are those restorative services provided in accordance with physician orders, by a physical therapist or by a physical therapist assistant working under the direct supervision of a licensed physical therapist, licensed by the state or province in which services are provided and acting within the scope of that license.
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- 40.01-21 **Psychiatric Nursing Services** are services provided by a registered professional nurse that is licensed by the state or province in which services are provided and has met requirements for approval to practice as an advanced practice psychiatric nurse or is certified as a psychiatric and mental health nurse by the appropriate national accrediting body.
- 40.01-22 **Rehabilitation Potential** is the documented expectation by a physician of measurable, “functionally significant improvement” (defined in Section 40.01-9) in the member’s condition in a reasonable, predictable period of time as the result of the prescribed treatment plan. The physician documentation of rehabilitation potential must include the reasons used to support the physician expectation and must follow guidelines detailed in MaineCare Benefits Manual (MBM), Chapter II, Section 90, Physician Services.40.01- 23 **Speech-Language Pathology Services** are those restorative services which are furnished in accordance with physician orders by a speech-language pathologist or speech language pathology assistant licensed by the state or province in which services are provided, who is acting within the scope of that license, and services meet the conditions described in Chapter II, Section 109 of the MBM. Services may be delivered by a speech-language pathology assistant who is registered and supervised by a Board licensed speech-language pathologist, as provided by 32 M.R.S.A., Section 6003 (7-A).

40.01 **DEFINITIONS (Cont)**

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- 40.01-24 **Start of Care Date (SOC)** shall mean the first billable visit. This date remains the same on subsequent plans of care until the member is discharged.
- 40.01-25 **The Unit of Home Health Service** is fifteen (15) minutes of personal contact in the member's place of residence made for the purpose of providing a covered service by a health worker on the staff of a home health agency or by others under contract or arrangement with the home health agency. If the unit of service is described as a "visit", providers will be reimbursed for a set rate regardless of the length of the visit. When two (2) or more persons simultaneously provide separate and distinct types of services, each provider's service is billed separately.
- 40.01-26 **Unstable Medical Condition** exists when the member's condition is fluctuating in an irregular way and/or is deteriorating and affects the member's ability to function independently. The fluctuations occur to such a degree that medical treatment and professional nursing observation, assessment and management are required at least three (3) times per week. An unstable medical condition requires increased physician involvement and should result in communication with the physician for adjustments in treatment and medication. Evidence of fluctuating vital signs, lab values, and physical symptoms and plan of care adjustments must be documented in the medical record.

40.02 **ELIGIBILITY FOR CARE**

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- 40.02-1 **Authorization Process.** The HHA must obtain authorization from the Department or its Authorized Agent for all members receiving services under this section except as provided in 40.02-5 subparagraph B.
- A. Plans of Care must be submitted to the Department or its Authorized agent within five (5) business days of the start of services. After the plans of care are reviewed for medical appropriateness, providers will receive a final authorization for the plan of care.
- B. A member who qualifies under 40.02-4 and requires psychotropic medication administration or psychotropic medication monitoring as his/her only services, shall be exempt from the authorization process outlined above. If the member requires any additional home health services, these shall follow the authorization process as outlined in 40.02-1 subparagraph A above.

The Department or its Authorized Agent must determine if the member continues to meet the eligibility for care requirements in Section 40.02. Members receiving services under Section 19, Home and Community Benefits for the Elderly and for Adults with Disabilities are not eligible for reimbursement for services under this Section because these services are also covered under Section 19.

40.02 **ELIGIBILITY FOR CARE** (cont.)

40.02-2 **General and Specific Requirements**

An individual may be found eligible to receive services as set forth in this Section, if he or she meets both the General MaineCare Eligibility Requirements and the Home Health Services Medical Eligibility Requirements.

40.02-3 **General MaineCare Eligibility Requirements.** Individuals must meet the financial eligibility criteria as set forth in the MaineCare Eligibility Manual. Some members may have restrictions on the type and amount of services they are eligible to receive.

