



KANSAS MEDICAL ASSISTANCE PROGRAM
Fee-for-Service Provider Manual

Home Health Agency

PART II
HOME HEALTH AGENCY FEE-FOR-SERVICE PROVIDER MANUAL

Introduction

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FORMS All forms pertaining to this provider manual can be found on the [public](#) website and on the [secure](#) website under Pricing and Limitations.

DISCLAIMER: This manual and all related materials are for the traditional Medicaid fee-for-service program only. For provider resources available through the KanCare managed care organizations, reference the [KanCare](#) website. Contact the specific health plan for managed care assistance.

PART II
HOME HEALTH FEE-FOR-SERVICE AGENCY PROVIDER MANUAL

Updated 06/12

This is the provider specific section of the manual. This section (Part II) was designed to provide information and instructions specific to home health agency providers. It is divided into three subsections: Billing Instructions, Benefits and Limitations, and Appendix.

The **Billing Instructions** subsection gives information regarding the billing form applicable to home health agency services.

The **Benefits and Limitations** subsection defines specific aspects of the scope of home health agency services allowed within the Kansas Medical Assistance Program (KMAP).

The **Appendix** subsection contains information concerning codes. These appendices were developed to make finding and using codes easier for the biller.

HIPAA Compliance

As a KMAP participant, providers are required to comply with compliance reviews and complaint investigations conducted by the Secretary of the Department of Health and Human Services as part of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with section 45 of the code of regulations parts 160 and 164. Providers are required to furnish the Department of Health and Human Services all information required by the Department during its review and investigation. The provider is required to provide the same forms of access to records to the Medicaid Fraud and Abuse Division of the Kansas Attorney General's Office upon request from such office as required by K.S.A. 21-3853 and amendments thereto.

A provider who receives such a request for access to or inspection of documents and records must promptly and reasonably comply with access to the records and facility at reasonable times and places. A provider must not obstruct any audit, review, or investigation, including the relevant questioning of the provider's employees. The provider shall not charge a fee for retrieving and copying documents and records related to compliance reviews and complaint investigations.

7000. HOME HEALTH AGENCY BILLING INSTRUCTIONS Updated 06/13

Introduction to the CMS-1500 Claim Form

Home health agency providers must use the CMS-1500 ~~claim form (unless submitting electronically)~~ when requesting payment for medical services and supplies provided under KMAP. Claims can be submitted on the KMAP secure website or billed through Provider Electronic Solutions (PES). When a paper form is required, it must be submitted on an original red claim form and completed as indicated. Any CMS-1500 claim not submitted on the red claim form will be returned to the provider.

An example of the CMS-1500 claim form and corresponding instructions are on the KMAP [public](#) and [secure](#) websites on the [Forms](#) page under the Claims (Sample Forms) heading.

The Kansas MMIS will be using electronic imaging and optical character recognition (OCR) equipment. Therefore, information will not be recognized if not submitted in the correct fields as instructed.

The fiscal agent does not furnish the CMS-1500 claim form to providers. ~~Refer to Section 1100 of the General Introduction Provider Manual.~~

SUBMISSION OF CLAIM

Send completed first page of each claim and any necessary attachments to:
Office of the Fiscal Agent
P.O. Box 3571
Topeka, KS 66601-3571

7010. HOME HEALTH AGENCY BILLING INFORMATION Updated 06/11

Enteral Supplies

Add modifier BO to the base code (XXXXX-BO) and place in field 24D when billing for oral supplemental nutrition.

Immunization Administration

Providers must bill the appropriate administration code in addition to the vaccine and toxoid code for each dose administered. Refer to Appendix I for a complete list of administration and vaccine procedure codes billable to KMAP. Reimbursement of *CPT*[®] codes for vaccines covered under the Vaccines for Children (VFC) program will not be allowed.

PACS software requires a charge on each line item being submitted. Providers billing electronically through the PACS system will need to indicate a charge of \$1 on the line for the vaccine/toxoid code. The MMIS system will deny the service even though a charge was submitted.

Parenteral Supplies

Add modifier BA to the base code (XXXXX-BA) and place in field 24D when billing for item supplies in conjunction with total parenteral nutrition.

BENEFITS AND LIMITATIONS

8100. COPAYMENT Updated 11/03

Home health services require a copayment of \$3 per skilled nursing visit.

Do **not** reduce charges or balance due by copayment amount. This reduction will be made automatically.

Medical supplies require no copayment.

BENEFITS AND LIMITATIONS

8300. Benefit Plans Updated 09/13

Beneficiaries are assigned to one or more medical assistance benefit plans. These benefit plans entitle the beneficiary to certain services. If there are questions about service coverage for a given benefit plan, refer to Section 2000 of the *General Benefits Fee-for-Service Provider Manual* for information on the plastic State of Kansas Medical Card and eligibility verification.

For example, home health services with limitations on durable medical equipment and supplies are covered for MediKan beneficiaries when medically necessary and a physician has established a treatment plan and certified the need for the service. Refer to Section 8400 in this manual.

Providers billing KMAP for home health agency services rendered to Medicare-eligible beneficiaries must either bill Medicare first and obtain a denial or use the GY (statutorily excluded) modifier to bypass the Medicare-denial requirement. The GY modifier may only be used if the beneficiary has a Medicaid-covered benefit plan.

Providers can bill KMAP for services rendered to a dually eligible beneficiary if the beneficiary is not “homebound.” Dually eligible beneficiaries have both Medicare and Medicaid coverage.

A beneficiary will be considered homebound if he or she has a condition due to an illness or injury which restricts his or her ability to leave the home without assistance. The beneficiary is dependent on the aid of supportive devices such as crutches, canes, wheelchairs and walkers, the use of special transportation, or the assistance of another person. A beneficiary is also considered homebound if his or her condition is such that leaving the home is medically contraindicated.

If a beneficiary is a qualified Medicare beneficiary (QMB) but does not meet eligibility for Medicaid coverage, **providers cannot bill KMAP for home health agency services rendered.** The beneficiary must have a Medicaid-covered benefit plan such as TXIX in addition to Medicare coverage to be eligible for fee-for-service home health visits.

Medical assistance benefits are provided through the Medicare program for QMBs. Medicaid will consider payment for Medicare coinsurance and deductible amounts only. If providers bill KMAP for home health agency services rendered to QMB-only beneficiaries, the money will be recouped.

BENEFITS AND LIMITATIONS

8400. MEDICAID Updated 09/13

Advance Directives

Home health providers participating in KMAP must comply with federal legislation (OBRA 1990, Sections 4206 and 4751) concerning advance directives. An "advance directive" is otherwise known as a living will or durable power of attorney. Every home health provider must maintain written policies, procedures and materials about advance directives.

Specific Requirements

1. Each home health agency must provide written information to every adult individual receiving medical care by or through the home health agency. This information must contain:
 - a. The individual's right to make decisions concerning his or her own medical care
 - b. The individual's right to accept or refuse medical or surgical treatment
 - c. The individual's right to make advanced directives
 - d. The Department of Social and Rehabilitation Services "Description of the Law of Kansas Concerning Advance Directives"

Note: **SRS** does not provide copies of the description to providers. It is up to providers to reproduce the description. Providers are free to supplement this description as long as they do not misstate Kansas law.
2. Additionally, each home health agency must provide written information to every adult individual about the home health agency's policy on implementing these rights.
3. A home health agency must document in every individual's medical record whether the individual has executed an advance directive.
4. A home health agency may not place any conditions on health care or otherwise discriminate against an individual based upon whether that individual has executed an advance directive.
5. Each home health agency must comply with State law about advance directives.
6. Each home health agency must provide for educating staff and the community about advance directives. This may be accomplished by brochures, newsletters, articles in the local newspapers, local news reports or commercials.

Incapacitated Individuals

An individual may be admitted to a facility in a comatose or otherwise incapacitated state, and be unable to receive information or articulate whether he or she has executed an advance directive. If this is the case, families of, surrogates for, other concerned persons of the incapacitated individual must be given the information about advance directives. If the incapacitated individual is restored to capacity, the home health agency must provide the information about advance directives directly to him or her even though the family, surrogate or other concerned person received the information initially.

If an individual is incapacitated, otherwise unable to receive information or articulate whether he or she has executed an advance directive, the home health agency must note this in the medical record.

8400. Updated 06/12

Mandatory Compliance with the Terms of the Advanced Directive

When a patient, relative, surrogate or other concerned/related person presents a copy of the individual's advance directive to the home health agency, the home health agency must comply with the terms of the advance directive to the extent allowed under State law. This includes recognizing powers of attorney.

DESCRIPTION OF THE LAW OF KANSAS CONCERNING ADVANCE DIRECTIVES

There are two types of "advance directives" in Kansas. One is commonly called a "living will" and the second is called a "durable power of attorney for health care decisions."

The Kansas Natural Death Act, K.S.A. 65-28,101, et seq.

This law provides that adult persons have the fundamental right to control decisions relating to their own medical care. This right to control medical care includes the right to withhold life-sustaining treatment in case of a terminal condition.

Any adult may make a declaration which would direct the withholding of life-sustaining treatment in case of a terminal condition. Some people call this declaration a "living will".

The declaration must be:

1. In writing
2. Signed by the adult making the declaration
3. Dated
4. Signed in front of two adult witnesses or notarized

There are specific rules set out in the law about the signature in case of an adult who can't write. There are specific rules about the adult witnesses. Relatives by blood or marriage, heirs, or people who are responsible for paying for the medical care may *not* serve as witnesses. A declaration has no effect during pregnancy.

The declaration may be revoked in three ways:

1. By destroying the declaration
2. By signing and dating a written revocation
3. By speaking an intent to revoke in front of an adult witness

Note: The witness must sign and date a written statement that the declaration was revoked.

Before the declaration becomes effective, two physicians must examine the patient and diagnose that the patient has a terminal condition.

The desires of a patient shall at all times supersede the declaration. If a patient is incompetent, the declaration will be presumed to be valid.

The Kansas Natural Death Act imposes duties on physicians and provides penalties for violations of the laws about declarations.

8400. Updated 11/03

**The Kansas Durable Power of Attorney for Health Care Decisions Law,
K.S.A. 58-625, et seq.**

A "durable power of attorney for health care decisions" (Power) is a written document in which an adult gives another adult (called an "agent") the right to make health care decisions. The Power applies to health care decisions even when the adult is not in a terminal condition.

The adult may give the agent the power to:

1. Consent or to refuse consent to medical treatment
2. Make decisions about donating organs, autopsies, and disposition of the body
3. Make arrangements for hospital, nursing home, or hospice care
4. Hire or fire physicians and other health care professionals
5. Sign releases and receive any information about the adult

A Power may give the agent all those five powers or may choose only some of the powers. The Power may *not* give the agent the power to revoke the adult's declaration under the Kansas Natural Death Act ("living will"). The Power only takes effect when the adult is disabled unless the adult specifies that the Power should take effect earlier.

The adult may *not* make a health care provider treating the adult the agent except in limited circumstances.

The Power may be made by two methods:

- In writing
- Signed by the adult making the declaration
- Dated
- Signed in front of two adult witnesses

OR

- Written and notarized

Relatives by blood or marriage, heirs, or people who are responsible for paying for the medical care may *not* serve as witnesses.

The adult, at the time the Power is written, should specify how the Power may be revoked.

The Patient Self-Determination Act, Section 1902(w) of the Social Security Act

This federal law, codified at 42 U.S.C. Sec. 1396a(w), was effective December 1, 1991. It applies to all Medicaid and Medicare hospitals, nursing facilities, home health agencies, hospices, and prepaid health care organizations. It requires these organizations to take certain actions about a patient's right to decide about health care and to make advance directives.

This law also required that each state develop a written description of the State law about advance directives. This description was written by the Health Care Policy Section of the Kansas Department of Social and Rehabilitation Services to comply with that requirement. If you have any questions about your rights to decide about health care and to make advance directives, please consult with your physician or attorney.

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KANSAS MEDICAL ASSISTANCE PROGRAM
HOME HEALTH AGENCY FEE-FOR-SERVICE PROVIDER MANUAL
BENEFITS & LIMITATIONS

8400. Updated 02/10

Communication with Physicians

The Home Health Agency health care team must communicate with the physician in an effort to coordinate appropriate, adequate, effective, and efficient care for the beneficiary.

Documentation

Home Health Agency services must meet the following criteria to be considered **medically necessary**:

- **Appropriate**
 - Needed service for the beneficiary without undermining the beneficiary's independence and initiative
 - Promote safe and professionally accepted practices
- **Adequate**
 - Sufficient service to meet the needs of the beneficiary while encouraging independence
- **Effective**
 - Documented progress towards achieving individualized long- and short-term goals
- **Efficient**
 - Dollars, time and staff used in a productive manner
 - Does not duplicate other resources
 - Family and other support systems used and enhanced

Documentation in the patient's medical record must support the service(s) billed. Home health nursing documentation must provide a "total picture" of the patient and surroundings by identifying the current reason for providing home health care and the patient's need for continuance of care **or** progress toward discharge.

Note: Documentation must specifically address the primary diagnosis for which home health services are prescribed.

Proper documentation need not appear in any specific format in the patient's record but **must** include the following:

- **Initial Assessment**
 - Date and signature of registered nurse (RN)
 - Review of systems
 - Family and other support system structure
 - Pertinent past and present medical history with approximate date of diagnoses
 - Other community resources available for care
 - Patient's environment
- **Care Plan**
 - Initiated and dated by RN
 - Individualized, follows from assessment
 - Reviewed at least every 60 days and updated as indicated
 - Documented utilization of available resources, family or other support systems
 - Discharge plan, identification of expected goals or outcomes

Providers can use the HCFA-485 Home Health Certification and Plan of Care in lieu of a separate plan of care. A copy of the completed HCFA-485 form must be retained in the patient's medical record.

8400. Updated 06/12

Documentation of Visits

Home health visits must be documented in the patient's medical record. Documentation shall consist of the following:

- Length of visit, including start and stop times
- Date and signature of individual making the visit
- Care plan with notations of deviations
- Purpose of visit/documentation of services performed

Note: If a skilled nursing visit is performed, documentation should include:

- Patient condition and response to care
- Progress toward goals

Residence – A person's residence is wherever he or she makes his or her home. This may be his or her own dwelling, an apartment, or a relative/caretaker's home but does not include hospitals, skilled nursing facilities, or intermediate care facilities for mental retardation (ICF/MRs).

The following home health services are noncovered:

- Any services determined not to be medically necessary
- Homemaker/chore services
- Medical social work services

DME Purchase/Rental

All durable medical equipment (DME) services are covered for in-home use only. DME services (purchase or rental) are noncovered in nursing facilities, swing bed facilities, state institutions, ICF/MRs, psychiatric residential treatment facilities (PRTFs), head injury (HI) facilities, rehabilitation facilities, and hospitals.

Note: If the facility receives a per diem rate for a beneficiary, the DME services are considered content of the per diem and are the responsibility of the facility.

