



Arkansas Department of Human Services

Division of Medical Services

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TO: Arkansas Medicaid Home Health Providers
DATE: June 1, 2004
SUBJECT: Provider Manual Update Transmittal No. 60

REMOVE

Section	Date
200.000 – 204.100	10-13-03
212.300 – 213.200	10-13-03
217.000 – 217.200	10-13-03
218.000 – 219.000	10-13-03
240.000 – 242.150	10-13-03

INSERT

Section	Date
200.000 – 206.000	6-1-04
212.300 – 213.200	6-1-04
217.000	6-1-04
None	
240.000 – 242.150	6-1-04

Explanation of Updates

Section 201.000: Provider enrollment procedures have been moved from this section to a new section, 201.010.

Section 201.010: This new section comprises the provider enrollment information previously contained in section 201.000 and additional details regarding enrollment procedures.

Section 202.000: Former section 202.000 has been incorporated into revised section 201.000.

Former section 203.000 has become revised section 202.000.

Sections 203.000 and 204.000: Former sections 204.000 and 204.100 have become revised sections 203.000 and 204.000, respectively. The renumbered and revised sections contain no new policy. Revisions are for clarity and to provide easier reading.

Section 205.000: Former section 219.000 has become revised section 205.000. Section 205.000 contains no new policy.

Section 206.000: Former section 218.000 has become revised section 206.000. Unnecessary requirements have been deleted. This section contains no new policy.

Section 212.301: This new section provides the qualifications and legal definition of a “qualified physical therapist.”

Section 212.302: This new section provides the qualifications and legal definition of a “qualified physical therapy assistant.”

Sections 212.310 through 212.347: These new and revised sections distinguish the home health physical therapy guidelines that apply to all ages from those that apply only to beneficiaries under the age of 21. A correction of fact has been made in section 212.341, part B. Former section 217.200 has become revised section 212.320.

Section 213.200: This section has been revised only for clarification of benefit limits.

Section 217.000: Former section 217.100 has become revised section 217.000.

“The Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act.”

Sections 242.100 through 242.150: These sections have been revised to incorporate official Notice DMS-03-I-2. Section 241.150 now reflects the maximum number of units allowed per date of service (date of delivery) of medical supplies.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 or 1-877-708-8191. Both telephone numbers are voice and TDD.

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Thank you for your participation in the Arkansas Medicaid Program.

Roy Jeffus, Director

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

200.000 HOME HEALTH GENERAL INFORMATION 6-1-04**201.000 Arkansas Medicaid Participation Requirements for Home Health Providers 6-1-04**

See section 140.000 for participation requirements for all Arkansas Medicaid providers.

- A. Only home health agencies licensed to operate in Arkansas may participate in the Arkansas Medicaid Home Health Program.
- B. A provider participating in the Arkansas Medicaid Home Health Program must be currently licensed by the Division of Health Facility Services, Arkansas Department of Health, as a Class A Home Health Agency.
- C. A provider participating in the Arkansas Medicaid Home Health Program must be currently certified by the Arkansas Home Health State Survey Agency as a participant in the Title XVIII (Medicare) Program.
- D. Providers participating in the Arkansas Medicaid Home Health Program must maintain documentation of current licensure and certification in their Medicaid provider enrollment files.
 - 1. Enrolled providers must submit copies of license and certification renewals to the Provider Enrollment Unit, Division of Medical Services (DMS), within 30 days of the issuance of those documents. [View or print Provider Enrollment Unit Contact information.](#)
 - 2. Failure to maintain current license and certification documentation will result in termination from the Medicaid Program.