40.02-4 **Home Health Services Medical Eligibility Requirements.** A member must meet the following requirements:

- A. The medical condition of the member must be such that it can be safely and appropriately treated by the home health agency under a plan of care reviewed and signed by a physician every certification period; AND
- B. The member must be in a place of residence and NOT in an institution that meets the definition of a hospital, nursing facility or ICF-MR except as allowed under Section 40.01-12 and Section 40.06; AND
- C. Home health services shall not be provided if services are available and safely accessible to the member on an outpatient basis. The plan of treatment signed by both the physician and the home health agency must include a statement of the medical necessity for receiving services at home citing the specific reasons outpatient care is contraindicated (defined in 40.01-3) or not possible. The reasons must be listed and the likelihood of a bad outcome must be probable or definite as opposed to possible or rarely; AND
- D. Observation and assessment by a nurse is not reasonable and necessary to the treatment of the illness/injury where these indications are part of a longstanding pattern of the member's condition and there is no significant change in health status; AND
- E. The condition of the member must require skilled nursing care on a "part-time" (as defined in Section 40.01-19) or "intermittent" (as defined in Section 40.01-13) basis or otherwise no less than twice per month, or physical therapy services, or speech-language pathology services, or occupational therapy services as described below.
 - 1. intraarterial, intravenous, intramuscular or subcutaneous injection, or intravenous feeding, all for treatment of unstable conditions requiring medical or nursing intervention. Daily insulin injections for an individual whose diabetes is under control do not meet the requirements of this Section; or

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40.02 **ELIGIBILITY FOR CARE** (cont.)

40.02-4 **Home Health Services Medical Eligibility Requirements.** (cont.)

2. nasogastric tube, gastrostomy, or jejunostomy feeding, for a new/recent (within past thirty (30) days) or unstable condition; or
3. nasopharyngeal suctioning or tracheostomy care; however, care of a tracheostomy tube must be for a recent (within the past thirty (30) days) or unstable condition; or
4. treatment and/or application of dressings when the physician has prescribed irrigation, the application of prescribed medication, or sterile dressings of stage III and IV decubitus ulcers, other widespread skin disorders (except psoriasis and eczema), or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, second or third degree burns, open surgical sites, fistulas, tube sites and tumor erosions); or
5. administration of oxygen on a regular and continuing basis when the member's medical condition warrants professional nursing observation for a new or recent (within past thirty (30) days) condition; or
6. professional nursing assessment, observation and management of an unstable medical condition (see Section 40.01-26); or
7. insertion and maintenance of a urethral or suprapubic catheter as an adjunct to the active treatment of a disease or medical condition may justify a need for skilled nursing care. In such instances, the need for a catheter must be documented and justified in the member's medical record; or
8. care to manage conditions requiring a ventilator/ respirator (Continuous Positive Airway Pressure (CPAP) or Bilevel Positive Airway Pressure (BIPAP) system or wearing an airway clearance system vest does not meet the requirements of this Section); or
9. direct assistance from a professional nurse is required for the safe management of an uncontrolled seizure disorder (i.e.: grandmal); or
10. assessment and management for a new or recent medical condition (within the past thirty (30) days); or
11. professional nursing care and monitoring for administration of treatments, procedures, or dressing changes, which involve prescription medications, according to physician orders, at least twice per month. Treatments include:
 - a. administration of medication via a tube;
 - b. tracheostomy care;

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40.02 **ELIGIBILITY FOR CARE** (cont.)

40.02-4 **Home Health Services Medical Eligibility Requirements.** (cont.)

11. c. urinary catheter change;
- d. urinary catheter irrigation;
- e. barrier dressings for Stage 1 or 2 ulcers;
- f. chest PT by RN;
- g. oxygen therapy by RN;
- h. other physician ordered treatments; or
- i. teaching and training activities for patient and family;

or

12. professional nursing care for members receiving:
 - a. radiation therapy;
 - b. chemotherapy given intravenously or by injection; or
 - c. hemodialysis or peritoneal dialysis;

or

13. a. physical therapy or occupational therapy services as part of a planned program that is designed, established and provided by, and requires the professional skills of a licensed or registered therapist. (Therapy services may be delivered by a qualified licensed or certified therapy assistant under the direction of a qualified professional therapist.) The findings of an initial evaluation and periodic reassessments must be documented in the member's medical record. Skilled therapeutic services must be ordered by a physician and be designed to achieve specific goals within a given time frame. The need for maintenance or preventative therapy does not meet the requirements of this Section.
- b. in addition to the requirements in Section 40.02-3(E)(13)(a), all members seeking occupational or physical therapy services must have rehabilitation potential (defined in Section 40.01-22) documented by a physician;

or

14. speech-language pathology services as part of a planned program that is designed, established, and provided by and requires the professional skills of a licensed speech-language pathologist or speech-language pathology assistant supervised by a Board licensed speech-language pathologist.

All members must be assessed by a physician. The physician must provide documentation that the member has

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40.02 ELIGIBILITY FOR CARE (cont.)

