

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: July 1, 2006

6.d. Other Practitioner's Services (Continued)

(5) Psychologist Services

Refer to Attachment 4.19-B, Item 4.b. (17).

- (a) Additional Reimbursement for Psychologists Services Associated with UAMS – Refer to Attachment 4.19-B, item 5.

(6) Obstetric-Gynecologic and Gerontological Nurse Practitioner Services

Reimbursement is the lower of the amount billed or the Title XIX maximum allowable.

The Title XIX maximum is based on 80% of the physician fee schedule except EPSDT procedure codes. Medicaid maximum allowables are the same for all EPSDT providers. Immunizations and Rhogam Rhod Immune Globulin are reimbursed at the same rate as the physician rate since the cost and administration of the drug does not vary between the nurse practitioner and physician.

Refer to Attachment 4.19-B, Item 27, for a list of the nurse practitioner pediatric and obstetrical procedure codes.

- (7) Advanced Practice Nurses Services Associated with UAMS – For additional reimbursement refer to Attachment 4.19-B, item 5.

- (8) Licensed Clinical Social Workers' Services Associated with UAMS – For additional reimbursement refer to Attachment 4.19-B, item 5.

- (9) Physicians' Assistant Services Associated with UAMS – For additional reimbursement refer to Attachment 4.19-B, item 5.

7. Home Health Services

- a. Intermittent or part-time nursing services furnished by a home health agency or a registered nurse when no home health agency exists in the area;
- b. Home health aide services provided by a home health agency; **and**
- c. **Physical therapy**

Reimbursement on basis of amount billed not to exceed the Title XIX (Medicaid) maximum.

The initial computation (effective July 1, 1994) or the Medicaid maximum for home health reimbursement was calculated using audited 1990 Medicare cost reports for three high volume Medicaid providers, Medical Personnel Pool, Arkansas Home Health, W. M. and the Visiting Nurses Association. For each provider, the cost per visit for each home health service listed above in items 7.a., b. **and** c. was established by dividing total allowable costs by total visits. This figure was then inflated by the Home Health Market Basket Index in Federal Register #129, Vol. 58 dated July 8, 1993- inflation factors: 1991 - 105.7%, 1992 - 104.1%, 1993 - 104.8%. The inflated cost per visit was then weighted by the total visits per providers' fiscal year (i.e., the visits reported on the 1990 Medicare cost reports) to arrive at a weighted average visit cost.

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7. Home Health Services (Continued)
a., b. and c. (Continued)

The physical therapy reimbursement rate calculated under this method will be submitted to the United States District Court for the Eastern District of Arkansas (case of Arkansas Medical Society v Reynolds) for its approval.

For registered nurses (RN) and licensed practical nurses (LPN) the Full Time Equivalent Employees (FTEs) listed on cost report worksheet S-1, Part II, were used to allocate nursing costs and units of service (visits). It was necessary to make these allocations because home health agencies are not required by Medicare to separate their registered nurses and licensed practical nurse costs or visits on the annual cost report.

RN and LPN salaries and fringes were separated using an Office of Personnel Management Survey, which indicated that RNs, on an average, are paid 36% more than licensed practical nurses. Conversely, if RNs are paid 36% more than LPNs, then LPNs are paid, on an average, 73.5% of what RNs earn. Cost report salaries and fringes were allocated based on 100% of RN FTEs and 73.5% of LPN FTEs. Other costs and service units (visits) were allocated based on 100% of RN FTEs and 100% of LPN FTEs. RN and LPN unit service (visit) costs were then inflated and weighted as outlined above.

Since home health reimbursement is based on audited costs, the home health rates will be adjusted annually by the Home Health Market Basket Index. This adjustment will occur at the beginning of the State Fiscal Year, July 1. Every third year, the cost per visit will be rebased utilizing the most current audited cost report from the same three providers and using the same formula described above to arrive at a cost per visit inflated through the rebasing year. (The first rebasing will occur in 1996 to be effective July 1, 1997.)