201.010 Enrollment Procedures for Arkansas Medicaid Home Health Providers 6-1-04

[View or print Provider Enrollment Unit Contact information.](#)

- A. A Class A Home Health Agency applying to enroll in the Arkansas Medicaid Home Health Program must complete and submit the following items to the DMS Provider Enrollment Unit:
 - 1. A provider application (form DMS-653),
 - 2. A Medicaid contract (form DMS-653), and
 - 3. A Request for Taxpayer Identification Number and Certification (Form W-9)
- B. The applicant must also submit to the DMS Provider Enrollment Unit a copy of the agency's current Class A Home Health Agency license, issued by the Division of Health Facility Services, Arkansas Department of Health.
- C. The applicant must submit to the DMS Provider Enrollment Unit a copy of the agency's current Title XVIII (Medicare) certification, issued by the Arkansas Home Health State Survey Agency.

[View or print a provider application \(form DMS-652\), Medicaid contract \(form DMS-653\) and Request for Taxpayer Identification Number and Certification \(form W-9\).](#)
- D. DMS must approve, by means of established and uniformly applied criteria, all Medicaid provider applications and Medicaid contracts before enrolling providers.
- E. Additionally, the DMS Provider Enrollment Unit reviews provider applications and Medicaid contracts for accuracy and completeness.

1. The Provider Enrollment Unit contacts applicants to correct errors or omissions in the enrollment documents. Some errors, such as failure to provide an original signature, necessitate returning the documents to the applicant for correction.
2. When the provider application and Medicaid contract are complete and correct, and DMS approves the application and contract, the Provider Enrollment Unit assigns a provider number, establishes a provider file and forwards to the provider written confirmation of the provider number and the effective date of the provider's enrollment.

202.000 Beneficiary Freedom of Choice**6-1-04**

- A. A Medicaid-eligible beneficiary has freedom of choice among Arkansas Medicaid-enrolled home health providers.
- B. Home health services may be furnished only by written consent of the beneficiary or the beneficiary's representative. The beneficiary's representative must be an individual who has legal guardianship of the beneficiary's person or whom the court has designated as the beneficiary's representative by the court pursuant to competency proceedings.
- C. The home health agency must allow the beneficiary or the beneficiary's representative to participate in the treatment planning.
- D. The home health agency must advise the beneficiary or the beneficiary's representative of changes in the beneficiary's treatment before the changes take place.
- E. The home health agency must advise the beneficiary or the beneficiary's representative regarding advance directives.

203.000 Home Health and the Primary Care Physician (PCP) Case Management Program (ConnectCare)**6-1-04**

- A. Home health care requires a PCP referral except in the following circumstances:
 1. Medicaid does not require Medicare beneficiaries to enroll with PCPs; therefore, a PCP referral is not required for home health services for Medicare/Medicaid dual-eligibles.
 2. Obstetrician/gynecologists may authorize and direct medically necessary home health care for postpartum complications without obtaining a PCP referral.
- B. A PCP may refer a beneficiary to a specific home health agency only if he or she ensures the beneficiary's freedom of choice by naming at least one alternative agency.
 1. PCPs, authorized attending physicians and home health agencies must maintain all required PCP referral documentation in beneficiary's clinical records and
 2. PCP referrals must be renewed when specified by the PCP or every six months, whichever period is shorter.
- C. PCP referral is not required to revise a plan of care during a period covered by a current referral, but the agency must forward copies of the signed and dated assessment and the revision to the PCP.

204.000 Authorized Attending Physician**6-1-04**

In this provider manual the term "authorized attending physician" means:

- A. An attending physician to whom the PCP has referred the patient,
- B. The attending physician of a patient who is not required to enroll with a PCP or

- C. An obstetrician/gynecologist directing a home health plan of care for a Medicaid-eligible patient with postpartum complications.

205.000 Record Retention Requirements

6-1-04

The record retention requirements in this section apply to the home health records of beneficiaries of all ages. Special documentation and record retention requirements apply to beneficiaries under the age of 21. See sections 212.340 through 212.347 for those additional requirements.