40.02-4 Home Health Services Medical Eligibility Requirements. (cont.)

experienced a significant decline in his or her ability to communicate orally, safely swallow, or masticate and has rehabilitation potential (defined in Section 40.01-22). The documentation of the physician's assessment must be signed by the physician and be part of the member's record.

For continued eligibility beyond the initial certification period for all members the home health agency must obtain a report completed by the speech-language pathologist documenting the member's progress and prognosis for improved speech, mastication, or swallowing functioning. The report must be forwarded to the member's physician for confirmation that rehabilitation potential still exists for the member. The report must be amended and signed by the physician to document the rehabilitation potential of the member. This report must be maintained in the member's medical record.

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40.02-5 Medical Eligibility Requirements for Psychotropic Medication Services.

A member may receive in-home psychotropic medications if he or she meets ALL of the following requirements:

- A. The member has a severe and disabling mental illness that meets the eligibility requirements set forth in Section 17.02, Community Support Services for persons with Severe and Disabling Mental Illness. A copy of the Department's approved Section 17 assessment tool shall be completed pursuant to the requirements in Section 17.

The signed assessment shall be maintained in the member's medical record. A copy of the signed assessment must be submitted to the Department along with the start of care form; AND

- B. The member requires psychotropic medication administration or monitoring for psychotropic medication; AND
- C. The member is not receiving psychotropic medication services under any other Sections of the MBM (except physician services are allowed); AND
- D. Home health services shall not be provided if services are available and safely accessible to the member on an outpatient basis. The plan of treatment signed by both the physician and the home health agency must include a statement of the medical necessity for receiving services at home citing the specific reasons outpatient care is contraindicated (defined in 40.01-4) or not possible. The reasons must be listed and the likelihood of a bad outcome must be probable or definite as opposed to possible or rarely.

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40.03 DURATION OF CARE

Each MaineCare member is eligible to receive as many covered services as are medically necessary as long as the member meets the eligibility requirements as set forth in Section 40.02, and services are provided in accordance with a valid, authorized certification period as required in Section 40.08-2, and there has been a valid Authorization Process and certification has been obtained. (see 40.02-1). The Department reserves the right to request additional information to evaluate medical necessity. Coverage will be denied if the services provided are not specified in the authorized plan of care. Home health services shall be reduced, denied, or terminated by the Authorized Agent or the Department, as appropriate, if any of the following situations occur:

- A. The member declines home health services;
- B. A significant change occurs in the member's medical or functional status such that a plan of care can no longer be developed and implemented safely;
- C. The member does not meet the medical eligibility criteria for home health services as set forth in Section 40.02-3, as determined by the Authorized Agent or the Department;
- D. The member is not financially eligible to receive MaineCare benefits;
- E. When the member's most recent assessment, and the clinical judgment of the Authorized Agent, determine that the authorized plan of care must be changed or reduced to match the member's needs as identified in the assessment, the plan of care shall be modified by the Authorized Agent, or the Department, to reflect the change in needs;
- F. The member has provided fraudulent information in connection with obtaining services;
- G. The Department, or the Authorized Agent, documents that the member, or other person living or visiting the member's residence, harasses, threatens or endangers the safety of individuals delivering services;

40.04 **STANDARDS OF CARE**

General Regulatory Compliance

All home health agencies must meet the following standards to qualify for MaineCare reimbursement:

- A. In order to qualify for reimbursement under this Section, a home health agency must have in effect a license pursuant to the Department's Regulations Governing the Licensing and Functioning of Home Health Care Services, as are currently in effect. A home health agency must also comply with all requirements of Title XIX of the Social Security Act and the regulations issued pursuant thereto, as are most currently in effect. These standards are incorporated into this Section by reference as if set out fully herein. The home health agency must have in effect a current MaineCare provider agreement with the MaineCare program.
- B. In order to qualify for reimbursement under this Section a home health agency must have in effect a current Medicare certification to participate pursuant to §1861(o) and 1891 of the Social Security Act and the regulations found at 42 CFR, Part 484, and regulations issued pursuant thereto as are most currently in effect. These standards are incorporated into this Section by reference as if set out fully herein.

40.05 **COVERED SERVICES**

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A covered service is a service for which payment to a provider is permitted under this Section of the MaineCare Benefits Manual. In order to be reimbursed under this Section, covered services must be delivered under a timely and complete plan of care, signed and certified by a qualified Physician and meet the authorization requirements as outlined under Section 40.02-5. The plan of care must meet the requirements of Section 40.08. The CMS-485 must be completed for each member under this Section. There must be documentation of a face-to-face encounter with the certifying physician or allowed nonphysician practitioner as listed in Section 40.01-7. If the Department or its Authorized Agent determines that the services are no longer medically necessary, the Department will not reimburse the HHA for continuing services.