- c. Medical Supplies, Equipment and Appliances Suitable for Use in the Home
(1) Medical Supplies

Effective for dates of service on or after October 1, 1994, medical supplies, for use by patient in their own home - Reimbursement is based on 100% of the Medicare maximum for medical supplies reflected in the 1993 Arkansas Medicare Pricing File not to exceed the Title XIX coverage limitations as specified in Attachment 3.1-A and Attachment 3.1-B, Item 12.c.7.



Arkansas Department of Health and Human Services

Division of Medical Services



P.O. Box 1437, Slot S-295
Little Rock, AR 72203-1437

Fax: 501-682-2480

TDD: 501-682-6789

Internet Website: www.medicaid.state.ar.us

TO: Arkansas Medicaid Health Care Providers – Home Health

DATE: November 1, 2006

SUBJECT: Provider Manual Update Transmittal #82

<u>REMOVE</u>		<u>INSERT</u>	
Section	Date	Section	Date
211.200	10-13-03	211.200	11-1-06
212.000	10-13-03	212.000	11-1-06
212.301	6-1-04	212.301	11-1-06
212.302	6-1-04	212.302	11-1-06
212.310	6-1-04	212.310	11-1-06
212.311	6-1-04	212.311	11-1-06
212.330	6-1-04	212.330	11-1-06
212.340	11-1-05	212.340	11-1-06
212.342	11-1-05	212.342	11-1-06
212.343	11-1-05	212.343	11-1-06
213.200	6-1-04	213.200	11-1-06
231.100	10-13-03	213.100	11-1-06
241.020	12-1-05	241.020	12-1-05
242.130	10-13-03	242.130	11-1-06

The primary purpose of this update transmittal is to restore Home Health physical therapy reimbursement methodology from Medicaid fee schedule per-unit (one unit equals 15 minutes) compensation to fee-schedule *per visit* remuneration, because visit-based costs and charges are integral to the Arkansas Title XIX State Plan’s reimbursement methodology for all other Home Health professional skilled services. Other revisions in this transmittal are to correct minor errors, clarify regulations, replace outdated terminology and to delete obsolete and redundant text.

Explanation of Updates

Section 211.200: This section is included to correct minor errors, clarify regulations, replace outdated terminology and to delete obsolete and redundant text.

Section 212.000: This section is included to correct minor errors, clarify regulations, replace outdated terminology and to delete obsolete and redundant text.

- Section 212.301: This section is included to correct minor errors, clarify regulations, replace outdated terminology and to delete obsolete and redundant text.
- Section 212.302: This section is included to correct minor errors, clarify regulations, replace outdated terminology and to delete obsolete and redundant text.
- Section 212.310: This section is included to clarify the conditions under which physical therapy may be a component of a Home Health plan of care.
- Section 212.311: This section is included to clarify coverage regulations and to reformat certain parts.
- Section 212.330: This section is included for reformatting purposes.
- Section 212.340: This section is included to clarify certain regulations regarding Home Health physical therapy for beneficiaries under age 21.
- Section 212.342: This section is included to clarify rules regarding maintenance physical therapy in the home.
- Section 212.343: This section is included to explicate rules regarding duration of services.
- Section 213.200: This section is included to discuss benefit limits with regard to Home Health physical therapy.
- Section 231.100: This section is one of the most important in this update transmittal, because it describes the revision in reimbursement methodology for Home Health physical therapy that is effective for dates of service on and after July 1, 2006.
- Section 241.120: This section comprises the new billing instructions, effective for dates of service on and after July 1, 2006, for Home Health physical therapy.
- Section 242.130: This section is included to add text inadvertently omitted from previous printings and update transmittals.

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 (TDD only).

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.

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.

Thank you for your participation in the Arkansas Medicaid Program.