- A. All required records must be kept for a period of 5 years from the ending date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever period is longer.
- B. Providers are required, upon request, to furnish their records to authorized representatives of the Arkansas Division of Medical Services (DMS), the state's Medicaid Fraud Control Unit and representatives of the Department of Health and Human Services.
- C. Furnishing records on request to authorized individuals and agencies is a contractual obligation of providers enrolled in the Medicaid Program. Sanctions will be imposed for failure to furnish medical records upon request.
- D. When the Medicaid Field Audit Unit conducts an audit of a provider's records, all documentation must be made available to authorized DMS personnel at the provider's place of business during normal business hours. Requested documentation that is stored off-site must be made available to DMS personnel within three business days.
- E. If an audit determines that recoupment of Medicaid payments is necessary, DMS will accept additional documentation for only thirty days after the date of the notification of recoupment. Additional documentation will not be accepted later.

206.000 Documentation of Services for Beneficiaries of all Ages

6-1-04

Home health providers must maintain the following records for patients of all ages. See sections 212.340 through 212.347 for additional documentation guidelines regarding physical therapy for patients under the age of 21.

- A. Signed and dated patient assessments and plans of care, including physical therapy evaluations and treatment plans when applicable.
- B. Signed and dated case notes and progress notes from each visit by nurses, aides, physical therapy assistants and physical therapists.
- C. Signed and dated documentation of *pro re nata* (PRN) visits, which must include the medical justification for each such unscheduled visit. The record must include vital signs and symptoms. It must include the observations of and measures taken by agency staff and reported to the physician. PRN documentation must include, the physician's comments, observations and instructions.
- D. Verification, by means of the physician's signed and dated certification or by means of the physician's medical record of the visit:
 - 1. That the beneficiary had a physical examination, with a history or history update, no more than twelve months before any period of extended benefits beginning on or after July 1, 2000, and
 - 2. That the beneficiary had a physical examination, with a history or history update, no more than twelve months before any new, revised or renewed plan of care that had a beginning date of service on or after July 1, 2000.

- E. Copies of current, signed and dated plans of care, including signed and dated interim and short-term plan-of-care modifications, in each patient's medical records.
- F. Copies of plans of care, PCP referrals, case notes, etc., for all previous episodes of care within the period of required record retention.
- G. The registered nurse's instructions to home health aides, detailing the aide's duties at each visit.
- H. The registered nurse's (or physical therapist's when applicable) notes from supervisory visits.
- I. All additional documentation required in sections 212.340 through 212.347 of this manual.

212.300 Physical Therapy in the Home Health Program 6-1-04**212.301 A Qualified Physical Therapist in the Home Health Program 6-1-04**

- A. A qualified physical therapist must be a graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association, as required by Federal Regulations [42 CFR 440.110(a) (2) (i)].
- B. A qualified physical therapist must be currently licensed to practice as a physical therapist in Arkansas [42 CFR 440.110 (a) (2) (ii)]. A copy of the qualified physical therapist's current Arkansas license must be on file with the home health agency.

212.302 A Qualified Physical Therapy Assistant in the Home Health Program 6-1-04

- A. A qualified physical therapy assistant must have at least a bachelor's degree or college-level associate degree in physical therapy approved by the American Physical Therapy Association.
- B. A qualified physical therapy assistant must have current licensure by the Arkansas State Board of Physical Therapy as a physical therapy assistant. A copy of the qualified physical therapist assistant's current state license must be on file with the home health agency.
- C. A qualified physical therapy assistant must be under the "supervision" (as defined by the Arkansas State Board of Physical Therapy and in section 212.320 of this manual) of a qualified physical therapist.

212.310 Home Health Physical Therapy Coverage 6-1-04

Medically necessary physical therapy is covered for all ages when it is:

- A. Included in a home health plan of care and it is
- B. Provided by a qualified physical therapist or by a qualified physical therapist assistant under the supervision of a qualified physical therapist.