- A. **Skilled Nursing Services.** To be covered as skilled nursing services, the services must meet the following conditions:
 - 1) require the skills of a registered nurse or a licensed practical nurse under the supervision of a registered nurse, to be safe and effective, considering the inherent complexity of the service, the condition of the member and accepted standards of medical and nursing practice; and

40.05 **COVERED SERVICES** (Cont)

A. Skilled Nursing Services (cont.)

- 2) be medically necessary to the treatment of the member's illness or injury. Medical necessity of services is based on the condition of the member at the time the services were ordered and what was, at that time, expected to be appropriate treatment throughout the certification period; and
- 3) be required on an intermittent or part-time basis (as defined in Section 40.01-13 and 40.01-19). To meet the requirement for intermittent skilled nursing care, a member must have a medically predictable recurring need for skilled nursing service; and be ordered by the physician for the member and are included in the physician's plan of care.

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B. Home Health Aide Services. The services must be required in conjunction with a skilled nursing service as described in 40.05(A) or physical therapy or occupational therapy as described in 40.05(C). Home health aide services must be ordered by the physician and specified as to frequency and duration in the physician's plan of care for the member. The services must be medically necessary to provide personal care to the member, to maintain health, or to facilitate treatment of the member's illness. Covered services include, but are not limited to:

- 1) personal care services;
- 2) simple dressing changes that do not require the skills of a registered or licensed nurse;
- 3) assisting the member with self-administering medications that do not require the skills of a registered or licensed nurse; home health aides cannot administer medications;
- 4) assistance with activities that directly support skilled therapy services and are listed on the Maine State Board of Nursing approved nursing assistant skills checklist;
- 5) routine care of prosthetic and orthotic devices;
- 6) incidental services. When a home health aide visits a member to provide a health-related service, the home health aide may also perform some incidental services that do not meet the above definition (for example, light cleaning, preparing a meal, removing trash, or shopping). However, the purpose of the home health aide visit must not be solely to provide these incidental services.

40.05 COVERED SERVICES (cont.)

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C. Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services.
Physical therapy, occupational therapy and speech-language pathology services must meet the following criteria:

- 1) prescribed by a physician;
- 2) directly and specifically related to an active treatment regimen;
- 3) of such a level, complexity and sophistication that the judgment, knowledge, and skills of a licensed therapist are required;
- 4) performed by a licensed therapist or by a licensed therapist assistant under the supervision of a licensed or registered therapist, each operating within the scope of his or her license;
- 5) provided based on the physician's assessment that the member has rehabilitation potential (defined in Section 40.01-22) and will improve significantly in a predictable period.

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- a. Once rehabilitation potential has been established for members aged twenty-one (21) or older, they are specifically eligible only for physical and occupational therapy in the following circumstances:
 - i. treatment following an acute hospital stay for a condition affecting range of motion, muscle strength, and physical functional abilities. Services must be initiated within sixty (60) days from the date of the physician's certification of the member's rehabilitation potential; and/or
 - ii. treatment after a surgical procedure performed for the purpose of improving physical function. Services must be initiated within sixty (60) days from the date of the physician's certification of the member's rehabilitation potential; and/or

40.05 COVERED SERVICES (cont.)

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- iii. treatment in those situations in which a physician has documented that the member has, in the preceding thirty (30) days, required extensive assistance (defined in Section 40.01-6) with at least one-person physical assist (defined in Section 40.01-18) in the performance of one (1) or more of the following activities of daily living: eating, toileting, locomotion, transfer or bed mobility;
 - iv. palliative care is limited to one (1) visit per year to design a plan of care and train the member or caretaker of the member to implement the plan or to reassess the plan of care;
- 6) considered under accepted standards of medical practice to be a specific and effective treatment for the member's condition;
- and
- 7) certified by the physician in a current certification period.

D. **Medical Social Services.** Medical social services that are provided by a qualified medical social worker may be covered as home health services when medical social services are required in conjunction with a skilled nursing service as described in 40.05(A) or physical therapy or occupational therapy as described in 40.05(C); AND when:

- 1) 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 member's medical condition or to affect his or her rate of recovery; and
- 2) the plan of care indicates how the services that are required necessitate the skills of a qualified medical social worker.
- 3) services may include: assessments of the social and emotional factors related to the member's illness, need for care, response to treatment and adjustment to care; assessment of the relationship of the member's medical and nursing requirements to the member's home situation, financial resources, and availability of community resources; appropriate action to obtain available community resources to assist in resolving the member's services to address general problems that do not clearly and directly impede treatment or recovery, as well as long-term social services, such as ongoing alcohol counseling, are not covered.