Manually Priced Items

- KMAP requires providers to follow current policy for DME and prosthetics and orthotics (P&O).
- Current policy requires DME and P&O to be priced at the lesser of 1, 2, or 3:
 - Set Medicaid rate
 - Providers cost plus 35 percent
 - Manufacturer suggested retail price (MSRP) minus 20 percent
- All DME and P&O prior authorization (PA) requests must be accompanied by an official MSRP.
- Providers actual cost and MSRP must be submitted with each PA request on all manually priced DME/P&O items and codes. This must be submitted at the same time as the PA request. All documents submitted must be free of any altering, covering up, or blacking out of information, except to maintain HIPAA requirements.

8400. Updated 05/10

- All MSRPs must be official from the manufacturer. No handwritten MSRPs are allowed. MSRPs cannot be altered or blacked out in any way except to maintain HIPAA requirements. For example, a Medicare explanation of benefits (EOB) can have multiple Medicare beneficiaries information listed on the same sheet.
- Provider's cost is the actual cost the provider paid for the item. Any discounts the provider receives must also be submitted. An official invoice from the supplier/manufacturer must be supplied. Handwritten or DME provider-manipulated invoices are not allowed. Invoices cannot be blacked out or altered in any way except to maintain HIPAA requirements.
- If an item is bought in bulk (or more than one at a time), the invoice showing the provider's actual cost and the number of units purchased must be submitted (per unit cost will be calculated).
- Costs of doing business (such as, employee's time, travel time and expenses, or office expenses) cannot be included in provider's cost.

Note: All wheelchairs, wheelchair accessories, wheelchair repairs, and covered specialty walkers are exempt from this requirement. These items will be paid at 75% of MSRP or the current Medicaid rate. Provider cost will not be required with each PA request.

Breast Pumps

- Codes E0602 and E0603 are covered for all female beneficiaries ages 10 through 65. Breast pumps are limited to a combined total of no more than one pump every year. The prescription written by a physician must be kept in the beneficiary's file.
- The following breast pump replacement parts are limited to no more than two of each per year: A4281, A4282, A4283, A4285 and A4286.
- Noncovered breast pumps and accessories: E0604 and A4284

Dressings and Supplies

- Dressings and supplies are content of service for all nursing facilities, HI facilities, rehab facilities, clinics, offices, and hospitals. They are only allowed for place of service 12 (home).
- Dressings are covered when either of the following criteria is met:
 - They are required for the treatment of a wound.
 - They are required after debridement of a wound.
- Dressings are noncovered for the following:
 - Drainage from a cutaneous fistula which has not been caused by or treated by a surgical procedure
 - Stage 1 pressure ulcer
 - First degree burn
 - Wounds caused by trauma which do not require surgical closure or debridement (skin tear or abrasion)

8400. Updated 05/10

- Venipuncture or arterial puncture site (blood sample) other than the site of an indwelling catheter or needle
- Silicone gel sheets used for the treatment of keloids or other scars
- Dressings include:
 - Primary dressings: therapeutic or protective coverings applied directly to wounds or lesions either on the skin or caused by an opening to the skin.
 - Secondary dressings: materials that serve a therapeutic or protective function and are needed to secure a primary dressing.
- Debridement of a wound may be any type:
 - Surgical (sharp instrument or laser)
 - Mechanical (irrigation or wet-to-dry dressings)
 - Chemical (topical application of enzymes)
 - Autolytic (application of occlusive dressings to an open wound)
- Products containing multiple materials are categorized according to the clinically predominant component (alginate, collagen, foam, gauze, hydrocolloid, hydrogel). Other multicomponent wound dressings not containing these specified components may be classified as composite or specialty absorptive dressings if the definition of these categories has been met. Multicomponent products may not be unbundled and billed as the separate components of the dressing.
- For all dressings, if a single dressing is divided into multiple portion/pieces, the code and quantity billed must represent the originally manufactured size and quantity.
- Modifiers A1-A9 indicate that a particular item is being used as a primary or secondary dressing on a surgical or debrided wound and also to indicate the number of wounds on which that dressing is being used. The modifier number must correspond to the number of wounds on which the dressing is being used, not the total number of wounds treated. Modifiers A1-A9 are used for informational purposes and are not required.
- Surgical dressings are covered for as long as they are medically necessary. Dressings over a percutaneous catheter or tube are covered as long as the catheter or tube remains in place and after removal until the wound heals.
- Dressing size must be based on and appropriate to the size of the wound. For wound covers, the pad size is usually about two inches greater than the dimensions of the wound. For example, a five cm. x five cm. (two in. x two in.) wound requires a four in. x four in. pad size.
- The quantity and type of dressings dispensed at any one time must take into account the current status of the wound, the likelihood of change, and the recent use of dressings.

8400. Updated 05/10

- Dressing needs may change frequently in the early phases of wound treatment with heavily draining wounds. Suppliers are expected to have a mechanism for determining the quantity of dressing that the patient is actually using and to adjust their provision of dressings accordingly. No more than a one month's supply of dressings may be provided at one time.
- Dressings must be tailored to the specific needs of an individual patient. When dressings are provided in kits, only those components of the kit that meet the definition of a dressing, that are ordered by the physician, and that are medically necessary are covered.
- It may not be appropriate to use some combinations of a hydrating dressing on the same wound at the same time as an absorptive dressing. Because composite dressings, foam wound covers, hydrocolloid wound covers, and transparent film, when used as a secondary dressing, are meant to be changed at frequencies less than daily, appropriate clinical judgment should be used to avoid their use with primary dressings which require more frequent dressing changes. While a highly exudative wound might require such a combination initially, with continued proper management, the wound usually progresses to a point where the appropriate selection of these products results in the less frequent dressing changes which they are designed to allow. An example of an inappropriate combination is the use of a specialty absorptive dressing on top of nonimpregnated gauze being used as a primary dressing.

ALGINATE DRESSINGS

- Codes A6196 through A6199 are covered for:
 - Moderately to highly exudative full thickness wounds (stage III or IV ulcers)
 - Alginate or other fiber gelling dressing fillers for moderately to highly exudative full thickness wound cavities (stage III or IV ulcers)
- Alginate or other fiber gelling dressing covers are not medically necessary on dry wounds or wounds covered with eschar. Usual dressing change is up to once per day. One wound cover sheet of the approximate size of the wound or up to two units of wound filler (one unit equals six inches of alginate or other fiber gelling dressing rope) is usually used at each dressing change. It is usually inappropriate to use alginates or other fiber gelling dressings in combination with hydrogels. The medical necessity for more frequent change of dressing must be documented.

COMPOSITE DRESSINGS

- Composite dressings are products combining physically distinct components into a single dressing that provides multiple functions. These functions must include, but are not limited to:
 - A bacterial barrier
 - An absorptive layer other than an alginate or other fiber gelling dressing, foam, hydrocolloid, or hydrogel
 - A semi-adherent or nonadherent property over the wound site
- Codes A6203-A6205
Usual composite dressing change is up to three times per week, one wound cover per dressing change. The medical necessity for more frequent change of dressing must be documented.

8400. Updated 05/10

COMPRESSION BANDAGES

- All of these bandages are noncovered when used for strains, sprains, edema, or situations other than as a dressing for a wound.
- Light compression bandages, self-adherent bandages, and conforming bandages are covered when they are used to hold wound cover dressings in place over any wound type.
- Moderate or high compression bandages, conforming bandages, self-adherent bandages, and padding bandages are covered when they are part of a multilayer compression bandage system used in the treatment of a venous stasis ulcer.
- Elastic bandages are those that contain fibers of rubber (latex, neoprene), spandex, or elastane. Roll bandages that do not contain these fibers are considered nonelastic bandages even though many of them (such as gauze bandages) are stretchable.
- Codes A6442 through A6447 describe roll gauze-type bandages made either of cotton or of synthetic materials such as nylon, viscose, polyester, rayon, or polyamide. These bandages are stretchable, but do not contain elastic fibers. These codes include short-stretch bandages.
- Codes A6448 through A6450 describe ACE-type elastic bandages.
- Codes A6451 and A6452 describe elastic bandages that produce moderate or high compression that is sustained typically for one week. They are commonly included in multilayer compression bandage systems.
- Suppliers billing these codes must be able to provide documentation from the manufacturer verifying that the performance characteristics specified in the code narratives have been met.
- When multilayer compression bandage systems are used for the treatment of a venous stasis ulcer, each component is billed using a specific code for the component: A6451, A6452, A6443, A6444, A6454, A6441 or A6456.
- Most compression bandages are reusable. Usual frequency of replacement would be no more than one per week unless they are part of a multilayer compression bandage system. The medical necessity for more frequent change of dressing must be documented.
- Conforming bandage dressing change is determined by the frequency of change of the selected underlying dressing.

CONTACT LAYER DRESSINGS

- Contact layers are thin, nonadherent sheets placed directly on an open wound bed to protect the wound tissue from direct contact with other agents or dressings applied to the wound. They are porous to allow wound fluid to pass through for absorption by an overlying dressing.

8400. Updated 05/10

- Contact layer dressings are used to line the entire wound. They are not intended to be changed with each dressing change. Usual dressing change is up to once per week. The medical necessity for contact layer dressings must be documented and submitted with each PA request. Further medical justification must be submitted for more frequent dressing changes.

FOAM DRESSINGS

Codes A6209-A6215

- Foam dressings are covered when used on full thickness wounds (stage III or IV ulcers) with moderate to heavy exudates.
- Usual dressing change for a foam wound cover used as a primary dressing is up to three times per week. When a foam wound cover is used as a secondary dressing for a wound with very heavy exudates, dressing change may be up to three times per week.
- Usual dressing change for foam wound fillers is up to once per day. The medical necessity for more frequent change of dressing must be documented.

GAUZE DRESSINGS

- Impregnated gauze dressings are woven or nonwoven materials into which substances such as iodinated agents, petrolatum, zinc paste, crystalline sodium chloride, chlorhexadine gluconate, bismuth tribromophenate, water, aqueous saline, hydrogel, or other agents have been incorporated into the dressing material by the manufacturer.
- Codes A6216-A6221, A6402-A6404, A6407
Usual nonimpregnated gauze dressing change is up to three times per day for a dressing without a border and once per day for a dressing with a border. It is usually not necessary to stack more than two gauze pads on top of each other in any one area. The medical necessity for more frequent change of dressing must be documented.
- Codes A6222-A6224, A6266
Usual dressing change for gauze dressings impregnated with other than water, normal saline, or hydrogel is up to once per day. The medical necessity for more frequent change of dressing must be documented.
- Codes A6228-A6230
Usual dressing change for gauze dressings impregnated with water or normal saline is up to once per day. The medical necessity for more frequent change of dressing must be documented.
- Gauze or gauze-like products are typically manufactured as a single piece of material folded into a multi-ply gauze pad. Coding must be based on the functional size of the pad as it is commonly used in clinical practice.

GLOVES (NONSTERILE)

Code A4927: PA required.

8400. Updated 11/09

- Nonsterile gloves are covered for patient or family use if the patient is currently infected with MRSA or VRE. A culture (C&S) performed within 30 days of the request must be submitted with each PA request. Upon each renewal, a new culture (C&S) performed within 30 days of the request must be submitted. This new culture must document current MRSA or VRE infection. Once the beneficiary no longer shows current MRSA or VRE infection, nonsterile gloves are noncovered.
- Nonsterile gloves for use by home health staff, home and community based services (HCBS) staff, or staff from any other paid company are considered content of service and will not be paid separately. Nonsterile gloves allowed for patient or family use may not be used by paid staff.
- Nonsterile gloves are limited to no more than one box (100 gloves) every three months.

HYDROCOLLOID DRESSINGS

Codes A6234-A6241

- Hydrocolloid dressings are covered for use on wounds with light to moderate exudates.
- Usual dressing change for hydrocolloid wound covers or hydrocolloid wound fillers is up to three times per week. The medical necessity for more frequent change of dressing must be documented.

HYDROGEL DRESSINGS

Codes A6231-A6233 and A6242-A6248

- Hydrogel dressings are covered when used on full thickness wounds with minimal or no exudates (stage III or IV ulcers).
- Hydrogel dressings are not usually medically necessary for stage II ulcers. Documentation must substantiate the medical necessity for use of hydrogel dressings for stage II ulcers (location of ulcer is sacro-coccygeal area).
- Usual dressing change for hydrogel wound covers without adhesive border or hydrogel wound fillers is up to once per day. Usual dressing change for hydrogel wound covers with adhesive border is up to three times per week. The medical necessity for more frequent change of dressing must be documented.
- The quantity of hydrogel filler used for each wound must not exceed the amount needed to line the surface of the wound. Additional amounts used to fill a cavity are not medically necessary.
- Documentation must substantiate the medical necessity for code A6248 billed in excess of three units (fluid ounces) per wound in 30 days.
- Use of more than one type of hydrogel dressing (filler, cover, or impregnated gauze) on the same wound at the same time is not medically necessary.

8400. Updated 11/09

SPECIALTY ABSORPTIVE DRESSINGS

- Specialty absorptive dressings are unitized multilayer dressings which provide:
 - A semi-adherent quality or nonadherent layer
 - Highly absorptive layers of fibers such as absorbent cellulose, cotton, or rayon
- These may or may not have an adhesive border.
- Codes A6251-A6256:
Specialty absorptive dressings are covered when used for moderately or highly exudative wounds (stage III or IV ulcers). Usual specialty absorptive dressing change is up to once per day for a dressing without an adhesive border and up to every other day for a dressing with a border. The medical necessity for more frequent change of dressing must be documented.

TAPE

Codes A4450 and A4452

- Tape is covered when needed to hold on a wound cover, elastic roll gauze, or nonelastic roll gauze. Additional tape is usually not required when a wound cover with an adhesive border is used. The medical necessity for tape in these situations must be documented.
- Tape change is determined by the frequency of change of the wound cover. Quantities of tape submitted must reasonably reflect the size of the wound cover being secured.
- Usual use for wound covers measuring 16 square inches or less is up to two units per dressing change; for wound covers measuring 16 to 48 square inches, up to three units per dressing change; for wound covers measuring greater than 48 square inches, up to four units per dressing change.

TRANSPARENT DRESSINGS

Codes A6257-A6259

- Transparent film dressings are covered when used for an open, partial-thickness wound with minimal exudates or closed wounds.
- Usual dressing change is up to three times per week. The medical necessity for more frequent change of dressing must be documented.

TUBULAR DRESSINGS

Code K0620 may be used to bill for either an elastic or nonelastic tubular dressing.

WOUND COVERS

- Wound covers are flat dressing pads. A wound cover with adhesive border is one which has an integrated cover and distinct adhesive border designed to adhere tightly to the skin.
- Some wound covers are available both without and with an adhesive border. For wound covers with an adhesive border, the code to be used is determined by the pad size, not by the outside adhesive border dimensions.

8400. Updated 11/09

- When a wound cover with an adhesive border is being used, no other dressing is needed on top of it and additional tape is usually not required. Reasons for use of additional tape must be well documented. An adhesive border is usually more binding than that obtained with separate taping and is therefore indicated for use with wounds requiring less frequent dressing changes.