212.311 Physical Therapy as the Sole Home Health Service 6-1-04

When the PCP or authorized attending physician prescribes medically necessary home health physical therapy and no other home health service, the following guidelines apply:

- A. Physical therapy is provided as the only home health service.
- B. The physical therapy treatment plan may serve as the home health plan of care.
- C. The qualified physical therapist (but not a qualified physical therapist assistant) may make the required initial and subsequent patient assessments and perform the duties that would otherwise be those of the registered nurse.
- D. The PCP or authorized attending physician must authorize the treatment plan before physical therapy may begin. See section 216.500 for conditions under which services may begin upon the physician's oral authorization.
- E. The PCP or authorized attending physician must review the treatment plan at the intervals required for home health plans of care.

- F. A comprehensive physical examination, with a complete history or history update, by the PCP or authorized attending physician, is required within the twelve months preceding the start date of a new, renewed or revised physical therapy treatment plan.

212.312 **Physical Therapy as a Component of a Home Health Plan of Care** 6-1-04

- A. When the PCP or authorized attending physician prescribes medically necessary home health physical therapy as a component of a home health plan of care, the physical therapy treatment plan must be incorporated into the home health plan of care.
- B. If the patient is under the age of 21, see sections 212.340 through 212.347 for additional requirements.

212.320 **Physical Therapist Supervision of Physical Therapy Assistants** 6-1-04

- A. When a physical therapy assistant provides a beneficiary's home health physical therapy, the supervising qualified physical therapist must be readily available by telephone during the entire time the assistant is providing physical therapy.
- B. The supervising qualified physical therapist must review, sign and date, at least once every 30 days, the physical therapist assistant's case notes for each patient.

212.330 **Qualified Physical Therapist Direction of Unlicensed Physical Therapy Students** 6-1-04

Physical therapy services carried out by an unlicensed therapy student may be covered only when the following criteria are met.

- A. Physical therapy carried out by an unlicensed student must be under the direction of a qualified therapist and the direction is such that the qualified therapist is considered to be providing the medical assistance.
- B. To qualify as providing the service, the qualified therapist must be present and engaged in student oversight during the entirety of any physical therapy encounter.

212.340 **Physical Therapy Guidelines for Home Health Patients Under the Age of 21** 6-1-04

212.341 **Additional Documentation Requirements for Physical Therapy Patients Under the Age of 21** 6-1-04

- A. Providers must maintain documentation supporting medical necessity of physical therapy services.
 - 1. Medicaid requires a referral from the primary care physician (PCP), or a referral from the authorized attending physician if the beneficiary is exempt from mandatory PCP enrollment.
 - 2. Medicaid requires a written prescription for physical therapy, signed and dated by the PCP or the authorized attending physician. Providers of physical therapy for beneficiaries under the age of 21 must use form DMS-640, Occupational, Physical and Speech Therapy Services for Medicaid Eligible Recipients Under age 21 Prescription/Referral, to obtain the prescription. [View or print form DMS-640.](#)
 - a. The PCP or authorized attending physician must complete and sign form DMS-640 with his or her original signature. A rubber stamp or automated signature is not acceptable.
 - b. The PCP or authorized attending physician must maintain the original prescription (form DMS-640) in the beneficiary's medical record.

- c. The home health provider must maintain a copy of the original prescription form in the patient's medical record.
 3. Medicaid requires that a physical therapy treatment plan be developed, signed and dated by a qualified physical therapist and/or a physician. The plan must include individualized goals that are functional, measurable and specific to the beneficiary's medical needs.
- B. Documentation must include, when applicable, an Individualized Family Services Plan (IFSP) established in accordance with part C of the Individuals with Disabilities Education Act (IDEA).
- C. Medicaid requires, when applicable, an Individualized Education Program (IEP) established in accordance with part B of IDEA.
- D. Documentation must be supported by therapy evaluation reports to substantiate medical necessity, signed or initialed and dated progress notes and any related correspondence.
- E. Documentation must include discharge notes and summary.

212.342**Retrospective Review of Physical Therapy for Beneficiaries Under the Age of 21**

6-1-04

The guidelines set forth in sections 212.342 through 212.347 apply to home health physical therapy services for beneficiaries under the age of 21.