40.05 COVERED SERVICES (cont.)

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- 4) certified by the physician or other allowed practitioner as defined in 40.01.7, authorized according to 40.08-1 and documented by the certifying physician according to 40.08-4.15.

E. Non-Routine Medical Supplies

- 1) In order to carry out the physician ordered service for the Member, it may be necessary for the Home Health Services provider to obtain and utilize particular medical supplies that are required for performance of the ordered procedure. The Home Health Service provider can bill for these “non-routine medical supplies”, as defined in Chapter II, Section 40.01-15, in addition to the per unit rate it is paid.
- 2) The Department or its designee will maintain a Home Health Services Supply List of non routine medical supplies covered under Chapter II. Only non routine medical supplies meeting the criteria contained in Section 40.01-15 and included on this list may be approved for reimbursement by the Department. The Department will make the list readily available to providers directly from the Department and electronically at the Provider Tab, “Portal Tools” section in the Procedure Code Lookup” at: <http://www.maine.gov/dhhs/oms>.
- 3) All covered supplies must be billed in accordance with the billing instructions for Home Health Services providers. Non routine medical supplies covered under Section 40 must be billed at the lower of either the acquisition cost or the durable medical equipment price which can be found at <https://mainecare.maine.gov/Billing%20Instructions/Forms/Publication.aspx> .
- 4) Members or providers on behalf of Members may request coverage for an item not currently on the Home Health Services Supply List by sending a written request to the Division of Consumer Services, explaining how the item meets the criteria of Section 40.01-15. In order to add an item to the Home Health Services Supply List for reimbursement, the Department or its designee must be satisfied that the item meets the criteria for a “non routine medical supply” as defined by Section 40.01-15.

40.06 LIMITATIONS

Services delivered under this Section shall not duplicate any other services delivered to the member. Duplication includes, but is not limited to:

- A. Services under this Section shall not be reimbursed for members who are receiving services under Section 19, Home and Community Benefits for the Elderly and for Adults with Disabilities, because nursing services and personal care services are provided under this Section.
- B. Home health aide services shall not be reimbursed for members who are receiving services under Section 2, Adult Family Care Services, or Section 12, Consumer Directed Attendant Care Services, or Section 21 Home and Community-Based Waiver Services for the Mentally Retarded or Section 22, Home and Community-Based Waiver Services for the Physically Disabled. Personal care services are covered services under these Sections.
- C. If the member resides in a Section 50, ICF-MR, a home health agency may provide services only if the facility's MaineCare reimbursement rate, or the facility's contract with the seeding state agency, does not include these services. Home health aide services shall not be reimbursed in Section 97 (PNMI) and Section 50 (ICF-MR) settings because personal care services are a covered service under these Sections.
- D. Nursing and home health aide services delivered to a member who is receiving Section 96, Private Duty Nursing (PDN) Services & Personal Care Services, shall count towards the member's authorized PDN cap. Occupational therapy, physical therapy, speech-language pathology and Medical Social Services may be provided and do not count toward the member's PDN cap.
- E. Excluding members whose medical condition is "unstable" (as defined in Section 40.01-26), assessment and management services, as well as teaching and training services, are limited to two (2) certification periods or a maximum of one hundred twenty (120) days, per admission.

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40.07 NON-COVERED SERVICES

The following services are not reimbursable by the MaineCare Program under this Section:

- A. Parenting skills training.
- B. Nursing services, physical therapy, and occupational therapy exercises that may be carried out by the member, or family member or friend who is trained, willing and able to safely perform the service after receiving instruction from the appropriate home health care professional.
- C. Services provided by a personal care attendant.
- D. Laboratory services as defined in Section 55 of this Manual.

40.07 **NON-COVERED SERVICES** (cont.)