WOUND FILLERS

- Wound fillers are dressing materials which are placed into open wounds to eliminate dead space, absorb exudates, or maintain a moist wound surface.
- Wound fillers come in hydrated forms (pastes, gels), dry forms (powder, granules, beads), or other forms such as rope, spiral, and pillows. Wound fillers not falling into any of these categories are noncovered.
- The units of service for wound fillers are one gram, one fluid ounce, six-inch length, or one yard depending on the product. If the individual product is packaged as a fraction of a unit, determine the units billed by multiplying the number of dispensed items by the individual product size and rounding to the nearest whole number.
- For some wound fillers, the units on the package do not correspond to the units of the code. For example, some pastes or gels are labeled as grams (instead of fluid ounces); some wound fillers are labeled as cc or ml (instead of fluid ounces or grams); some are described by linear dimensions (instead of grams). In these situations, the supplier must contact the manufacturer to determine the appropriate conversion factor or unit of service which corresponds to the code.
- Use of more than one type of wound filler or more than one type of wound cover in a single wound is rarely medically necessary, and the reasons must be well documented.

WOUND POUCH

Code A6154:

Limited to 12 units per 30 days. A wound pouch is a waterproof, collection device with a drainable port that adheres to the skin around a wound.

Enteral Nutrition

Modifiers

Modifier BO is required when applicable for oral supplemental nutrition.

General Requirements

All enteral nutrition, pumps, and miscellaneous supplies must be prescribed. Providers must maintain a copy of the prescription in the beneficiary's file. Nutrients and supply items are to be billed for quantities expected to supply the beneficiary for no more than one month.

Enteral Nutritional Products

PA must be obtained for all enteral nutritional products provided to non-KAN Be Healthy (KBH) beneficiaries.

8400. Updated 06/12

Any new or existing enteral nutritional product that has been reviewed by CMS and assigned a HCPC code may be covered when the beneficiary meets criteria. The provider must identify the CMS-assigned procedure code when requesting a PA. Enteral nutritional products that have not been reviewed by CMS and assigned a procedure code are considered noncovered. KBH-eligible beneficiaries must determine WIC eligibility before obtaining enteral nutrition from KMAP. If the beneficiary is eligible for WIC, enteral nutrition must be obtained from WIC services before obtaining from KMAP. Enteral nutrition products provided to KBH eligible beneficiaries do not require PA.

Food Thickener

Food thickener requires PA for all beneficiaries.

Oral Supplementation

- Oral supplemental nutrition is covered for KBH-eligible beneficiaries who require supplemental nutrition over and above normal daily nutrition due to medical conditions. Normal daily nutrition is not considered supplemental and is noncovered.
- Oral supplemental nutrition is noncovered for non-KBH beneficiaries. Extreme medical cases in which a beneficiary is in immediate life-threatening jeopardy may be reviewed for coverage.

Enteral Supplies

- Enteral supplies that have an assigned HCPC code must be requested under the appropriate code. Enteral supplies that do not have an assigned HCPC code may be covered under B9998 with PA. B9998 requires PA for all ages.

Note: PA must be obtained for all enteral supplies provided to non-KBH beneficiaries with the exception of B4087 and B4088.

- Button G-Tubes are covered under B4087 and B4088 up to a combined total of six per year without PA.
- Extension sets are covered with PA under B9998 up to a maximum of four per month.
- Enteral feeding supply kits are limited to one per day. Providers may dispense one month supply at a time. An individual 60cc syringe is not considered a feeding supply kit and may not be billed as such. If supplying an individual 60cc syringe, PA must be requested under B9998.
- Nasogastric tubing, with or without stylet or a combination of the two, are limited to a combined total of three tubes per 90 days, regardless of provider.
- Stomach and gastrostomy tubing are limited to a combined total of six per year, regardless of provider.
- Haberman Feeders for cleft lip/palate are covered for KBH beneficiaries. They are limited to two per six months and require PA at all times.

8400. Updated 11/09

- Individual 60 cc syringes may be covered under B9998 with PA up to a maximum of four per month.

Home Blood Glucose Monitors and Supplies

- Home blood glucose monitors and supplies are covered for insulin-treated diabetes (Type I) and noninsulin-treated diabetes (Type II). PA is required on voice-synthesized monitors and reusable pens. For regular monitors and other supplies, PA is not required unless the request exceeds the covered limits. For requests over the limits covered by KMAP, a PA must be obtained. All types of home blood glucose monitors are limited to one device every two years per beneficiary (no matter what kind).
- Modifier KX must be used if the beneficiary is insulin treated (insulin-dependent diabetic). Modifier KS must be used if the beneficiary is not insulin treated (noninsulin-dependent diabetic). Modifiers KX and KS cannot be billed together on each detail line. If no modifier is included, the claim will deny.
- Code E2100 requires PA and is allowed only for beneficiaries with a severe visual impairment defined as a best corrected visual acuity of 20/200 or worse.
- Insulin delivery devices (reusable pens) are covered with a limit of 1.5 ml or 3 ml size per year. The beneficiary must have impaired visual acuity of 20/200 or worse and/or severely impaired manual dexterity. Medical necessity must show why the beneficiary cannot use a multidose vial, and the beneficiary must not have home health visits for the purpose of filling insulin syringes.
- The following devices are noncovered by KMAP:
 - Replacement battery, any type, for use with medically necessary home blood glucose monitor owned by beneficiary
 - Replacement lens shield cartridge for use with laser skin piercing device
 - Blood glucose monitor with integrated lancing/blood sample
 - Skin piercing device for collection of capillary blood, laser
- For home blood glucose supplies, providers must not dispense a quantity of supplies exceeding a beneficiary's expected usage. Regardless of usage, a supplier must not dispense more than a three-month quantity of glucose testing supplies at a time. Suppliers should stay attuned to atypical usage patterns on behalf of their clients and verify with the ordering physicians that the atypical usage is, in fact, warranted. Suppliers must not automatically dispense a quantity of supplies on a predetermined regular basis, even if the beneficiary has authorized this in advance.
- The ordering physician does not have to approve the order refill; however, the beneficiary or the beneficiary's caregiver must specifically request refills of glucose monitor supplies before they are dispensed.
- **Testing strips are to be billed 1 UNIT equals 1 BOTTLE (50 strips)**. Billing of testing strips will be reviewed at least yearly. Any inappropriate billing will be recouped.

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- Providers must keep the order for home blood glucose monitoring supplies and monitors on file. The order must include all of the following elements:
 - Item to be dispensed
 - Quantity of item(s) to be dispensed
 - Specific frequency of testing
 - Whether the beneficiary has insulin-treated or noninsulin-treated diabetes
 - Treating physician's signature
 - Date of the treating physician's signature
 - Start date of the order (only required if start date is different than signature date)

- Orders that state "as needed" are not acceptable and will result in those items being denied as not medically necessary.

- The supplier is required to have a renewal order from the treating physician every 12 months. This renewal order must also contain the required information specified above.

- For beneficiaries to be eligible for home blood glucose monitors and supplies, they must meet all of the following basic criteria:
 - Beneficiary has diabetes (ICD-9 codes 250.00-250.93) which is being treated by a physician.
 - Glucose monitor and related accessories and supplies were ordered by a physician who is treating the beneficiary's diabetes, and the treating physician maintains records reflecting the care provided including, but not limited to, evidence of medical necessity for the prescribed frequency of testing.
 - Beneficiary (or beneficiary's caregiver) successfully completed training or is scheduled to begin training in the use of the monitor, test strips, and lancing devices.
 - Beneficiary (or beneficiary's caregiver) is capable of using the test results to ensure appropriate glycemic control of the beneficiary's diabetes.
 - Device is designed for home use.

- For beneficiaries to be eligible for more than the limits listed above, a PA is required and the beneficiary must meet the following criteria:
 - Coverage criteria listed above for glucose monitoring supplies are met.
 - Supplier of test strips and lancets or lens shield cartridge maintains in its records the order from the treating physician.
 - Beneficiary has nearly exhausted the supply of test strips and lancets or useful life of one lens shield cartridge previously dispensed.
 - Treating physician has ordered a frequency of testing that exceeds the usage guidelines and has documented in the beneficiary's medical record the specific reason for the additional materials for that particular beneficiary.
 - Treating physician has seen the beneficiary and has evaluated his or her diabetes control within six months prior to ordering quantities of strips and lancets or lens shield cartridges that exceed the usage guidelines.

8400. Updated 11/09

- If a refill of supply quantities is dispensed that exceeds the usage guidelines, there must be documentation in the physician's records (such as a specific narrative statement that adequately documents the frequency at which the beneficiary is actually testing or a copy of the beneficiary's log) or in the supplier's records (such as a copy of the beneficiary's log) that the beneficiary is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed. If the beneficiary is regularly using supply quantities that exceed the usage guidelines, new documentation must be present at least every six months.
- Home blood glucose monitor and supplies limits for insulin-treated diabetes (Type I) are:
 - One monitor is allowed every two years, regardless of the type.
 - Test strips (1 unit equals 1 bottle) are allowed at six units (300 strips or 6 bottles) every 30 days.
 - Platforms (1 unit equals 1 box) are allowed at one unit (1 box) every 30 days.
 - Calibration solution/chips are allowed at four units per year.
 - Spring-powered device for lancet is allowed at one unit every six months.
 - Lancets (1 unit equals 1 box) are allowed at three units (3 boxes).
 - One reusable pen insulin delivery device (either size) is allowed every year.
- Home blood glucose monitor and supplies limits for noninsulin-treated diabetes (Type II) are:
 - One monitor is allowed every two years, regardless of the type.
 - Test strips (1 unit equals 1 bottle) are allowed at two units (100 strips or 2 bottles) every 30 days.
 - Platforms (1 unit equals 1 box) are allowed at one unit (1 box) every 90 days.
 - Calibration solution/chips are allowed at two units per year.
 - Spring-powered device for lancet is allowed at one unit every six months.
 - Lancets (1 unit equals 1 box) are allowed at one unit (1 box) every 30 days.

Oral Supplemental Nutrition

- Oral supplemental nutrition is covered for KBH beneficiaries only. To bill, use the appropriate HCPCS code.
- Supplemental nutrition is not covered for adults and non-KBH beneficiaries.

Modifiers

Modifier BA is required when applicable, to be used for items supplied in conjunction with total parenteral nutrition (TPN).

General Requirements

All parenteral nutrition, pumps, and miscellaneous supplies must be prescribed. Providers must maintain a copy of the prescription in the beneficiary's file. DME services provided for parenteral administration of total nutritional replacements and intravenous (IV) medications in the recipient's home require the participation of services from a local Home Health Agency, physician, advanced registered nurse practitioner or pharmacist.

8400. Updated 11/09

Parenteral Nutrition

TPN in conjunction with enteral or oral feedings is covered for a KBH-eligible beneficiary when enteral/oral nutrition constitutes a small portion of the beneficiary's dietary intake and/or the beneficiary is being weaned from TPN feedings. Nutrients and supply items are to be billed for quantities expected to supply the beneficiary for no more than one month.

Parenteral Supplies

- Parenteral supplies that have an assigned HCPC code must be requested under the appropriate code. Parenteral supplies that do not have an assigned HCPC code may be covered (with PA) under B9999 if the beneficiary meets criteria.
- Parenteral kits and their components are generally considered all-inclusive items necessary to administer therapy. Payment will not be made to suppliers or beneficiaries for additional components billed separately. Usual items in the different kits include but are not limited to these items:

A4221 - SUPPLY KIT PRE-MIX

Gloves	Gauze Sponges
Alcohol Wipes	Micropore Tape
Iso. Alcohol	Plastic Tape
Acetone	Injection Caps
Providone Iodine Scrub	Syringes
Providone Iodine Ointment	Needles
Providone Swabs	Ketodiastix
Providone Sticks	Destructclip

B4222 - SUPPLY KIT HOME MIX

Containers	Gauze Sponges
Gloves	Injection Caps
Alcohol Wipes	Micropore Tape
Iso. Alcohol	Plastic Tape
Acetone	Needles
Providone Iodine Scrub	Syringes
Providone Iodine Ointment	Ketodiastix
Providone Sticks	Destructclip

A4222, A4223 ADMIN KIT

Admin Sets/Leur Lock &	Clamps
Micron Filter	Extension Sets
Pump Cassettes	2- or 3-way connectors

Family Planning

- Family planning is any medically approved treatment, counseling, drugs, supplies or devices which are prescribed or furnished by a provider to individuals of child-bearing age for purposes of enabling such individuals to freely determine the number and spacing of their children.
- When a service provided in conjunction with a KBH screen relates to family planning, complete the family planning block (24H) on the claim form to ensure that federal funding is used appropriately.

8400. Updated 09/13

Immunizations/Vaccines

Reimbursement for covered immunizations for children is limited to the administration of the vaccine only. Vaccines are supplied at no cost to the provider through Vaccines for Children, a federal program administered by KDHE.

Home Health Aide

- Home health services must be performed by a home health aide under the general supervision of a RN. A home health aide care plan outlining specific duties of the aide is required. Home health aide services need not be related to skilled nursing visits. A supervisory visit of a home health aide is required at least every two weeks when the patient is under a skilled service plan of care.
- Home health aide services must be prior authorized for all beneficiaries. Beneficiaries not on an HCBS waiver can receive home health aide services and skilled nursing services on the same day with PA.
- Use code G0156 for home health aide services, for the first 15 minutes, and T1004 for subsequent 15-minute intervals. Up to one hour of home health aide services can be prior authorized but cannot exceed one unit per day of G0156 and three units per day of T1004. G0156 and T1004 cannot be billed on the same day as T1021.
- A supervisory visit of a home health aide is required to be performed by an RN every two weeks unless:
 - The patient is receiving only skilled therapy services and home health aide services. A skilled therapist may make the supervisory visit at least every two weeks in lieu of an RN.
 - The Home Health Agency is providing care for patients other than those requiring an active medical care program (such as patients who require supportive home health aide care). Only such supervision as the Home Health Agency feels necessary is required in such cases.
- If the sole purpose of a home health aide visit in excess of twice weekly is to provide personal hygiene, medical necessity of the visit(s) must be documented. (Refer to Section 4100 of the *General Special Requirements Fee-for-Service Provider Manual*.)
- Home health aide duties include but are not limited to the following:
 - Personal hygiene (such as shampoo, routine nail care)
 - Linen change
 - Maintenance exercises
 - Medication
 - Assistance with routine oral medications in accordance with 42 CFR (Code of Federal Regulation) 484.36(c)(2)
 - May check compliance and report to RN
 - May apply over-the-counter topical medications
 - Vital signs: Must be addressed in care plan and reported to RN

8400. Updated 02/10

- Bowel/bladder procedures
 - May obtain urine specimens
 - May perform enemas or impaction removal if:
 - Ordered by physician
 - No contraindications exist
 - Bowel condition is chronic
 - May empty ostomy/urine bags
- Simple, nonsterile dressing changes
- Other procedures for which specific and adequate training has been provided

- Home health aide duties **do not** include the following:
 - Set-up of medications
 - Ordering or having medications refilled
 - Performing blood sugars
 - Whirlpool treatments for vascular or wound conditions
 - Warm moist packs
 - Physical assessments beyond vital signs
 - Sterile, wet-to-dry, or complex dressing changes
 - Packing or debridement of wounds
 - Health-related teaching

Medical Supplies

- Medical supplies are allowed when all of following apply:
 - Are necessary and reasonable for treatment of the patient's illness or injury
 - Are used in the patient's home
 - Are properly prescribed
 - Are a covered service

- Prescriptions for medical supplies are **only** accepted from the following professionals:
 - Doctors of Medicine (M.D.)
 - Doctors of Osteopathy (D.O.)
 - Doctors of Podiatric Medicine (D.P.M.)
 - Chiropractors (may prescribe cervical collars and "soft type" spinal supports only)

Ostomy Adhesives

Ostomy adhesives are limited to one type every 30 days. Liquid adhesive is limited to four units every 30 days and disk or foam pad is limited to 20 units every 30 days.