- A. Physical therapy services are medically prescribed services for the evaluation and treatment of movement dysfunction.
- B. Physical therapy services must be medically necessary for the treatment of the individual's illness or injury. To be considered medically necessary, the following conditions must be met.
 1. The services must be considered under accepted standards of practice to be specific and effective treatments for the patient's condition.
 2. The services must be of such a level of complexity, or the patient's condition must be such, that the services required can be safely and effectively performed only by or under the supervision of a qualified physical therapist.
 3. There must be a reasonable expectation that therapy will result in meaningful improvement or a reasonable expectation that therapy will prevent a worsening of the condition.
- C. A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. Assessment for physical therapy includes a comprehensive evaluation of the patient's physical deficits and functional limitations, and a treatment plan with goals that address each identified problem.
- D. The Quality Improvement Organization (QIO), Arkansas Foundation for Medical Care, Inc., (AFMC), under contract to the Arkansas Medicaid Program, performs retrospective reviews of medical records to determine the medical necessity of services reimbursed by Medicaid.
- E. Failure to follow the instructions in the Arkansas Medicaid provider manual and failure to respond to requests made by the QIO in a complete and timely manner are considered technical failures to establish eligibility for therapy services. The QIO does not have the authority to allow reconsideration of technical denials.

212.343**Retrospective Review of Physical Therapy Evaluations for Beneficiaries Under the Age of 21**

6-1-04

A physical therapy evaluation must contain:

- A. The date of evaluation.
- B. The patient's name and date of birth.
- C. The diagnosis or diagnoses specifically applicable to the proposed therapy.
- D. Background information, including pertinent medical history.
- E. Standardized test results, including all subtest scores, if applicable. Test results, if applicable, should be adjusted for prematurity if the patient is a child one year old or younger. The test results must be noted in the evaluation.
- F. Objective information describing the patient's gross and fine motor abilities and deficits, which shall include range of motion measurements, manual muscle testing results and a narrative description of the patient's functional mobility skills.
- G. An assessment of the results of the evaluation, including recommendations for frequency and intensity of treatment.
- H. The signature and credentials of the qualified physical therapist or physician performing the evaluation.

212.344 **Retrospective Review of Standardized Testing for Beneficiaries Under the Age of 21**

6-1-04

Standardized tests must be norm-referenced and specific to physical therapy.

- A. A test must be age appropriate for the patient.
- B. Test results must be reported as standard scores, Z scores, T scores or percentiles. Age-equivalent scores and percentage of delay are not sufficient justification for physical therapy services.
- C. A score of -1.50 standard deviations or more from the mean in at least one subtest area or composite score is required to qualify for services.
- D. If a patient cannot be tested with a norm-referenced standardized test, then criterion-based testing or a functional description of the patient's gross and fine motor deficits may be used. Documentation of the reason a standardized test cannot be used must be included in the evaluation.
- E. The mental measurement yearbook is the standard reference to determine reliability and validity.

212.345 **Other Objective Tests and Measures**

6-1-04

- A. **Range of Motion:** A limitation of greater than ten degrees and/or documentation of how a deficit limits function.
- B. **Muscle Tone:** Modified Ashworth Scale.
- C. **Manual Muscle Test:** A deficit is a muscle strength grade of fair (3/5) or below that impedes functional skills. With increased muscle tone, as in cerebral palsy, testing is unreliable.
- D. **Transfer Skills:** Documented as the amount of assistance required to perform a transfer, such as maximum, moderate or minimal assistance. A deficit is defined as the inability to perform a transfer safely and independently.