- E. Blood glucose monitoring, i.e. glucometer, if the member is stable and does not need teaching of diabetic management.
- F. Routine foot care, unless the member suffers severe circulatory impairment, or metabolic, neurological, or systemic diseases where nonprofessional care may pose a threat to the member's condition.
- G. Homemaking services (for example; vacuuming, laundry) and chore services, except when delivered as "incidental" services, as described in Section 40.05 (B).
- H. RN supervisory visits made for the purpose of supervising home health aide services to the member.
- I. Nursing evaluation visits, unless skilled observation and assessment by a licensed nurse would result in a change of the treatment of the member.
- J. Visits made solely to remind the member to follow instructions.
- K. Services that can be appropriately provided by other community resources, e.g., homemaker services, adult protective services, "Meals on Wheels".
- L. Respite services.
- M. Venipuncture if this is the sole skilled service provided during the visit.
- N. Custodial care.
- O. A monthly injection if this is the sole skilled nursing service provided during the visit.
- P. Monthly catheter change, beyond the acute phase.

40.08 **POLICIES AND PROCEDURES**

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40.08-1 **Authorization of the Plan of Care**

All services under this Section require an authorization (see Section 40.02-1), from the Department or its Authorized Agent. At the Department's discretion a medical eligibility assessment may be performed in order to approve an authorization request. Home health services will be authorized only if all requirements set forth in this Section are met. The authorization determines only the medical necessity for services and does not establish or waive any other prerequisites for payment, such as member eligibility or coverage by other third party payor.

40.08 **POLICIES AND PROCEDURES** (cont.)

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40.08-1 Authorization of Plan of Care (cont.)

- A. Notice of Approval. For all approved authorization requests for home health services, the Authorized Agent will provide written notice to the HHA.
- B. Notice of Denial or Modification and Right to Appeal. For all denied or reduced authorization requests, the Authorized Agent will notify both the member and the HHA of the denial or modification, reason, right to appeal, and appeal procedures (see Section 40.08-5).
- C. The home health agency must notify the Department of a member's start of care date for the initial certification period. The admit/discharge form must be submitted to the Department within five (5) days of admission.
- D. All home health services shall be authorized and covered for an approved certification period. The home health agency must submit the following information for each certification period within five (5) calendar days of the certification period end date:
 - 1. The CMS 485, including the documentation of rehabilitation potential for any physical therapy, occupational therapy and speech-language pathology services being received by the member, and
 - 2. Documentation of why the member cannot receive home health services in an outpatient hospital setting.
 - 3. Documentation supporting the medical necessity for the Home Health Service.
 - 4. For the certification period at start of services the Home Health Agency must also submit documentation by the certifying physician that the physician himself or herself or a nonphysician practitioner has had a face-to-face encounter with the individual member as defined in section 40.01-7 prior to authorization of the plan of care and has documented the encounter as required by section 40.08-4.15.

The beginning and end dates of the individual's eligibility period correspond to the beginning and end dates for MaineCare coverage of the Home Health Service.

40.08 **POLICIES AND PROCEDURES** (cont.)

40.08-2 **Plan of Care Requirements**

In accordance with licensing requirements, all home health services must be provided under a plan of care established by the HHA, individually for each member.

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A. **Providers Qualified to Establish a Plan of Care.**

1. The member's physician or other specified provider as defined in 40.01-7 working in collaboration with the provider certifying the Home Health Service must establish a written plan of care. The physician must recertify and sign the plan of care for each certification period (Section 40.01- 2). Recertification is required at least every 60 days.
2. A HHA nurse or skilled therapist or social worker may establish an additional, discipline oriented plan of care, when appropriate. These plans of care may be incorporated into the physician's plan of care or prepared separately, but do not substitute for the physician's plan of care.

B. **Content of the Plan of Care.** The orders on the plan of care must specify the nature, frequency and duration of each service to be provided to the member and the type of professional who must provide it. The physician must sign the plan of care before the HHA submits its claim for those services to the Department for payment. The plan of care must contain:

1. all pertinent diagnoses, including the member's mental status;
2. the types of services, supplies, and equipment ordered;
3. the frequency and duration of the visits for each discipline to be made. A discipline may be one (1) or more of the following: skilled nursing, physicaltherapy, speech-language pathology services, occupational therapy, medicalsocial services, or home health aide;
4. the prognosis, rehabilitation potential, goals, functional limitations, permitted activities, nutritional requirements, medications, and treatments;
5. any safety measures to prevent injury;
6. the discharge plans;
7. any additional items the home health agency or physician chooses to include;

40.08 **POLICIES AND PROCEDURES** (cont.)

40.08-2 **Plan of Care Requirements** (cont.)

8. the member's address and type of residence, whether private home or residential care facility, etc; and
9. identify any other community resources and services, as well as care management, care coordination, targeted case management or social work services.