Ostomy Belts

Purchase of ostomy belts (all kinds) is limited to one unit every 30 days.

Ostomy Deodorants

Ostomy deodorants are limited to one type every 30 days. Liquid deodorant is limited to eight units every 30 days and solid is limited to 100 units every 30 days.

8400. Updated 02/10

Ostomy Skin Barriers

- Only one selection of the following skin barriers is allowed within a 30-day time frame with the following limits, regardless of provider:
 - Ostomy skin barrier, liquid is limited to two units every 30 days.
 - Ostomy skin barrier, powder is limited to 10 units every 30 days.
 - Ostomy skin barrier, nonpectin-based, paste is limited to four units every 30 days.
 - Ostomy skin barrier, pectin-based, paste is limited to four units every 30 days.
 - Skin barrier, wipes or swabs is limited to 150 units every 30 days.
(1 unit equals 1 wipe/swab.)

- The following items (or combinations of these items) are limited to a combined total of 20 units every 30 days, regardless of provider:
 - Ostomy skin barrier, solid 4x4 or equivalent
 - Ostomy skin barrier, with flange
 - Skin barrier, solid, 6x6 or equivalent
 - Skin barrier, solid, 8x8 or equivalent

Ostomy Pouches

- Drainable and urinary ostomy pouches are limited to a combined total of 20 units every 30 days.

- Closed ostomy pouches are limited to a combined total of 60 units every 30 days.

Miscellaneous Ostomy Supplies

- Stoma caps and continent device stoma plugs are limited to a combined total of 31 units every 30 days.

- The following individual items are limited to the amount stated below every 30 days:
 - Percutaneous catheter/tube anchoring device, adhesive skin attachment - 10 units
 - Appliance cleaner, incontinence and ostomy appliances – 1 unit
 - Ostomy accessory, convex insert – 10 units
 - Continent device, catheter for continent stoma – 1 unit
 - Ostomy absorbent material (sheet/pad/crystal packet) – 60 units
 - Ostomy ring – 10 units
 - Ostomy lubricant – 4 units
 - Ostomy irrigation supply, bag – 2 units
 - Ostomy irrigation set – 2 units
 - Ostomy irrigation supply, cone/catheter – 2 units
 - Ostomy irrigation supply, sleeve – 4 units
 - Ostomy faceplate equivalent, silicone ring – 3 units
 - Adhesive remover wipes – 150 units
 - Ostomy filters (any type) – 50 units
 - Ostomy faceplate – 3 units
 - Ostomy clamps – 10 units

- Ostomy vents are limited to two units every 180 days.
- Code A4421 is noncovered.

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8400. Updated 04/10

Other Medical Supplies

- Humidifying filters are limited to 36 filters per calendar month.
- Code A4554 is limited to three units per month. (One unit equals 50 pads.)

Pain Management

Providers are encouraged to use the Pain Management Guidelines developed by The Federation of State Medical Boards of the United States, Inc. and adopted by the Adult and Medical Services Commission. The guidelines are the following:

Evaluation of the Patient

1. A complete medical history and physical examination must be conducted and documented in the medical records.
2. The medical records should document the nature and intensity of the pain, evaluate underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of substance abuse.
3. The medical record should also document the presence of one or more recognized medical indications for the use of a controlled substance.

Treatment Plan

1. The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned.
2. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

Informed Consent and Agreement for Treatment

1. The physician should discuss the risks and benefits of the use of controlled substances with the patient, significant other(s) or guardian.
2. The patient should receive prescriptions from one physician and one pharmacy where possible.
3. If the patient is determined to be at high risk for medication abuse or have a history of substance abuse, the physician may employ the use of a written agreement between physician and patient outlining patient responsibilities including:
 - Urine/serum medication levels screening when requested
 - Number and frequency of all prescription refills
 - Reasons for which drug therapy may be discontinued (i.e. violation of agreement)

Periodic Review

1. At reasonable intervals based upon the individual circumstance of the patient, the physician should review the course of opioid treatment and any new information about the etiology of the pain.

8400. Updated 11/09

2. Continuation or modification of opioid therapy should depend on the physician's evaluation of progress toward stated treatment objectives such as improvement in patient's pain intensity and improved physical and/or psychosocial function, such as ability to work, need of health care resources, activities of daily living and quality of social life.
3. If reasonable treatment goals are not being achieved, despite medication adjustments, the physician should re-evaluate the appropriateness of continued opioid treatment.
4. The physician should monitor patient compliance in medication usage and related treatment plans.

Consultation

1. The physician should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives.
2. Special attention should be given to those pain patients who are at risk for misusing their medications and those whose living arrangement pose a risk for medication misuse or diversion.
3. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder requires extra care, monitoring, documentation and consultation with or referral to an expert in the management of such patients.

Medical Records

1. The physician should keep accurate and complete records to include:
 - Medical history and physical examination
 - Diagnostic, therapeutic and laboratory results
 - Evaluations and consultations
 - Treatment objectives
 - Discussion of risks and benefits
 - Treatments
 - Medications (including date, type, dosage, and quantity prescribed)
 - Instructions and agreements
 - Periodic reviews
2. Records should remain current and be maintained in an accessible manner and readily available for review.

Compliance with Controlled Substances Law and Regulations

1. To prescribe controlled substances, the physician must be licensed in the State of Kansas, have a valid controlled substances registration and comply with federal and state regulations for issuing controlled substances prescriptions.
2. Physicians are referred to the Physicians Manual of the U.S. Drug Enforcement Administration (and any regulations issued by the State Medical Board) for specific rules governing issuance of controlled substance prescriptions as well as applicable state regulations.

8400. Updated 11/09

Definitions

For the purposes of the pain management guidelines for Kansas Medicaid, the following terms are defined as follows:

Acute Pain - Acute pain is the normal, predicted physiological response to an adverse chemical, thermal, or mechanical stimulus and is associated with surgery, trauma, and acute illness. It is generally time limited and is responsive to opioid therapy, among other therapies.

Addiction - Addiction is a neurobehavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use despite harm. Addiction may also be referred to by terms such as "drug dependence" and "psychological dependence". Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and should not be considered addiction.

Chronic Pain - A pain state that is persistent and in which the cause of the pain cannot be removed or otherwise treated and which, in the generally accepted course of medical practice, no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts. Chronic pain may be associated with a long-term incurable or intractable medical condition or disease.

Physical Dependence - Physical dependence is a physiologic state of neuroadaptation to an opioid which is characterized by the emergence of a withdrawal syndrome if the opioid use is stopped or decreased abruptly, or if an antagonist is administered. Withdrawal may be relieved by readministration of the opioid. Physical dependence appears to be an inevitable result of opioid use. Physical dependence, by itself, does not equate with addiction.

Substance Abuse - Substance abuse is the use of any substance(s) for nontherapeutic purposes; or use of medication for purposes other than those for which it is prescribed.

Tolerance - Tolerance is a physiologic state resulting from regular use of a drug in which an increase dosage is needed to produce the same effect or a reduced effect is observed with a constant dose. Tolerance occurs to different degrees for various drug effects, including sedation, analgesia and constipation. Analgesic tolerance is the need to increase the dose of opioid to achieve the same level of analgesia. Analgesic tolerance may or may not be evident during opioid treatment and does not equate with addiction.

Passive Motion Exercise

Rental of a passive motion exercise device is covered for outpatient use for a maximum period of 14 consecutive days postoperatively. Use code E0935RR.

Phototherapy

Phototherapy is covered for newborns with a total bilirubin level above 12/dL. Use code E0202RR for phototherapy (bilirubin) light or blanket with photometer. When billing E0202RR, one unit equals one day and is limited to 10 consecutive days per lifetime.

8400. Updated 03/10

Services/Supplies for Medicare-Eligible Individuals

Modifier GY can be used to designate those services/supplies provided to a Medicare beneficiary when the service is reasonably believed by the provider to be noncovered by Medicare. Use modifier GY with the following codes and the codes listed in Appendix II when filing claims to Medicaid for services rendered to Medicare-eligible beneficiaries:

G0154, G0156, S0315, S0316, S9128, S9129, S9131, S9460, T1002, T1003, T1004, T1021, T1023, T1030, T1031, T1502, 99600, 99601, 99602

Note: Medicare must be billed first if there is a possibility they will allow payment on a claim. If Medicare does not allow payment, the claim may be submitted to Medicaid along with the Medicare denial.

Skilled Nursing

- Skilled nursing services must be provided by an RN or a licensed practical nurse (LPN). Skilled nursing services are those services requiring substantial and specialized nursing skill. **Skilled nursing services require a physician's order. The agency is required to maintain plans of care containing the physician's signature on file in the medical record located at the home health agency.** Skilled nursing services must be prior authorized for all beneficiaries.
- In accordance with Medicare guidelines, a service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a nurse. If a service can be safely and effectively performed by a nonmedical person (or self-administered) without the direct supervision of a nurse, the service cannot be regarded as a skilled nursing service although a nurse actually provides the service. Similarly, the unavailability of a competent person to provide a nonskilled service, notwithstanding the importance of the service to the beneficiary, does not make it a skilled service when a nurse provides the service.
- For beneficiaries receiving services through the Acute Care Home Health Service Plan, use code G0154 for the first 15 minutes of a skilled nurse visit (RN or LPN) in a home health setting. Use code T1002 for subsequent intervals of an RN visit, up to 15 minutes, and code T1003 for subsequent intervals of an LPN visit, up to 15 minutes. Up to one hour can be prior authorized for skilled nursing visits. Documentation must support the duration of each visit.
- Information on the Long-Term Care Home Health Service Plan and the Diabetes Management Service Plan is documented in Appendix III of this manual.
- Skilled nursing responsibilities by an **RN** include but are not limited to the following:
 - Initial and ongoing assessments
 - Initiating and updating care plans
 - Communication with physicians
 - Supervision of aides
 - Medication set-up
 - IV/IM medication administration requiring the skill level of a nurse
 - Invasive procedures requiring the skill level of a nurse
 - Individualized teaching as outlined by the care plan
 - Diabetic nail care
 - Treatment and evaluation of wounds

8400. Updated 02/10

- Skilled nursing responsibilities by an **LPN** include but are not limited to the following:
 - Ongoing assessments
 - Updating care plan
 - Communication with physicians
 - Medication set-up
 - Venipuncture for blood draws
 - Individual teaching as outlined by the care plan excluding teaching related to parenteral procedures (e.g., IVs, Hickman catheters)
 - Diabetic nail care
 - Treatment and evaluation of wounds
 - **Medication administration requiring the skill of a nurse, excluding IVs***

*LPNs who have successfully completed an IV fluid therapy course may, under the supervision of a registered professional nurse, engage in a limited scope of IV fluid treatment, including the following: 1) monitoring; 2) maintaining; 3) discontinuing IV flow and an IV access device not exceeding three inches in length in peripheral sites only; and 4) changing dressing for IV access devices not exceeding three inches in length in peripheral sites only.

- Combination of services:
 - A skilled nursing visit and a supervisory visit when performed at the same time constitute one visit.
 - An RN performing both aide and skilled nursing duties constitutes a skilled visit.
 - **A nonskilled visit performed by an RN or LPN constitutes a home health aide visit.**

Note: Only one home health aide or restorative aide visit to the same individual may be reimbursed for the same date of service.

- If services in excess of the following limitations on skilled nursing services are desired, documentation of medical necessity is required:
 - Medication set-up - once a week
 - Insulin syringes filling - once a week for a stable patient
 - General assessment - every 60 days for a stable patient
 - Supervisory visits
 - No more often than every two weeks if the patient is **also** receiving skilled services
 - At least every 60 days if the patient is receiving **nonskilled** services only

Home Telehealth

- Home telehealth uses real-time, interactive, audio/video telecommunication equipment to monitor beneficiaries in the home setting as opposed to a nurse visiting the home. This technology may be used to monitor the beneficiary for significant changes in health status, provide timely assessment of chronic conditions, and provide other skilled nursing services.
- Home telehealth services must be provided by an RN or LPN. **Agencies may bill skilled nursing services on the same date of service as telehealth services.**

Note: Use modifier GT (interactive telecommunication) with the following codes when filing claims to Medicaid for home telehealth visits: T1030 and T1031.

8400. Updated 02/10

Stockings, Compression and Surgical

The following limitations apply to coverage of compression and surgical stockings:

- Stockings are limited to no more than a combined total of eight units per 365 days for the following codes:

A4490	A4495	A4500	A4510	A6530
A6531	A6532	A6533	A6534	A6535
A6536	A6537	A6538	A6539	A6540
A6541	A6545			
- Stockings are limited to no more than four units per 365 days for code A6544.
- Code A6549 is noncovered.
- Place of service is equal to 12 (home).
- Each time new stockings (any kind) are ordered, the provider is required to remeasure the beneficiary for proper size.
- Custom-made and lymphedema stockings require PA.

Therapy

- Therapy treatments are not covered for psychiatric diagnosis.
- Habilitative - Therapy is covered for any birth defects/developmental delays only when approved and provided by an Early Childhood Intervention (ECI), Head Start or Local Education Agency (LEA) program. Therapy treatments performed in the LEA settings may be habilitative or rehabilitative for disabilities due to birth defects or physical trauma/illness. Therapy of this type is covered only for beneficiaries age zero to under the age of 21. Therapy **must** be medically necessary. The purpose of this therapy is to maintain maximum possible functioning for children.
- Rehabilitative - All therapies must be physically rehabilitative. Therapies are covered only when rehabilitative in nature and provided following physical debilitation due to an acute physical trauma or physical illness and prescribed by the attending physician.
- Therapy services are limited to six months for non-KBH beneficiaries (except the provision of therapy under HCBS), per injury, to begin at the discretion of the provider. There is no limitation for KBH beneficiaries.
- All therapy services are limited to one unit per day. Therapy services must be prior authorized and these services are included in the combined total Acute Care Home Health Service Plan (nursing and therapy services) limitation of 120 visits per calendar year.

Occupational

Services must be prescribed by a physician and provided by a registered occupational therapist or by a certified occupational therapy assistant working under the supervision of a registered occupational therapist. Supervision must be clearly documented. This may include, but is not limited to, the registered occupational therapist initializing each treatment note written by the certified occupational therapy assistant, or the registered occupational therapist writing "Treatment was supervised" followed by his or her signature.

8400. Updated 06/12

Physical

All physical therapy services must be initially prescribed by a physician and performed by either a registered physical therapist or by a certified physical therapy assistant working under the supervision of a registered physical therapist. Supervision must be clearly documented. This may include, but is not limited to, the registered physical therapist initializing each treatment note written by the certified physical therapy assistant, or the registered physical therapist writing "Treatment was supervised" followed by his or her signature.