212.346 **Frequency, Intensity and Duration of Physical Therapy Services for Beneficiaries Under the Age of 21** **6-1-04**

- A. Frequency, intensity and duration of physical therapy services must be medically necessary and realistic for the age of the patient and the severity of the deficit or disorder.
- B. Therapy is indicated if improvement will occur as a direct result of these services and if there is a potential for improvement in the form of functional gain.
 - 1. **Monitoring:** May be used to ensure that the patient is maintaining a desired skill level or to assess the effectiveness and fit of equipment, such as orthotics and other durable medical equipment. Monitoring frequency should be based on time intervals that are reasonable for the complexity of the problems being addressed.
 - 2. **Maintenance Therapy:** Services that are performed primarily to maintain range of motion or to provide positioning services for the patient do not qualify for physical therapy services. These services can be provided to the child as part of a home program that can be implemented by the child's caregivers and do not necessarily require the skilled services of a physical therapist to be performed safely and effectively.
 - 3. **Duration of Services:** Therapy services should be provided as long as reasonable progress is made toward established goals. If reasonable functional progress cannot be expected with continued therapy, services should be discontinued and monitoring or establishment of a caregiver-administered home program should be implemented.

212.347 **Retrospective Review of Progress Notes for Beneficiaries Under the Age of 21** **6-1-04**

Progress notes must be legible and contain:

- A. The patient's name.
- B. The date of service.
- C. The beginning and ending time of each therapy session.
- D. Objectives addressed during the session. (These must correspond directly to the plan of care.)
- E. Descriptions of the physical therapy modalities provided daily and the activities involved during each therapy session, along with a form measurement.
- F. The qualified physical therapist's full signature, dated and with credentials, on each entry.
- G. The supervising qualified physical therapist's co-signature when a graduate student performs the physical therapy.

213.000 **Benefit Limits and Benefit Extensions** **6-1-04**

213.100 **Home Health Visit Benefit Limit** **6-1-04**

The Arkansas Medicaid Program benefit limit for medically necessary home health visits is 50 visits per state fiscal year (SFY, July 1 through June 30) per beneficiary.

- A. The annual benefit limit is 50 home health visits by a registered nurse, a licensed practical nurse, a home health aide or a combination of the three.
- B. Visits made on a *pro re nata* (PRN or "as needed") basis are not exempt from this benefit limit; they count toward the beneficiary's 50 visits per SFY.

- C. Benefit extensions are available. See section 213.510.

213.200 Physical Therapy Benefit Limit

6-1-04

- A. Medicaid imposes no limit on the number of medically necessary home health physical therapy visits a beneficiary may receive.
 - 1. Home health physical therapy must be prescribed by the beneficiary's PCP or authorized attending physician and established on a current home health plan of care.
 - 2. Home health physical therapy for beneficiaries under the age of 21 is subject to the additional requirements in sections 212.340 through 212. 347.
- B. Home health physical therapy is limited to one hour per day for beneficiaries of all ages.

- 217.000** **Registered Nurse Supervision of Home Health Aide Services** **6-1-04**
- A. The supervising registered nurse must issue written instructions to the home health aide.
 - 1. The instructions must specify the aide's specific duties at each visit.
 - 2. The aide must note that he or she has performed each task and note, with written justification of the omission, which tasks he or she did not perform.
 - B. If a beneficiary is receiving home health aide services only, the registered nurse must visit the beneficiary at least once every 62 days to assess his or her condition and to evaluate the quality of service provided by the home health aide.
 - C. If a beneficiary is receiving only physical therapy and home health aide services, with no skilled nursing services, either the registered nurse or the qualified physical therapist may make this required supervisory visit.

240.000	BILLING PROCEDURES	10-13-03
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241.000	Introduction to Billing	6-1-04
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Home Health providers use the CMS-1450 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one beneficiary.

Section III of this manual contains information about Provider Electronic Solutions (PES) and other available options for electronic claim submission.

242.000	CMS-1450 Billing Procedures for Home Health Services	6-1-04
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242.100	Home Health Procedure Codes	6-1-04
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Some HCPCS procedure codes in these sections may require modifiers that are not listed here. Until you receive official Medicaid correspondence regarding necessary modifiers, contact EDS Provider Assistance Center for the most up-to-date modifier requirements.