C. Certification Period. Both the plan of care, required under Section 40.08-2(A)(1), and the discipline-oriented plan of care, as provided for in 40.08-2 (A)(2), must be reviewed and signed by a physician for each certification period as defined in Section 40.01-2.

D. Verbal Orders

1. Services that are provided from the beginning of the certification period and before the physician signs the plan of care are considered to be provided under a plan of care established and approved by the physician if:
 - a. the clinical record contains a documented verbal order for the care before the services are furnished; and
 - b. the services are included in a signed plan of care.
2. Any increase in the frequency of services or any addition of new services during a certification period must be authorized in advance by a physician with verbal or written orders. The Department will pay for care provided based on verbal orders only if they are followed by a written order signed by the physician before the Department is billed.

40.08-3 **Awaiting Placement**

A member who is currently receiving home health services under this Section and who no longer meets the eligibility criteria under this Section, but has been determined eligible, by the Department or its Authorized Agent, for any of the following in-home long term care services, Section 96, Private Duty Nursing & Personal Care Services, any Home and Community Benefit program, Section 43 Hospice Services, or Section 12, Consumer Directed Attendant Services, may be classified as "awaiting placement". "Awaiting placement" status may be used, if necessary, until an appropriate service provider begins delivering services. Under awaiting placement status, members will be covered for services under this Section.

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40.08 **POLICIES AND PROCEDURES** (cont.)

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40.08-3 **Awaiting Placement** (cont.)

Coverage of services under “Awaiting placement” is for a specified period of time approved by the Department or its Authorized Agent. For coverage to continue beyond the approved period, the HHA must submit a completed request form along with a current CMS 485, to the Authorized Agent at least five (5) calendar days prior to the end date of the member’s approved period. If upon review, the Department or its Authorized Agent determines the member is no longer eligible for any of the other in-home programs, continued coverage for home health services shall be denied.

40.08-4 **Member's Record**

Content of Records

There shall be a specific record for each member, which shall include, but not necessarily be limited to:

1. The member's name, address, and birth date;
2. The name of the attending physician;
3. The member's social and medical history and diagnosis;
4. The member's need for teaching and the member's ability to learn;
5. Community resources available to meet the needs of the member;
6. A personalized plan of care, which meets the requirements in Section 40.08-2 and Section 40.08-4.15;
7. Plans for coordination with other health care agencies for the delivery of services. For psychiatric nursing services, plans will include coordination with other mental health and social services agencies;
8. Discharge plan for the member;
9. Written progress notes and/or flow sheets including (at a minimum):
 - a. Identification of the service provided, the date, and the provider;
 - b. Progress toward the achievement of long and short-range goals;
 - c. Signature of the service provider; and
 - d. Date and full description of any unusual condition or unexpected event.

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40.08 **POLICIES AND PROCEDURES** (cont.)

40.08-4 **Member's Record** (cont.)

Content of Records (cont.)

10. Entries are required for each date of service billed;
11. The plan of care signed and reviewed as necessary by the supervising physician;
12. Documentation of skilled nursing and home health aide hours. The HHA must maintain records, which show the entrance and exit times of each skilled nurse's and each aide's visits and total time spent in the home by each. Exclude travel time;
13. The signed CMS-485 must be retained and available upon request. Complete the form in its entirety. Do not leave any blank items. However, there are items where "not applicable" (N/A) is acceptable;
14. Documentation of rehabilitation potential as defined in this Section for members receiving physical therapy, occupational therapy and speech-language pathology services.
15. Documentation by the physician certifying the Home Health Services that a face to face encounter meeting the requirements of 40.01-7 has taken place prior to making such certification. The documentation of the face-to-face encounter must be a separate and distinct section of, or an addendum to, the certification and must be clearly titled, dated and signed by the certifying physician. A nonphysician practitioner performing the face-to-face encounter must document the clinical findings of the face-to-face member encounter and communicate those findings to the certifying physician. Documentation shall indicate that the encounter has occurred no more than 90 days prior to the start of the Home Health care. If a face-to-face member encounter occurred within 90 days of the start of care but is not related to the primary reason the member requires home health services, or if the member has not seen the certifying physician or allowed nonphysician practitioner within the 90 days prior to the start of the home health episode for the primary reason requiring home health services, the certifying physician or nonphysician practitioner must have a face-to-face encounter with the patient within 30 days of the start of the Home Health care. The documentation shall include an explanation of why the clinical findings of the face-to-face encounter support that the patient meets the requirements of 40.02-3 C and is in need of intermittent skilled nursing services or therapy services from Home Health Services.