Restorative Aide

Restorative aide service is only covered for physical therapy. Services must be restorative and rehabilitative physical therapy provided by a restorative aide under an outpatient physical therapy plan of care developed by a registered physical therapist. Services cannot be billed on the same date of service as a home health aide service. Use T1021.

Speech

Services must be prescribed by a physician and provided by a certified speech pathologist.

Respiratory

Respiratory therapy is covered for KBH beneficiaries only.

Urinary Equipment

Insertion Trays

- Codes A4310, A4311, A4312, A4313, A4314, A4315, A4316 and A4354 are limited to a combined total of two units per month.
- One insertion tray is covered per episode of indwelling catheter insertion up to the KMAP limit.
- Catheter insertion trays are not medically necessary for clean, nonsterile, intermittent catheterization and are noncovered.

Irrigation Trays/Bulbs

- Codes A4320 and A4322 are limited to a combined total of up to 15 per month.
- Routine, intermittent irrigations are defined as those performed at predetermined intervals. Routine, intermittent irrigations of a catheter are noncovered. Irrigation solutions containing antibiotics and chemotherapeutic agents are noncovered. Irrigating solutions such as acetic acid or hydrogen peroxide are noncovered.
- When sterile saline, water, syringes, and trays are used for routine irrigation, those items are noncovered. Therapeutic agents for irrigation are noncovered.
- Continuous irrigation is a temporary measure. Continuous irrigation for more than two weeks is rarely medically necessary. The beneficiary's medical records should indicate this medical necessity and be maintained in the beneficiary's DME file. The beneficiary's medical records may be requested by KMAP.

8400. Updated 06/12

External Catheters and Collection Devices

- Codes A4326 and A4349 are limited to 30 per month.
- Code A4327 is limited to one per 365 days.
- Codes A4328 and A4330 are limited to four per month.
- Male external catheters or female external urinary collection devices are covered for beneficiaries who have permanent, urinary incontinence when used as an alternative to an indwelling catheter.
- Male external catheters or female external urinary collection devices are noncovered when ordered for beneficiaries who also use an indwelling catheter.

Extension/Drainage Tubes

- Code A4331 is limited to two per month.
- Code A4355 is limited to 15 units per month.

Miscellaneous

- Code A4332 is limited to 36 per month.
- Code A4333 is limited to 12 per month.
- Codes A4334, A5113 and A5114 are limited to a combined total of one per month.
- Codes A4335, A4336, A4356, A4360 and A5105 are noncovered.

Catheters

- Codes A4338, A4340, A4344, and A4346 are limited to a combined total of two per month.
- Codes A4351, A4352, and A4353 are limited to a combined total of 36 per month.
- When codes A4340, A4344, A4312, or A4315 are used, there must be documentation in the beneficiary's medical record (and DME record) of the medical necessity for that catheter rather than a straight Foley-type catheter with coating (such as recurrent encrustation, inability to pass a straight catheter, or sensitivity to latex). In addition, the particular catheter must be necessary for the beneficiary. For example, use of code A4340 in female beneficiaries is rarely medically necessary. Documentation of medical necessity may be requested by KMAP and must be kept in the beneficiary's DME file.
- Codes A4346, A4313, or A4316 are covered only in continuous catheter irrigation if medically necessary.

Drainage Bags and Bottles

Codes A4357 and A5102 are limited to a combined total of two per month.
Codes A4358 and A5112 are limited to a combined total of two per month.

8400. Updated 02/10

Leg bags are indicated for beneficiaries who are ambulatory or are chair or wheelchair bound. The use of leg bags for bedridden beneficiaries is noncovered. Payment is made for either a vinyl leg bag or a latex bag. The use of both is not medically necessary and is noncovered. The following medical supplies are noncovered:

Common Items:

- applicators, tongue blades
- armboards
- band aids, compresses, tape
- denture cup
- disposable briefs
- emesis basins, bath basins
- enemas and enema equipment
- first aid ointments
- footboard/foot cradles
- gloves (rubber, plastic and sterile)
- heating pads
- ice bags, hot water bottles
- lotions and creams (baby oil and lotion)
- paper tissues/cotton balls
- restraints
- thermometers
- water pitchers, glasses, straws
- weighing scales

Educational Items:

- tape records
- language boards
- communications items

Wearing Apparel:

- standard shoes
- hosiery
- sleeping gowns or
pajamas
- girdles (cosmetic)
- supports (non-RX)

Vacuum Assisted Wound Closure Therapy

Vacuum assisted wound closure therapy is covered for specific benefit plans. PA is required and criteria must be met. Refer to the *DME Fee-for-Service Provider Manual* for criteria. For questions about service coverage for a given benefit plan, contact Customer Service at 1-800-933-6593 or 785-274-5990. All PA must be requested in writing by a KMAP DME provider. All medical documentation must be submitted to the KMAP DME provider.

APPENDIX I

HOME HEALTH AGENCY CODES
Updated 06/12

Appendix I represents an all-inclusive list of home health agency services billable to KMAP. All other procedures are considered noncovered.

- Prior authorization (PA) is required for all home health nursing and therapy services.
- Providers cannot bill KMAP for medical supplies unless they first obtain PA for service codes to render nursing and therapy visits.
- Home Health Agencies can only bill for medical supplies used during a medically necessary home health visit.
- If a medical supply code required PA prior to March 1, 2010, this requirement remains.

Please use the following resources to determine coverage and pricing information. For accuracy, use your provider type and specialty as well as the beneficiary ID number or benefit plan.

- Information is available on the [public website](#).
- Information is available on the [secure website](#) under Pricing and Limitations.

A chart has been developed to assist providers in understanding how KMAP will handle specific modifiers. The Coding Modifiers chart is available on both the [public](#) and [secure](#) websites. It is under Reference Codes on the main provider page and Pricing and Limitations on the secure portion. Information is available on the [American Medical Association website](#).

For further assistance, contact the Customer Service at 1-800-933-6593. (Refer to Section 1000 of the *General Introduction Fee-for-Service Provider Manual*.)

COVERAGE INDICATORS

- KBH - KBH medical participation is required.
- MN - Medical necessity documentation is required.
- PA - Prior authorization is required.

Refer to Section 4300 of the *General Special Requirements Fee-for-Service Provider Manual* for additional PA information and Section 8400 of this manual for benefits and limitations.

DURABLE MEDICAL EQUIPMENT

Coverage	Code		Coverage	Code
PA	E0202RR			

MEDICAL SUPPLIES

Refer to Appendix II of this manual.

KAN BE HEALTHY SCREENING

Refer to the *KAN Be Healthy Fee-for-Service Provider Manual*.

Appendix I Updated 03/10

HOME HEALTH AIDE SERVICES

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
PA	G0156		PA	T1004

SKILLED NURSING SERVICES

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
PA	G0154		PA	T1030
PA	S0315		PA	T1031
PA	S0316		PA	T1502
PA	S9460		PA	99600
PA	T1002		PA	99601
PA	T1003		PA	99602
PA	T1023			

HOME TELEHEALTH SERVICES

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
PA	T1030		PA	T1031

Note: Use modifier GT with codes T1030 and T1031, per visit for home telehealth codes. Bill T1030 and T1031 with both modifiers GY and GT for telehealth skilled nursing visits for Medicare-eligible beneficiaries with a Medicaid-covered benefit plan.

THERAPY - OCCUPATIONAL

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
PA	S9129			

THERAPY - PHYSICAL

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
PA	S9131			

THERAPY - RESTORATIVE

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
PA	T1021			

RESPIRATORY THERAPY SERVICES

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
PA	S5181			

SPEECH THERAPY SERVICES

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
PA	S9128			

Appendix I Updated 01/13

PREVENTATIVE MEDICINE

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
KBH	99381		KBH	99391
KBH	99382		KBH	99392
KBH	99383		KBH	99393
KBH	99384		KBH	99394
KBH	99385		KBH	99395

FAMILY PLANNING

When services provided in conjunction with a KBH screen relates to family planning, complete the family planning block (24H) on the claim form to ensure that federal funding is utilized appropriately.

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
	A4261			A4268
	A4266			A4269
	A4267			J7302

IMMUNIZATION ADMINISTRATION

Providers must bill the appropriate administration code in addition to the vaccine and toxoid code for each dose administered. Reimbursement of *CPT*[®] codes for vaccines covered under the Vaccines for Children (VFC) program will not be allowed for children 18 years of age and younger.

COVERAGE INDICATORS

- ADLT Vaccine covered for adults (19 years of age and older)
- VFC Vaccine covered by VFC (18 years of age and younger)

ADMINISTRATION CODES

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
	90471			90473
	90472			90474

Appendix I Updated 01/13

VACCINE CODES

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
VFC	90698		VFC, ADLT	90656
VFC	90700		VFC	90657
VFC	90702		VFC, ADLT	90658
VFC	90720		VFC, ADLT	90660
VFC	90696		VFC, ADLT	90707
VFC	90723		VFC, ADLT	90710
ADLT	90632		VFC	90733
VFC	90633		VFC, ADLT	90734
VFC	90634		VFC	90669
ADLT	90636		VFC, ADLT	90670
ADLT	90740		VFC, ADLT	90732
VFC	90743		VFC, ADLT	90713
VFC	90744		VFC	90680
ADLT	90746		VFC	90681
ADLT	90747		VFC	90703
VFC	90748		VFC, ADLT	90714
VFC	90644		VFC, ADLT	90715
VFC	90645		VFC, ADLT	90716
VFC	90646		ADLT	90736
VFC	90647		VFC, ADLT	90672
VFC	90648		ADLT	90739
VFC, ADLT	90649		VFC	Q2035
VFC, ADLT	90650		VFC	Q2036
VFC, ADLT	90653		VFC	Q2037
VFC	90654		VFC	Q2038
VFC	90655		VFC	Q2039

APPENDIX II MEDICAL SUPPLY CODES

Updated 09/13

The following procedure codes represent an all-inclusive list of medical supply services billable to KMAP. Procedures not listed here are considered noncovered.

- Prior authorization (PA) is required for all home health nursing and therapy services.
- Providers cannot bill KMAP for medical supplies unless they first obtain PA for service codes to render nursing and therapy visits.
- Home Health Agencies can only bill for medical supplies used during a medically necessary home health visit.
- If a medical supply code required PA prior to March 1, 2010, this requirement remains.

Please use the following resources to determine coverage and pricing information. For accuracy, use your provider type and specialty as well as the beneficiary ID number or benefit plan.

- Information is available on the [public website](#).
- Information is available on the [secure website](#) under Pricing and Limitations.

A chart has been developed to assist providers in understanding how KMAP will handle specific modifiers. The Coding Modifiers chart is available on both the [public](#) and [secure](#) websites. It is under Reference Codes on the main provider page and Pricing and Limitations on the secure portion. Information is available on the [American Medical Association website](#).

For further assistance, contact the Customer Service at 1-800-933-6593. (Refer to Section 1000 of the *General Introduction Fee-for-Service Provider Manual*.)

HOME HEALTH SUPPLY CODES WITH MODIFIER GY

Home health agencies may only bill for supplies used during a medically necessary home health visit. Supplies used must be documented in the nursing notes.

The date of service for supplies billed must correspond with the date of service the home health visit was provided.

Supplies may be billed using modifier GY when the beneficiary is dually eligible and the provider is reasonably certain Medicare will not cover the supplies.

All coverage indicator requirements will still apply.

COVERAGE INDICATORS

MN	-	Medical necessity documentation required.
PA	-	Prior authorization is required. NOTE: DME claims will not bypass PA when there is a partial payment by a third party payer or Medicare.
SSPA	-	Skilled service PA required for all supplies and services.
INV	-	An itemized retail invoice must be kept available in your files.
KBH	-	KBH medical participation is required.
NC	-	Noncovered KMAP service.
*	-	Reference Section 8400 of this manual for a complete definition of these kits.
KS	-	Modifier indicating noninsulin dependent.
KX	-	Modifier indicating insulin dependent.

Refer to Section 8400 of this manual for additional benefits and limitations.

Appendix II Updated 02/10

ANTISEPTIC PRODUCTS

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
SSPA	A4244		INV, SSPA	A4246
SSPA	A4245		INV, SSPA	A4247

BREAST PUMPS

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
SSPA	E0602		SSPA	A4283
SSPA	E0603		SSPA	A4285
SSPA	A4281		SSPA	A4286
SSPA	A4282			

DRESSINGS/PADS

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
SSPA	A4554		SSPA	A6218
PA	A4927		SSPA	A6219
SSPA	A6010		SSPA	A6220
SSPA	A6011		SSPA	A6221
SSPA	A6024		SSPA	A6222
SSPA	A6154		SSPA	A6223
SSPA	A6196		SSPA	A6224
SSPA	A6197		SSPA	A6228
SSPA	A6198		SSPA	A6229
SSPA	A6199		SSPA	A6230
SSPA	A6021		SSPA	A6231
SSPA	A6022		SSPA	A6232
SSPA	A6023		SSPA	A6233
SSPA	A6203		SSPA	A6234
SSPA	A6204		SSPA	A6235
SSPA	A6205		SSPA	A6236
PA	A6206		SSPA	A6237
PA	A6207		SSPA	A6238
PA	A6208		SSPA	A6239
SSPA	A6209		SSPA	A6240
SSPA	A6210		SSPA	A6241
SSPA	A6211		SSPA	A6242
SSPA	A6212		SSPA	A6243
SSPA	A6215		SSPA	A6244
SSPA	A6410		SSPA	A6245
SSPA	A6411		SSPA	A6246
SSPA	A6412		SSPA	A6247
SSPA	A6213		SSPA	A6248
SSPA	A6214		SSPA	A6251
SSPA	A6216		SSPA	A6252
SSPA	A6217		SSPA	A6253

Appendix II Updated 02/10

DRESSINGS/PADS (continued)

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
SSPA	A6254		SSPA	A6444
SSPA	A6255		SSPA	A6445
SSPA	A6256		SSPA	A6446
SSPA	A6257		SSPA	A6447
SSPA	A6258		SSPA	A6448
SSPA	A6259		SSPA	A6449
SSPA	A6260		SSPA	A6450
SSPA	A6266		SSPA	A6451
SSPA	A6231		SSPA	A6452
SSPA	A6232		SSPA	A6453
SSPA	A6402		SSPA	A6454
SSPA	A6403		SSPA	A6455
SSPA	A6404		SSPA	A6456
SSPA	A6441		SSPA	A6407
SSPA	A6442		SSPA	A6457
SSPA	A6443			

ENTERAL THERAPY*

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
PA	B4034		PA, INV	B4150
PA	B4035		PA, INV	B4152
PA	B4036		PA, INV	B4153
SSPA	B4081		PA, INV	B4154
SSPA	B4082		PA, INV	B4155
SSPA	B4083		PA, INV	B4157
SSPA	B4087		PA, INV	B4158
SSPA	B4088		PA, INV	B4159
PA	B4100		PA, INV	B4160
PA, INV	B4102		PA, INV	B4161
PA, INV	B4103		PA, INV	B4162
PA, INV	B4149		PA, INV	B9998

Note: Add modifier BO to the base code (XXXXX-BO) and place in field 24D when billing for oral supplemental nutrition.