242.110	Home Health Visits	6-1-04
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Procedure Codes	Modifiers	Description
T1021		Home Health Aide Visit
T1002	TD	Home Health Registered Nurse Visit
T1003	TE	Home Health Licensed Practical Nurse Visit

242.120	Home Health Physical Therapy	6-1-04
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Procedure Code	Modifier	Description
97110	52	Home Health Physical Therapy by a Qualified Physical Therapy Assistant
97110		Home Health Physical Therapy by a Qualified Licensed Physical Therapist

242.130	Specimen Collection	10-13-03
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National Codes		
36415*	P9612	

***Venipuncture (drawing blood to obtain a blood sample) is excluded from the eligibility criteria for intermittent skilled nursing services under the home health benefit. If venipuncture to obtain a blood sample is the only skilled service that is needed by the patient, that individual does not qualify for skilled services.**

242.140	Injections	10-13-03
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242.141	Epogen Injection for Renal Failure	6-1-04
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National Codes

Q0136

242.142 Epogen Injections for Diagnosis other than Renal Failure

6-1-04

National Codes

Q9920	Q9921	Q9922	Q9923	Q9929
Q9930	Q9931	Q9932	Q9933	Q9934
Q9935	Q9936	Q9937	Q9938	Q9939
Q9940				

242.150 Home Health Medical Supplies

6-1-04

HCPCS CODES	MAXIMUM UNITS PER DATE OF SERVICE	HCPCS CODES	MAXIMUM UNITS PER DATE OF SERVICE	HCPCS CODES	MAXIMUM UNITS PER DATE OF SERVICE
A4206	1,316	A4214	31	A4221	11
A4222	6	A4253	7	A4256	37
A4259	17	A4265	19	A4310	42
A4311	18	A4312	16	A4313	15
A4314	12	A4315	12	A4316	11
A4320	59	A4322	98	A4323	27
A4326	20	A4327	7	A4328	31
A4330	45	A4338	21	A4340	15
A4344	20	A4346	17	A4348	205
A4351	139	A4352	46	A4353	36
A4354	20	A4355	20	A4356	6
A4357	34	A4358	48	A4359	9
A4361	15	A4362	83	A4364	100
A4365	26	A4367	43	A4368	532
A4369	119	A4371	78	A4394	74
A4397	57	A4398	17	A4399	24
A4400	5	A4402	97	A4404	130
A4405	84	A4406	84	A4455	116
A4483	57	A4622	5	A4623	42
A4625	34	A4626	70	A4628	77
A4629	30	A4772	7	A4927	1,563
A5051	124	A5052	189	A5053	138

HCPCS CODES	MAXIMUM UNITS PER DATE OF SERVICE	HCPCS CODES	MAXIMUM UNITS PER DATE OF SERVICE	HCPCS CODES	MAXIMUM UNITS PER DATE OF SERVICE
A5054	150	A5055	202	A5061	76
A5062	114	A5063	104	A5071	59
A5072	80	A5073	92	A5081	107
A5082	24	A5093	157	A5102	10
A5105	7	A5112	12	A5113	49
A5114	25	A5119	29	A5121	36
A5122	24	A5126	170	A5131	21
A6154	20	A6196	23	A6197*	varies**
A6198	13	A6203	1	A6204	67
A6205	70	A6211	6	A6212	35
A6213	23	A6216	439	A6220	128
A6221	108	A6229	128	A6230	108
A6234	43	A6235	21	A6236	13
A6237	43	A6238	21	A6239	13
A6242	71	A6243	23	A6244	6
A6245	71	A6246	23	A6247	6
A6248	22	A6257	214	A6258	67
A6259	30	A6403	128	A6404	108
A6421	144	A6422	144	A6424	144
A6426	144	A6428	144	A6430	781
A6432	781	A6434	781	A6436	781
B4086	7	E0776	3	L8239***	4

*Procedure code has multiple listings with different amounts of allowed units. Modifier required with procedure code. Call EDS for modifier and units information.

**Maximum units vary by modifier.

*** Requires prior authorization.

Z2481, "Thick-It", per 8 oz. can, must be billed on a paper claim.