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40.08 **POLICIES AND PROCEDURES** (cont.)

40.08-5 **Member Appeals**

See Chapter I of the MaineCare Benefits Manual for information regarding appeals. Members under age twenty-one (21) years shall submit a request for an appeal in accordance with Chapter I. An appeal by members who are age twenty-one (21) years and over regarding services under this Section must be requested in writing and mailed to:

Director
Office of Elder Services
c/o Hearings
11 State House Station
442 Civic Center Dr.
Augusta, Maine 04333-0011

40.08-6 **Program Integrity**

All providers are subject to the Department's Program Integrity activities. Refer to Chapter I, General Administrative Policies and Procedures for rules governing these functions.

40.09 **REIMBURSEMENT**

- A. The amount of payment for services rendered shall be the lowest of the following:
1. The amount listed in Chapter III, Section 40, "Allowances for Home Health Services" of the MaineCare Benefits Manual; or
 2. The lowest amount allowed by the Medicare carrier; or
 3. The provider's usual and customary charge.
- B. In accordance with Chapter I of the MaineCare Benefits Manual, it is the responsibility of the provider to seek payment from every other source that is available for payment of a rendered service prior to billing MaineCare.
- C. The eligibility requirements and limits on home health services under this Section do not apply to members with Medicare coverage or other third party health insurance until the coverage for these home health services, (including occupational therapy, physical therapy and speech-language pathology services) by the other third party payor has been exhausted. MaineCare will cover the co-insurance and deductible in these cases.

40.10 COPAYMENT

- A. A copayment will be charged to each MaineCare member for each day home health services are provided. The amount of the copayment shall not exceed \$3.00 per day for services provided, according to the following schedule:

MaineCare Payment for Service	Member Copayment
\$10.00 or less	\$.50
\$10.01 - 25.00	\$1.00
\$25.01 - 50.00	\$2.00
\$50.01 or more	\$3.00

- B. The member shall be responsible for copayments up to \$30.00 per month whether the copayment has been paid or not. After the \$30.00 cap has been reached the member shall not be required to make additional copayments and the provider shall receive full MaineCare reimbursement for covered services.
- C. No provider may deny services to a member for failure to pay a copayment. Providers must rely upon the member's representation that he or she does not have the cash available to pay the copayment. A member's inability to pay a copayment does not, however, relieve him/her of liability for a copayment.
- D. Providers are responsible for documenting the amount of copayments charged to each member (regardless of whether the member has made payment) and shall disclose that amount to other providers, as necessary, to confirm previous copayments.

Providers are subject to the Department's copayment requirements. Refer to Chapter I, General Administrative Policies and Procedures for rules governing copayment requirements, exemptions and dispute resolution.

40.11 CONFIDENTIALITY

The disclosure of information regarding individuals participating in the MaineCare program is strictly limited to purposes directly connected with the administration of the MaineCare program. Providers shall maintain the confidentiality of information regarding these individuals in accordance with 42 CFR §431 et seq. and other applicable sections of state and federal law and regulation.

40.12 BILLING INSTRUCTIONS

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- A. Billing must be accomplished in accordance with the Department's billing requirements in "Billing Instructions for Home Health Agencies" that are available on the provider portal at www.maine.gov/dhhs/oms or by contacting MaineCare Services, Division of Customer Service, 11 State House Station, Augusta, ME 04330, or calling 1-800-321-5557.
- B. In order to receive full MaineCare reimbursement for claims submitted for a service that is defined as an exemption in Chapter I, refer to the billing instructions distributed by the Department and to Chapter I, General Administrative Policies and Procedures.
- C. All services provided on the same day shall be submitted on the same claim form for MaineCare reimbursement.

40.13 BILLING APPEALS FOR DUAL MAINECARE/MEDICARE MEMBERS

- A. An agency document must be on file signed by the MaineCare member or guardian noting that services are denied Medicare coverage and all claims will be submitted to MaineCare.
- B. The agency will obtain and keep on file a signed departmental "Authorization to Represent" form on all MaineCare members. This form will be provided by the Department. The agency will present this form to the Department or its designee when an Initial Determination and/or Reconsideration or Administrative Law Judge is requested.
- C. The Department will find the home health agency liable for the cost of services following an adverse decision by Medicare in response to a Department appeal detailing a technical denial. Examples of a technical denial shall include but not be limited to:
 - 1) Plan of Care not authorized by a physician.
 - 2) Information not received.
 - 3) No documentation for services billed.
 - 3) Time Limit Reject.