Appendix II Updated 02/10

PARENTERAL THERAPY

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
SSPA	B4164		SSPA	B4199
SSPA	B4168		SSPA	B4216
SSPA	B4172		SSPA	B4220
SSPA	B4176		SSPA	B4222*
SSPA	B4178		SSPA	B4224
SSPA	B4180		SSPA	B5000
SSPA	B4185		SSPA	B5100
SSPA	B4189		SSPA	B5200
SSPA	B4193		PA, INV	B9999
SSPA	B4197			

Note: Add modifier BA to the base code (XXXXX-BA) and place in field 24D when billing for item supplies in conjunction with total parenteral nutrition.

IV DRUG THERAPY

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
SSPA	B4222*		SSPA	A4222*
SSPA	J7060		SSPA	A4223
SSPA	A4221*			

GLUCOSE MONITORING SUPPLIES

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
SSPA	A4253 KS		SSPA	A4258
SSPA	A4253 KX		SSPA	A4259 KS
SSPA	A4255 KS		SSPA	A4259 KX
SSPA	A4255 KX		SSPA	E2100
SSPA, INV	A4256 KS		SSPA	S5560
SSPA, INV	A4256 KX		SSPA	S5561

NEEDLES/SYRINGES

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
SSPA	A4206		SSPA	A4213
SSPA	A4207		SSPA	A4215
SSPA	A4208		SSPA	A4657
SSPA	A4209		SSPA	S8490
SSPA	A4212			

Appendix II Updated 12/12

OSTOMY SUPPLIES

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
SSPA	A4361		SSPA	A4412
SSPA	A4362		SSPA	A4413
SSPA	A4363		SSPA	A4414
SSPA	A4364		SSPA	A4415
SSPA	A4366		SSPA	A4416
SSPA	A4367		SSPA	A4417
SSPA	A4368		SSPA	A4418
SSPA	A4369		SSPA	A4419
SSPA	A4371		SSPA	A4420
SSPA	A4372		SSPA	A4422
SSPA	A4373		SSPA	A4423
SSPA	A4375		SSPA	A4424
SSPA	A4376		SSPA	A4425
SSPA	A4377		SSPA	A4426
SSPA	A4378		SSPA	A4427
SSPA	A4379		SSPA	A4428
SSPA	A4380		SSPA	A4429
SSPA	A4381		SSPA	A4430
SSPA	A4382		SSPA	A4431
SSPA	A4383		SSPA	A4432
SSPA	A4384		SSPA	A4433
SSPA	A4385		SSPA	A4434
SSPA	A4387		SSPA	A4435
SSPA	A4388		SSPA	A4450
SSPA	A4389		SSPA	A4452
SSPA	A4390		SSPA	A4455
SSPA	A4391		SSPA	A4456
SSPA	A4392		SSPA	A5051
SSPA	A4393		SSPA	A5052
SSPA	A4394		SSPA	A5053
SSPA	A4395		SSPA	A5054
SSPA	A4396		SSPA	A5055
SSPA	A4397		SSPA	A5061
SSPA	A4398		SSPA	A5062
SSPA	A4399		SSPA	A5063
SSPA	A4400		SSPA	A5071
SSPA, INV	A4402		SSPA	A5072
SSPA	A4404		SSPA	A5073
SSPA	A4405		SSPA	A5081
SSPA	A4406		SSPA	A5082
SSPA	A4407		SSPA	A5083
SSPA	A4408		SSPA	A5093
SSPA	A4409		SSPA	A5120
SSPA	A4410		SSPA	A5121
SSPA	A4411			

Appendix II Updated 09/13

OSTOMY SUPPLIES continued

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
SSPA	A5122		SSPA	A5131
SSPA	A5126		SSPA	A5200

OTHER MEDICAL SUPPLIES

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
SSPA	A7018		SSPA	A4264
SSPA	S8100		SSPA	A4267
SSPA	S8101		SSPA	A4268
SSPA	A4216		SSPA	A4269
SSPA	A4217		SSPA	A4660
SSPA	A4623		SSPA	A7520
SSPA	A4624		SSPA	A7521
SSPA	A4627		SSPA	A7522
SSPA	A4628		SSPA	A7525
SSPA	A4629		SSPA	A7526
SSPA	A4663		SSPA	S8096
PA	A4483		SSPA	S8185
SSPA	A4614		SSPA	S8186
SSPA	A4561		SSPA	S8999
SSPA	A4562			

PASSIVE MOTION EXERCISE DEVICE

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
SSPA	E0935			

SPLINTS

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
SSPA	A4565		SSPA	S8451
SSPA	A4570			

SUPPORTS

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
SSPA, INV	A4490		SSPA, INV	A6535
SSPA, INV	A4495		SSPA, INV	A6536
SSPA, INV	A4500		SSPA, INV	A6537
SSPA, INV	A4510		SSPA, INV	A6538
SSPA, INV	A6530		SSPA, INV	A6539
SSPA, INV	A6531		SSPA, INV	A6540
SSPA, INV	A6532		SSPA, INV	A6541
SSPA, INV	A6533		SSPA, INV	A6544
SSPA, INV	A6534		SSPA, INV	A6545

Appendix II Updated 02/10

URINARY EQUIPMENT

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
SSPA	A4250		SSPA	A4346
SSPA	A4310		SSPA	A4333
SSPA	A4311		SSPA	A4334
SSPA	A4312		SSPA	A4351
SSPA	A4313		SSPA	A4352
SSPA	A4314		SSPA	A4353
SSPA	A4315		SSPA	A4354
SSPA	A4316		SSPA	A4355
SSPA	A4320		SSPA	A4357
SSPA	A4322		SSPA	A4358
SSPA	A4326		SSPA	A4331
SSPA	A4327		SSPA	A5102
SSPA	A4328		SSPA	A5112
SSPA	A4330		SSPA	A5113
SSPA	A4349		SSPA	A5114
SSPA	A4332		SSPA	A5121
SSPA	A4338		SSPA	A5122
SSPA	A4340		SSPA	A5126
SSPA	A4344			

VACUUM ASSISTED WOUND CLOSURE THERAPY

<u>Coverage</u>	<u>Code</u>		<u>Coverage</u>	<u>Code</u>
SSPA	97605		SSPA	97606

APPENDIX III

Updated 05/11

Revision Effective: May 2011

Home Health Criteria

Home Health Services

Skilled nursing, home health aide, and skilled therapy services provided on a part-time or intermittent basis at the beneficiary's place of residence are defined as the following:

- Part-time is less than eight hours each day and 28 or fewer hours each week.
- Intermittent is skilled nursing care that is provided or needed fewer than seven days each week or fewer than eight hours per day for 21 days or less.
- Residence is defined as where the person regularly makes his or her home, for example, a house or apartment. This does not include nursing facilities, hospitals, or ICF/MRs.
- Skilled services are those services requiring the substantial specialized knowledge and skill of a licensed professional nurse.
- According to Medicare guidelines, a service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a nurse. If a service can be safely and effectively performed by a nonmedical person (or self-administered) without the direct supervision of a nurse, the service cannot be regarded as a skilled nursing service although a nurse actually provides the service. Similarly, the unavailability of a competent person to provide a nonskilled service, notwithstanding the importance of the service to the patient, does not make it a skilled service when a nurse provides the service.
- Unskilled services are those services not requiring the skill level of a licensed person.

Goals of Home Health Services

The two main goals of home health services are:

- Maximize independence of the beneficiary by teaching/training the beneficiary or other caregiver to provide medical care to maintain the beneficiary in the community
- Provide medically related services the beneficiary or unpaid caregiver is unable to perform

Medical Supply Codes

- Prior authorization (PA) is required for all home health nursing and therapy services.
- Providers cannot bill KMAP for medical supplies unless they first obtain PA for service codes to render nursing and therapy visits.
- Home health agencies can only bill for medical supplies used during a medically necessary home health visit.
- If a medical supply code required PA prior to March 1, 2010, this requirement remains.

Prior Authorization Requirements

PA is required for all home health services.

Home health services are prior authorized depending upon the skill level of care, frequency, and duration of visits and chronicity of the beneficiary's condition. Providers use the Acute Care Home Health Service Plan to render services for time-limited conditions and the Long-Term Care Service Plan for beneficiaries who require assistance to manage chronic conditions. Providers use the Diabetes Management Home Health Service Plan to care for beneficiaries with diabetes.

Appendix III Updated 05/11

Acute Care Home Health Service Plan

The Acute Care Home Health Service Plan is to be used when beneficiaries are initially admitted for home health services following an acute injury or illness. This level of care could be warranted after a hospitalization or a surgical procedure. The Acute Care Home Health Service Plan is for the provision of services that are medically predictable.

Although homebound status is not required for acute care home health services, many of the beneficiaries in need of acute care home health services experience difficulty leaving home due to physical impairments related to their illness, injury, or postsurgical status.

A start of care Outcome and Assessment Information Set (OASIS) C assessment and physician certification of the new plan of care (485) are required to initiate an acute care home health plan of care.

The following apply for the provision of acute care home health services:

- All acute care home health service codes are limited to a combined total of 120 visits per calendar year per beneficiary. Acute care visits are granted through PA if there are units remaining that have not been authorized.
- Acute care home health limitations are based on a calendar year.
- Providers use codes 99601, 99602, G0154, G0156, T1002, T1003, T1004, and T1023 for acute care skilled nursing and home health aide visits. Skilled nursing visits and home health aide visits can be prior authorized for up to one hour with documentation to support that the service is reasonable and necessary.
- Home health aide visits are limited to two (up to one-hour) visits per week with supporting medical necessity documentation. Providers must submit additional documentation supporting medical necessity to exceed two home health visits per week. This is to ensure effective and efficient use and accurate reimbursement. These requests are considered on a case-by-case basis. Providers cannot bill more than one home health aide visit per date of service.
- Home health aide services are noncovered on the same date of service as restorative aid services for the same beneficiary.
- Code 99602 is used in circumstances when an IV infusion requires continuous monitoring and cannot be administered in two hours. Providers use code 99602 for each additional hour of IV infusion. If there is concern about potential side effects, the medication should be administered in an outpatient setting.
- Code T1023 is allowed for skilled nursing visits that include information gathering for OASIS C assessments, certifications, or recertifications. This code is limited to six visits per year and can be billed under all three home health service plans.
- OASIS C assessments for which a home visit is not mandated (transfers, death, or unplanned discharge) are not billable with T1023.
- If a beneficiary is under 18 years of age or pregnant, an OASIS C assessment is not required; therefore providers should use G0154, T1002, and T1003 codes for the admission assessment.
- KMAP will not reimburse providers for nonvisit assessments.
- If it becomes evident home health services are needed long-term, the agency should switch the beneficiary to the Long-Term Care Home Health Service Plan prior to exhausting all acute care visits.
- Providers can change a beneficiary from acute care to long-term care during a certification period or at any time it is determined the services will be needed long-term in an effort to preserve acute care units if needed for future acute episodes.

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- The provider must fax the Change in Home Health Service Plan or Discharge From Service form to notify the PA department of a switch or discharge from a plan within five business days of the event.
- Home health beneficiaries may have more than one episode of acute care services.
- Acute care home health services can be prior authorized for up to 60 days.
- Providers use codes S9128, S9129 and S9131 for rehabilitative therapy services rendered under the Acute Care Home Health Service Plan. All therapy visits count toward the 120 visits per year acute care limitation.
- Therapy services involving activities for the general welfare of any beneficiary, such as general exercises to promote overall fitness or flexibility and activities to provide diversion or general motivation, do not constitute skilled therapy. Nonskilled individuals without the supervision of a therapist can perform those types of services.

Long-Term Care Home Health Service Plan

The Long-Term Care Home Health Service Plan is to be used for beneficiaries who receive frequent and brief intervals of home health services for assistance with monitoring chronic conditions. The beneficiaries often have diagnoses that include asthma, COPD, diabetes, and heart disease. The beneficiaries are relatively stable and require frequent monitoring to prevent exacerbation of symptoms which would warrant emergent care or hospitalization. Long-term care home health services often include health maintenance services the beneficiaries cannot provide for themselves due to cognitive or physical limitations.

Although homebound status is not a requirement for the Long-Term Care Home Health Service Plan, many beneficiaries of long-term care experience difficulty leaving home due to cognitive and physical limitations.

The documentation requirements for the Long-Term Care Home Health Service Plan includes nursing service codes specific to the Long-Term Care Home Health Service Plan. Providers must submit the most current OASIS C assessment, 485, and all other required documents to initiate the long-term care home health service. Renewals require the most current 485 and 60-day summary documentation.

The following apply for the provision of long-term care home health services:

- All long-term care home health services are for the provision of reasonable and medically necessary health maintenance tasks to assist beneficiaries in managing chronic health conditions in the home setting and thereby avoid placement in nursing facilities or other institutions.
- Long-term care home health visits must not duplicate other resources available to the beneficiary.
- Providers use codes 99600, 99601, 99602, G0156, S0316, T1004, T1023, T1030, T1031, and T1502 for the provision of long-term care home health skilled nursing and home health aide visits.
- Providers use code 99600 for brief, routine skilled nursing visits in accordance with the plan of care. This is a per visit code.
- Code 99602 is used in circumstances when an IV infusion requires continuous monitoring and cannot be administered in two hours. Providers use 99602 for each additional hour of the IV infusion. If there is concern about potential side effects, the medication should be administered in an outpatient setting.

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- Code T1023 is allowed for skilled nursing visits that include information gathering for OASIS C assessments, certifications, or recertifications. This code is limited to six visits per year and can be billed for all three home health service plans.
- OASIS C assessments for which a home visit is not mandated (transfers, death, or unplanned discharge) are not billable with T1023.
- If a beneficiary is under 18 years of age or pregnant, an OASIS C assessment is not required; therefore, providers should use S0316 for the long-term care admission assessment.
- KMAP will not reimburse providers for nonvisit assessments.
- Providers use code S0316 for skilled nursing visits of a longer duration, for example, visits that include an assessment and medication setup. This is a per visit code.
- Providers use codes T1030 and T1031 for the provision of telehealth visits under the Long-Term Care Home Health Service Plan. See specific provider requirements for the provision of telehealth services.
- Providers use code T1502 for medication administration. This is to be used when nonskilled nursing visits are provided by a RN or LPN to assist beneficiaries with cognitive and physical impairments with their care such as, but not limited to, oral medication administration and nebulizer treatments (treatments that are generally self-administered), when the service cannot be received through other resources.
- Long-term skilled nursing visits are reimbursed per visit.
- Home health aide visits are limited to two (up to one-hour) visits per week with supporting medical necessity documentation. Providers must submit additional documentation supporting medical necessity to exceed two home health visits per week. This is to ensure effective and efficient use and accurate reimbursement. These requests are considered on a case-by-case basis. Providers cannot bill more than one home health aide visit per date of service.
- Home health aide services are not covered on the same date of service as restorative aide services for the same beneficiary.
- If the beneficiary experiences a separate and distinct acute illness or injury while receiving services through long-term care, the agency can switch the beneficiary to an acute care episode. Supporting documentation must include a resumption of care or significant change OASIS C assessment to support the provision of acute care services.
- Once the acute condition has resolved or stabilized, the agency can switch the beneficiary back to the Long-Term Care Home Health Service Plan.
- Providers can change a beneficiary from acute care to long-term care during a certification period or at any time it is determined the services will be needed long-term in an effort to preserve limited acute care visits for future acute episodes.
- The provider must fax the Change in Home Health Service Plan or Discharge From Service form to notify the PA department of a switch or discharge from a plan within five business days of the event.
- Long-term care home health services can be prior authorized for up to six months for beneficiaries who require this level of care until placement in a nursing facility.
- Providers use codes S9128, S9129, and S9131 for rehabilitative therapy services rendered under the Long-Term Care Home Health Service Plan. The same yearly limitations in place for therapy services under the acute care benefit also apply under the long-term care benefit.
- Providers use code T1021 for restorative aide visits.