Roy Jeffus, Director

211.200 Program Criteria for Home Health Services

11-1-06

- A. A Medicaid beneficiary is eligible for home health services only if he or she has had a comprehensive physical examination and a medical history or history update by his or her PCP or authorized attending physician within the twelve months preceding the beginning date of a new plan of care, the first date of service in an extended benefit period or the beginning date of service in a revised or renewed plan of care.
- B. The appropriateness of home health services is determined by the beneficiary's PCP or authorized attending physician.
1. An individual's PCP or authorized attending physician determines whether the patient needs home health services, the scope and frequency of those services and the duration of the services.
 2. The PCP or authorized attending physician is responsible for coordination of the patient's care, both in-home and outside the home.
- C. An individual may be eligible for home health services when all three of the following conditions exist.
1. The individual is unable to leave home unattended or without supportive devices or assistance.
 - a. The individual's inability to leave home unattended or without supportive devices or assistance makes it impossible or extremely difficult to treat the individual through outpatient services.
 - b. Lack of transportation does not constitute inability to leave home unattended or without supportive devices or assistance.
 2. The part-time and intermittent services or the part-time, short-term services provided by a home health agency can meet the beneficiary's medical needs that would be met through outpatient services if it were possible for the individual to leave home unattended or without supportive devices or assistance.
 3. The only available alternatives to home health services are inpatient admission to a hospital or admission to a nursing facility.
- D. Some examples of individuals for whom home health services may be suitable are those who need:
1. Specialized nursing procedures with regard to catheters or feeding tubes,
 2. Detailed instructions regarding self-care or diet or
 3. Rehabilitative services administered by a physical therapist.
- E. Some beneficiaries may require home health services of very short duration while they or their caregiver receive training enabling them to provide for particular medical needs with little or no assistance from the home health agency.
- F. Some individuals may need only intermittent monitoring or skilled care. When an individual's skilled care is so infrequent that more than 62 days elapse between services, that individual requires a new assessment and a new plan of care for each episode of care, unless the physician documents that the interval without such care is no detriment and appropriate to the treatment of the beneficiary's illness or injury.

212.000 Coverage

11-1-06

Home health in the Arkansas Medicaid Program, when authorized by the client's PCP or authorized attending physician in accordance with the regulations set forth in this manual,

comprises skilled nursing services (including home IV therapy), home health aide services, physical therapy, certain injections, disposable medical supplies and diapers and underpads.

- A. Skilled nursing services of Arkansas state-licensed, registered professional nurses and licensed practical nurses, as defined in the State Nurse Practice Act and this provider manual, are covered.
 - 1. Home IV Therapy is a skilled service, included in the coverage of LPN or RN home health visits.
 - a. The necessary supplies for home IV therapy may be furnished by the home health agency or by a Medicaid Prosthetics Program provider.
 - b. Drugs and biologicals are obtained through the Medicaid Pharmacy Program.
 - 2. Administration of Epogen is a skilled service that is covered separately from the nursing services included in a home visit.
- B. Home health aide services under the supervision of a registered professional nurse are covered. Aides must have current Title XVIII (Medicare) certification, whether the aide is an employee of a home health agency or is working under an arrangement with a home health agency.
- C. Physical therapy furnished by or under the supervision of a qualified, certified physical therapist is covered. Physical therapy assistants must meet or exceed Title XVIII (Medicare) requirements for physical therapy assistants employed by or working under an arrangement with a home health agency.
- D. Disposable medical supplies suitable for use in the home are covered.
- E. Diapers and underpads for incontinence attributable to conditions other than infancy are covered.

212.300 Physical Therapy in the Home Health Program 11-1-06

212.301 A Qualified Physical Therapist in the Home Health Program 11-1-06

- 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 licensed to practice as a physical therapist in Arkansas [42 CFR § 440.110(a)(2)(ii), with proof of the qualified physical therapist's current Arkansas licensure on file with the home health agency.