Appendix III Updated 05/11

- It is anticipated that rehabilitative therapy will rarely be prescribed for a beneficiary receiving home health services through the long-term care benefit.
- Therapy services involving activities for the general welfare of any beneficiary, such as general exercises to promote overall fitness or flexibility and activities to provide diversion or general motivation, do not constitute skilled therapy. Nonskilled individuals without the supervision of a therapist can perform these services.

Diabetes Management Home Health Service Plan

The Diabetes Management Home Health Service Plan is used for beneficiaries who receive frequent and brief intervals of home health services for assistance with managing their diabetes. The beneficiaries and their unpaid caregivers must be unable to manage the diabetes due to cognitive or physical limitations.

The beneficiaries are relatively stable but require frequent skilled nursing visits for diabetes management, which includes blood glucose monitoring and insulin administration. The beneficiaries and their caregivers are deemed unable to manage the condition. Home health services are provided to assist the beneficiary in maintaining stable blood glucose levels and obtaining periodic assessments according to the current best practice guidelines in order to prevent or delay costly complications associated with diabetes.

Although homebound status is not a requirement for the Diabetes Management Home Health Service Plan, many beneficiaries have other chronic health conditions and experience difficulty leaving the home due to these conditions in addition to their cognitive and physical limitations.

The documentation requirements for the Diabetes Management Home Health Service Plan include nursing service codes specific to diabetes management and a quality indicator form. Providers must submit the most current OASIS C assessment, 485, and all other required documents to initiate the Diabetes Management Home Health Service Plan. Renewals require a current 485 and 60-day summary.

The following apply for the provision of diabetes management home health services:

- All diabetes management home health services are for the provision of reasonable and medically necessary health maintenance tasks to assist beneficiaries in managing their diabetes in the home setting and thereby avoiding placement in nursing facilities or other institutions.
- Diabetes management home health visits must be reasonable and necessary and must not duplicate other resources available to the beneficiary.
- Providers use codes 99601, 99602, G0156, S0315, S9460, T1004, T1023, T1030, and T1031 for the provision of skilled nursing visits to render diabetes management services.
- Diabetes management skilled nursing visits are reimbursed per visit.
- Home health aide visits are limited to two (up to one hour) visits per week with supporting medical necessity documentation. Providers must submit additional documentation supporting medical necessity to exceed two home health visits per week. This is ensure effective and efficient use and accurate reimbursement. These requests are considered on a case-by-case basis. Providers cannot bill more than one home health aide visit per date of service.
- Home health aide services are not covered on the same date of service as restorative aide services for the same beneficiary.

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- Code 99602 is used in circumstances when an IV infusion requires continuous monitoring and cannot be administered in two hours. Providers use 99602 for each additional hour of the IV infusion. If there is concern regarding potential side effects, the medication should be administered in an outpatient setting.
- Code T1023 is allowed for skilled nursing visits that include information gathering for OASIS C assessments, certifications, or recertifications. This code is limited to six visits per year and can be billed for all three home health service plans.
- OASIS C assessments for which a home visit is not mandated (transfers, death, or unplanned discharge) are not billable with T1023.
- KMAP will not reimburse providers for nonvisit assessments.
- Providers use code T1502 for medication administration. This is to be used when nonskilled nursing visits are provided by a RN or LPN to assist beneficiaries who have cognitive and physical impairments with their care, such as, but not limited to, oral medication administration and nebulizer treatments (that are generally self-administered), when the service cannot be received through other resources.
- Providers use code S0315 for skilled nursing visits of a longer duration, for example, visits that include an assessment, medication setup, and periodic assessment in accordance with current best practices for the treatment of diabetes. This is a per visit code.
- Providers use code S9460 for skilled nursing visits of a brief duration in accordance with the plan of care for blood glucose monitoring in addition to insulin administration. This is a per visit code.
- Providers use codes T1030 and T1031 for the provision of telehealth visits to assist beneficiaries in managing their diabetes. See specific provider requirements for the provision of telehealth services.
- If the beneficiary experiences a separate and distinct acute illness or injury while receiving services through the Diabetes Management Home Health Service Plan, the agency can switch the beneficiary to an acute care episode. Supporting documentation must include a significant change assessment to support the provision of acute care services.
- Once the acute condition has resolved or stabilized, the agency can switch the recipient back to the Diabetes Management Home Health Service Plan.
- Providers can change a beneficiary from acute care back to the Diabetes Management Home Health Service Plan during a certification period or at any time the acute care condition is resolved or it is determined the services will be needed long-term in an effort to preserve limited acute care visits for future acute episodes.
- The provider must fax the Change in Home Health Service Plan or Discharge From Service form to notify the PA department of a switch or discharge from a plan within five business days of the event.
- Diabetes management home health services can be prior authorized for up to six months for beneficiaries who will probably require this level of care until placement in a nursing facility.
- Providers use codes S9128, S9129, and S9131 for rehabilitative therapy services rendered under the Diabetes Management Home Health Service Plan. The same yearly limitations in place for therapy services under the acute care benefit also apply under the Diabetes Management Home Health Service Plan.
- Providers use code T1021 for restorative aide visits.

Appendix III Updated 05/11

- It is anticipated that rehabilitative therapy will rarely be prescribed for a beneficiary receiving home health services through the Diabetes Management Home Health Service Plan.
- Therapy services involving activities for the general welfare of any beneficiary, such as general exercises to promote overall fitness or flexibility and activities to provide diversion or general motivation, do not constitute skilled therapy. Nonskilled individuals without the supervision of a therapist can perform these services.

HCBS Waiver Beneficiaries

HCBS waiver beneficiaries are assigned one of the following waivers:

- Mental retardation/developmental disabilities (MR/DD) waiver
- Traumatic brain injury (TBI) waiver (previously head injury)
- Physical disability (PD) waiver
- Technology assisted (TA) waiver
- Frail elderly (FE) waiver
- Money Follows the Person (MFP), including MFP-FE, MFP-MRDD, MFP-PD, and MFP-TBI
- Work Opportunities Reward Kansans (WORK), should only be needed for acute episodes
- Severely emotionally disturbed (SED) waiver

Note: The SED waiver only provides some mental health services.

Beneficiaries assigned to the HCBS waivers can receive reasonable and necessary home health services that are not duplicative of waiver services. Most waivers include attendant care services. The personal care attendants perform the same types of services home health aides usually perform.

Health maintenance activities, such as monitoring vital signs, supervision, or training of nursing procedures, ostomy care, catheter care, enteral nutrition, medication administration/assistance, wound care, and range of motion, can be provided to self-directed HCBS waiver beneficiaries in accordance with K.S.A. 65-6201(b)(2)(A).

Skilled Services Limitations

- Nursing services are RN or LPN level of care. (Home health aide is not skilled.)
- Occupational therapy (OT), physical therapy (PT), and speech therapy are limited to no more than one unit per day and are included in the combined total acute care service limitation of 120 visits per year.
- These services must be restorative and rehabilitative and can only be provided following physical debilitation due to acute physical trauma or physical illness. This is limited to six months in duration for adult beneficiaries.
Note: This limit cannot be overridden with PA.
- KBH-eligible beneficiaries can receive reasonable and necessary rehabilitative therapy services for the duration needed.
- Respiratory therapy is limited to KBH-eligible beneficiaries. (Beneficiary must be under 21 years of age.) Respiratory therapy is limited to one unit per day. The code S5181 is not subject to the limitations of other home health services due to KBH specifications, reasonable, and necessary services to correct or ameliorate a condition.

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Home Telehealth Service Limitations

- Providers must bill T1030 and T1031 with modifier GT for home telehealth skilled nursing visits. These codes are per visit.
- Providers must bill T1030 and T1031 with both modifiers GY and GT for home telehealth skilled nursing visits for Medicare-eligible beneficiaries with a Medicaid-covered benefit plan.
- PAs are entered for no more than 60 days. Home telehealth services cannot be approved for durations of more than 60 days. Additional documentation may be required to support continuation of home telehealth service requests that exceed 60 days.
- Telehealth visits must be provided by a RN or LPN.
- Telehealth visits must use face-to-face, real-time, interactive video contact to monitor beneficiaries in the home setting as opposed to a nurse visiting the home. This technology can be used to monitor a beneficiary's health status and to provide timely assessment of chronic conditions and other skilled nursing services.
- HCBS beneficiaries eligible for face-to-face skilled nursing visits provided by a home health agency (05-050) may also receive home telehealth visits with documentation of medical necessity and PA. The PA request must include units to cover the duration and frequency of home telehealth visits.
- **Oral medication administration or monitoring is not considered skilled care.**

Nonskilled Services Limitations

Nonskilled (home health aide) level services are rarely approved for persons on an HCBS waiver, due to potential duplication of services and similarities in the scope of services provided by the home health aide and personal care attendants. Nonskilled level services should be provided as noted below:

- FE waiver – Nonskilled services should be provided by FE Level II attendant.
- PD waiver – Nonskilled services should be provided by PD personal services.
- MR/DD waiver – Nonskilled services should be provided by attendants or family if the beneficiary is receiving supportive home care or family individual support or through the facility if the beneficiary is receiving residential services.
- TBI waiver – Nonskilled services should be provided through TBI personal services.
- SED waiver – There may be rare requests for home health services for this waiver. Each request should be judged on its merits. Documentation must support the medical necessity for the requested service.

Nonskilled Services Descriptions and Examples

Home health aide level services include, but are not limited to:

- Administration of routine oral medications, eye drops, and topical ointments (assistance with medications ordinarily self-administered that do not require the skills of a licensed nurse to be provided safely and effectively)
- General maintenance care of colostomy and ileostomy
- Routine services to maintain satisfactory functioning of indwelling bladder catheters
- Simple dressing changes for wounds, noninfected postoperative, or chronic condition
- Prophylactic and palliative skin care, including bathing and application of creams or treatment of minor skin problems
- Routine care of the incontinent patient, including use of diapers and protective sheets
- General maintenance care in connection with a plaster cast
- Routine care in connection with braces and similar devices

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- Periodic turning and positioning in bed
- Assistance with dressing, eating, and going to the toilet
- Routine range of motion (ROM) activities
- Gastrostomy and enteral feedings
- Vital signs

Note: Code T1021 cannot be approved on the same date of service as home health aide visits.

Money Follows the Person Demonstration Grant Beneficiaries

- MFP beneficiaries are assigned to one of the following LOCs:
 - MFP MR/DD demonstration grant
 - MFP TBI demonstration grant
 - MFP PD demonstration grant
 - MFP FE demonstration grant
- Most MFP services will include attendant care, which provides the same services home health aides usually perform.

Nonwaiver Beneficiaries

PA limitations will be determined based upon the level of care and anticipated duration in which services are required, using the Acute Care Home Health Service Plan, Long-Term Care Home Health Service Plan, or Diabetes Management Home Health Service Plan.

Home Health Aide Service

Beneficiaries not on a waiver can receive reasonable and medically necessary home health aide visits with PA. Home health aide visits are included in the combined total of 120 acute home health visits per year. Long-term care and diabetic management service plans are limited to up to one-hour visits no more than twice per week. Providers must submit documentation supporting medical necessity to exceed two home health visits per week to ensure effective and efficient use and accurate reimbursement. This will be considered on a case-by-case basis. Providers cannot bill more than one home health aide visit per date of service.

Skilled Therapy Services

Speech, occupational, and physical therapy are limited to one unit per day. Services should not exceed six months duration and require PA. Respiratory therapy is limited to KBH-eligible beneficiaries and is limited to one unit per day.

PRN Visits

PRN visits can be requested at the time they occur or within five working days after a visit has been made. Calls made to the PA department during nonworking hours are considered to be notification of the request. Agencies have 15 working days from the time of the call to submit a physician's order and completed, appropriate home health services PA request form to the PA department. If the required documentation is not submitted within the timeframe, the request will be denied.

PRN telehealth visits are noncovered.

Appendix III Updated 05/11

Paperwork Requirements

Initial Request

- Completed, appropriate home health services PA request form
- 485 or plan of care that includes physician's orders
- Completed, up-to-date OASIS C
- Physician assessment form of quality indicators and best practice interventions for beneficiaries receiving care for diabetes management

Note: The OASIS C is a requirement of MCR and therefore MCD. The OASIS C assessment is not required for MCR for children (18 years of age and younger) and is not required documentation for children for MCD home health requests. The OASIS C is not required for maternity beneficiaries. The OASIS C is not required by MCR for these beneficiaries, thus it is not required for MCD.

The provider must fax the Change in Home Health Service Plan or Discharge From Service form to notify the PA department of a switch or discharge from a plan within five business days of the event.

Supporting Documentation for Reconsideration or Renewal Requests

- Completed, appropriate home health services PA request form
- 485 or plan of care that includes physician's orders
- Documentation of the 60-day summary or 486 which includes beneficiary's response to treatment and supports continuance of home health services

Recertification summaries should have information from the clinical and progress notes that are communicated to the physician to determine continuation of home health services. The summary should include specifics about the beneficiary's health status, any changes in the beneficiary's condition, and progress toward established goals. Specific information may include:

- Hospitalization
- Emergency room visits
- New diagnosis or changes in the severity of current diagnosis
- Medication changes
- Vital sign ranges
- Blood sugar ranges
- Training attempted
- Beneficiary and caregiver responses and progress in response to training
- Actions taken to encourage and foster beneficiary independence with self-care and health maintenance activities
- Any significant changes which impact the beneficiary's care
- Documentation to support continued home health services
- Physician assessment form of quality indicators and best practice interventions for beneficiaries receiving care for diabetes management

Providers can submit additional documentation to support the need for requested services, such as blood glucose logs and insulin administration records for the most recent 30-day period.

The provider must fax the Change in Home Health Service Plan or Discharge From Service form to notify the PA department of a switch or discharge from a plan within five business days of the event.

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Call In Requests

- Providers must phone or fax the PA department indicating a switch or discharge from a plan within five business days of the event.
- The paperwork can be mailed to KMAP, Office of the Fiscal Agent, P.O. Box 3571, Topeka, KS 66601-3571 or faxed to 785-274-5956 or 1-800-913-2229. The Home Health Services Prior Authorization Request Form is also available at on the [Forms page](#) of the KMAP website.