212.302 A Qualified Physical Therapy Assistant in the Home Health Program 11-1-06

- 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 be licensed by the Arkansas State Board of Physical Therapy, with proof of the qualified physical therapist assistant's current state license 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 11-1-06

Medically necessary physical therapy is covered in the Home Health Program for all ages under the following conditions.

- A. There must be a reasonable expectation that the intervention will result in clinically discernible functional gain(s) or will prevent a worsening of the condition.
- B. The physical therapy treatment plan must be Included in a home health plan of care.
- C. The therapy must be performed 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 11-1-06

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. The physical therapy treatment plan serves as the home health plan of care.
- B. 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.
- C. 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.
- D. The PCP or authorized attending physician must review the treatment plan at the intervals required for home health plans of care.
- E. 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.

212.330 Qualified Physical Therapist Direction of Unlicensed Physical Therapy Students 11-1-06

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

- A. Physical therapy carried out by an unlicensed student must be under the direction of a qualified physical therapist, and the direction must be such that the qualified therapist is considered to be providing the physical therapy.
- B. To qualify as the performing provider, the qualified therapist must be present and engaged in observing and supervising the student during the entire physical therapy encounter.

212.340 Frequency, Intensity and Duration of Physical Therapy Services for Beneficiaries Under the Age of 21 11-1-06

- A. Frequency, intensity and duration of physical therapy services must be medically necessary and appropriate to the age of the patient and the severity of the deficit or disorder.
- B. Therapy may be indicated if there is a reasonable expectation that the intervention will result in clinically measurable functional gain(s) or will prevent a worsening of the condition.

212.342 Maintenance Therapy 11-1-06

- A. Services that are performed primarily to maintain range of motion or to provide positioning services for the patient do not qualify as physical therapy services.
- B. Such maintenance services can be provided to the child as part of a home program administered by the child's caregivers and do not require the skilled services of a physical therapist in order to be performed safely and effectively.

212.343 Duration of Services 11-1-06

- A. Therapy services should be provided as long as objectively measured progress is made toward established goals.
- B. 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.

213.200 Physical Therapy Benefit Limit 11-1-06

Home health physical therapy is limited to one visit per day for beneficiaries of all ages, but there is no weekly, monthly or annual limit on the number of prescribed, medically necessary home health physical therapy visits that a beneficiary aged 21 or older may receive.

- A. 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.
- B. Home health physical therapy for beneficiaries under the age of 21 is subject to additional requirements.

230.000 REIMBURSEMENT 11-1-06**231.000 Method of Reimbursement 11-1-06**

- A. Medicaid reimbursement for home health services is by fee schedule, at the lesser of the amount billed or the Title XIX (Medicaid) maximum fee.
- B. The Arkansas Medicaid Program reimburses providers for administration of covered injections by fee schedule, at the lesser of the amount billed or the Title XIX (Medicaid) maximum fee.
- C. The Arkansas Medicaid Program reimburses providers by the visit for nursing services, aide services and physical therapy.
- D. The Arkansas Medicaid Program reimburses providers by fee schedule, at the lesser of the amount billed or the Title XIX (Medicaid) maximum fee per covered item, for disposable medical supplies, diapers and underpads.

242.120 Home Health Physical Therapy 11-1-06

Procedure Code	Modifier	Description
S9131		Home Health Physical Therapy by a Qualified Licensed Physical Therapist
S9131	UB	Home Health Physical Therapy by a Qualified Physical Therapy Assistant

242.130 Specimen Collection

11-1-06

Procedure Codes

36415 P9612

- A. Venipuncture (drawing blood to obtain a blood sample) and catheterization to collect urine specimens are excluded from the eligibility criteria for intermittent skilled nursing services under the home health benefit.
- B. When venipuncture to obtain a blood sample or catheterization to collect a urine specimen is the only skilled service that is needed by the patient, that individual does not qualify for skilled services.