Physician's Orders

- All home health services require a physician's order. Either a physician's order or a verbal order signed by a RN from a physician is acceptable to initiate treatment. Upon postpay review, if the record contains physician's orders that were not signed by the physician, those services are subject to recoupment.
- The agency is required to maintain plans of care containing the physician's signature on file in the medical record located at the home health agency.

GY Modifier

- Providers billing KMAP for home health services rendered to Medicare-eligible beneficiaries must either bill Medicare first and obtain a denial or use the GY (statutorily excluded) modifier to bypass the Medicare denial requirement. The GY modifier can only be used if the beneficiary has a Medicaid-covered benefit plan.
- Providers can request Medicaid coverage when a beneficiary is not "homebound."
- **If a beneficiary is a QMB but does not meet eligibility for Medicaid coverage, providers cannot bill KMAP for home health services rendered to a QMB-only beneficiary.** The beneficiary must have a Medicaid-covered benefit plan such as TXIX in addition to Medicare coverage to be eligible for fee-for-service home health visits.

Adjusting Existing PA

- Adjustments can be made to existing PAs when RN level of care needs to be changed to LPN or vice versa for the Acute Care Home Health Plan.
- The total units should not be increased or decreased without specific documentation as to the need for the increased or decreased units. Requests for this type of adjustment should be accompanied by a completed, appropriate home health services prior authorization request form.

Guidelines

Time Allowed Per Visit

All services performed during the visit are to be considered concurrent. For instance, an RN doing a dressing change would not need an additional hour to do an assessment because the RN should be assessing while doing the dressing change. Consider which services can be combined in determining the total time required for each visit. Documentation provided for each visit must support the amount of time billed.

Appendix III Updated 05/11

Licensed Professional Services Defined

Services generally considered to require the skill level of a licensed professional include, but are not limited to:

- Assessments
- Care plan development
- Catheter insertion and replacement
- Diabetic nail care
- Dressing changes/wound care – complicated
- Infusions
- Injections
- Medication setup
- Observation and assessment of an unstable beneficiary
- Parenteral feedings
- Prefilling insulin and other syringes
- Procedures requiring use of sterile technique
- Psychiatric nursing requiring RN level of care
- Supervision
- Teaching and training activities
- Tracheostomy tube changes
- Treatment of extensive decubitus ulcers or other widespread skin disorders
- Venipuncture requiring RN level of care

Aide Level (Nonskilled) Services Defined

Services generally considered not to require the skill level of a licensed professional include, but are not limited to:

- Administration of routine oral medications, eye drops, and topical ointments
- Assistance with bathing, dressing, eating, and toileting
- Bowel and bladder procedures – bowel stimulation, obtaining specimens, performance of enemas, or impaction removal if:
 - Self-directed (HCBS waivers only)
 - Ordered by the physician
 - No contraindications exist
- Chronic bowel condition
- Emptying of ostomy or urine bag
- Gastrostomy and enteral feedings
- General maintenance care of colostomy, ileostomy, and catheters
- Prophylactic and palliative skin care
- Routine ROM activities
- Simple, nonsterile dressing changes
- Treatment of minor skin problems
- Vital signs

Services which generally do not require the skill level of a licensed professional may require a licensed professional if the beneficiary's condition is complicated or compromised or if other extenuating circumstances exist. In these circumstances, the documentation must support the use of a licensed professional. Reimbursement for services paid at a skill level higher than the skill level supported by the documentation will be recouped.

Appendix III Updated 05/11

Time Frames

- Providers who bill beyond the frequency and duration established by PA may be subject to nonpayment or postpay recoupment if the documentation does not support the services provided.
- All services that can be completed within the same visit should be completed within the same visit rather than scheduling multiple visits to perform different skilled tasks.

Assessments/Evaluations/Reassessments

- An OASIS C assessment, if performed in the absence of any other skilled service, is reimbursable every 60 days to determine the beneficiary's skilled service needs and to develop or revise the plan of care.
- If the OASIS C assessment is completed during a visit in conjunction with any other skilled service, providers will only be reimbursed for T1023.
- Visits for assessments may be allowed if there is a change in the beneficiary's condition or modifications to the plan of care is needed. Providers should use codes such as S0315 and S0316 for such assessments. G0154 and T1002 should be used for acute care visits.
- The use of T1023 is only billable for comprehensive assessments/reassessments in which the OASIS C tool is completed and is used to update the plan of care.
- Providers can request PRN visits to facilitate compliance with Medicare assessment guidelines.
- Providers can adjust the visit schedule to allow recertifications to be conducted at regularly scheduled visits.

Care Plan Development

Care plan development is not a separate billable service. (It is included in the assessment/evaluation reimbursement rate.)

Catheters Insertion and Replacement

- **Foley:** Up to one hour per month plus up to two one-hour PRN visits if ordered by the physician. (Up to 30 minutes once per month plus up to two PRN visits if the beneficiary has newly acquired the catheter or has a history of complications.)
- **Straight Catheter:** Up to 30 minutes up to four times daily. Document the efforts to train the beneficiary or caregiver to perform the catheterization (up to 30 minutes).

Chronic Illness Monitoring

Up to 60 minutes twice monthly. Skilled nursing services may be provided on a limited basis to chronically ill beneficiaries with the potential for exacerbation or instability. One-hour visits up to twice monthly for six months may be approved if the documentation supports a history of frequent hospital admissions, exacerbations to acute stages of the chronic disease, or overall debility which puts the beneficiary at risk of instability (up to two 30-minute visits per month).

Dressing Changes/Wound Care Non-MRSA

Generally, up to two hours per day; this may be one hour twice a day (BID) for 10 days and up to one hour per day for an additional four days when supported by the physician's order and plan of care (30 minutes BID up to ten days and up to 30 minutes daily for up to four days). Authorization for longer periods can be allowed with proper documentation.

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Dressing Changes/Wound Care MRSA or VRE

Up to two 90-minute visits daily for a total of up to three hours daily, for a maximum of 60 days (up to 60 minutes BID up to 60 days). The duration of skilled nursing visits are determined based upon the complexity of the wounds. Documentation must support the time billed.

Decubitus Ulcers

Treatment of extensive decubitus ulcers will vary depending upon the services needed and the extent of the problem. Documentation must support the time billed.

Note: The duration of skilled nursing visits is determined based upon the complexity of the wounds. Documentation must support the time billed for wound care and must include measurements, status of the wound bed and surrounding area, progress towards wound healing and barriers to wound healing, such as nutrition, low albumin, inadequate pressure relief, and noncompliance. Documentation must support the treatment regimen is periodically reassessed and reviewed to promote continued wound healing.

Diabetic Nail Care

30 minutes monthly. This service should usually be done in conjunction with some other service and rarely as a stand-alone service (20-30 minutes monthly).

Eye Drops

15 minutes per visit. Documentation must support the need for a licensed nurse visit for the purpose of instilling eye drops, such as new postsurgery or newly diagnosed acute medical condition (up to four visits daily, up to 10 minutes).

Glucose Monitoring

Up to four 15-minute visits per day. Generally this is not a skilled service and is usually performed by the beneficiary or caregiver but may be allowed as a skilled nursing service if the documentation demonstrates the beneficiary or caregiver is unable to perform glucose monitoring. A skilled visit may also be allowed if the beneficiary is unstable and the documentation supports a clinical need for assessment, management, and reporting to the physician of specific conditions and/or symptoms which are unstable or unresolved. (Five minutes up to four times per day for up to two weeks if stand-alone service. If provided with insulin administration, 5 to 10 minutes are allowed.)

Infusion Therapy

Code 99601 (GY) is used for IV infusion therapy for beneficiaries who have a Medicaid-covered benefit plan. The code description states up to two hours of service. This code is a per visit code. An agency may use this code for each visit made to the home to provide infusion therapy. Agencies providing infusion services will typically be in the home longer and should use 99601. One unit of 99601 is expected to encompass both the initiation and disconnection of an infusion along with performance of other tasks in the home while the IV infuses. If an infusion is started and the nurse leaves while the IV infuses and returns to disconnect the IV, this is considered to be one visit. If a nurse performs an infusion in the morning and while the infusion is running does other tasks, such as a dressing change, and must return later in the day to perform another skilled nursing service, such as change the second dressing of the day, the second visit should be billed using appropriate nursing codes.

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Code 99602 is used in circumstances when an IV infusion requires continuous monitoring and cannot be administered in two hours. Providers use 99602 for each additional hour of the IV infusion. If there is concern regarding potential side effects, the medication should be administered in an outpatient setting.

Note: Flushing ports or disconnecting a previously setup infusion are not considered infusion therapy and will not be reimbursed using 99601 or as a separate reimbursable visit. Administration of medications using manual IV push is not considered infusion therapy and will not be reimbursed using 99601. Infusion pumps using syringe cartridges are considered infusions and will be reimbursed using code 99601.

Injections

Up to five minutes for injections, up to 30 minutes for observation for allergy injections. (Allergy injections should not be provided in the home to a person who routinely goes out of the home and could obtain the injection from his or her physician's office or a clinic.)

Insulin Injections/Diabetes Management

Up to 15 minutes up to four times per day, depending upon the physician's orders. Allowed for 5 to 10 minutes up to four times a day (QID) for two weeks during the unstable phase. Allowed for 5 to 10 minutes up to four times a day for two weeks to teach and train once stable.

- Insulin injections may be allowed if the beneficiary is unable to self-inject, there is no other person available to give the injection, and attempts to use other technology or to teach the patient to self-inject have failed. Documentation must demonstrate the beneficiary and/or caregiver is unable to administer the injections.
- Documentation must support the need for diabetes management and reporting specific conditions or symptoms which are unstable or unresolved.

Medication Administration

Routine oral medication administration is a home health aide level service and should not require skilled nursing services. Exceptions may exist when the beneficiary is compromised or requiring assessment prior to medication administration, or when medications must be crushed or administered through a G-tube. Inhalers should be administered by the waiver attendants, or beneficiary should be taught to self-administer inhalers. In rare cases, a beneficiary may not be able to self-administer an inhaler and home health services may be authorized.

Note: If a patient is on a waiver, medication administration is content of the waiver service and should not require home health services.

Medication Setup

- Medications should be obtained setup from the pharmacy or in unit dose packs to aid in the proper administration of routine oral medications by the beneficiary, caregiver, attendants, or aides.
- When a nurse must set up medications in a beneficiary's home, the nurse performs the medication setup in conjunction with other skilled activities. Rarely should it be necessary for a nurse to perform a skilled visit solely for the purpose of medication setup.
- When possible, medications should be set up for more than a one-week period of time.
- Time allowed to set up medications depends on the number and complexity of the medications and the number of weeks being set up.

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- Prefilling insulin syringes should be included as part of medication setup. If this is the only medication required by the beneficiary to be set up, prefilled syringes should be obtained from the pharmacy, if possible.

Ostomy Care

- Rarely should ostomy care require a licensed professional but could be indicated in a situation such as the acute postoperative period or in the presence of complications.
- Ostomy care should occur in conjunction with other services, such as teaching or training rather than as a stand-alone service.
- Documentation must support the need for the licensed professional.
- Insertion/replacement of a gastrostomy or urostomy tube may be approved up to one hour every month with a maximum of two additional one-hour PRN visits per month.

Psychiatric Nursing

- Documentation should support the time spent. Assessments, mental status exams, and other therapeutic interventions designed to relieve psychiatric symptoms are considered psychiatric nursing.
- Psychiatric nursing services provided by home health agencies are not limited to the homebound. Nonhomebound patients should be encouraged to use community mental health centers.
- Psychiatric nursing services must be provided by a RN.
- In accordance with Medicare guidelines, the evaluation, psychotherapy, and teaching needed by a patient suffering from a diagnosed psychiatric disorder requiring active treatment by a psychiatrically trained nurse and the costs associated with the psychiatric nurse's services may be covered as a skilled nursing service. Psychiatrically trained nurses are nurses who have special training and/or experience beyond the standard curriculum required for a RN. The services of the psychiatric nurse are to be provided under a plan of care established and reviewed by a physician.
- Because the law precludes agencies primarily providing care and treatment of mental diseases from participating as a home health agency, psychiatric nursing must be furnished by an agency not primarily providing care and treatment of mental diseases. If a substantial number of a home health agency's beneficiaries attend partial hospitalization programs or receive outpatient mental health services, verification is required to determine whether the patients meet the eligibility requirements specified and whether the home health agency is primarily engaged in care and treatment of mental diseases.
- Services of a psychiatric nurse would not be considered reasonable and necessary to assess or monitor use of psychoactive drugs being used for nonpsychiatric diagnoses or to monitor the condition of a beneficiary with a known psychiatric illness who is on treatment but is considered stable. A person on treatment would be considered stable if his or her symptoms were absent or minimal or if symptoms were present but relatively stable and did not create a significant disruption in the patient's normal living situation.

(Medicare Benefit Policy Manual, Chapter 7 – Home Health Services: 40.1.2.15)

Supervision

- Nursing visits for the purpose of supervising aides are not a separate billable service. Supervisory visits should occur during visits scheduled for other skilled services such as medication setup, assessment, catheter change, and so forth.

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- Supervision of home health aides is required every two weeks only if the patient is receiving skilled nursing services. If the patient is receiving only home health aide level of care, supervision is only required every 60 days.

Teaching and Training

- Teaching and training activities requiring skilled nursing personnel to teach a beneficiary, the beneficiary's family, or caregivers how to manage the beneficiary's treatment regimen constitute skilled nursing services as long as the services are appropriate to the beneficiary's functional loss, illness, or injury.
- All teaching and training should be associated with the performance of an actual service, such as wound care, ostomy care, or glucose monitoring.
- Documentation must support the need for teaching and training and beneficiary, family, or caregiver response to teaching. If the beneficiary, family, or caregivers are unable to be trained, further teaching and training would cease to be reasonable and necessary. Documentation in the record should note why training was unsuccessful.
- Three types of teaching and training are recognized:
 - Initial teaching of a new skill
 - Reinforcement of teaching or training previously provided in an institutional setting
 - Reteaching when there is a change in the beneficiary's condition or the task is being carried out incorrectly
- Teaching and training activities requiring the skill of a licensed nurse include, but are not limited to, the following teaching:
 - Self-administration of injectable medications or complex range of medications
 - Newly diagnosed diabetic or caregiver all aspects of diabetes management, including how to prepare and administer insulin injections, to prepare and follow a diabetic diet, to observe foot care precautions, and to recognize and understand signs of hyperglycemia and hypoglycemia
 - Self-administration of nebulizer and breathing treatments
 - Wound care where the complexity of the wound, the overall condition of the beneficiary, or the ability of the caregiver makes teaching necessary
 - Care for a recent ostomy or reinforcement of ostomy care when needed
 - Self-catheterization
 - Self-administration of gastronomy or enteral feedings
 - Care for and maintenance of peripheral and central venous lines and administration of IV medications through such lines
 - Bowel or bladder training when bowel or bladder dysfunction exists
 - How to perform the activities of daily living when the beneficiary or caregiver must use special techniques and adaptive devices due to a loss of function
 - Transfer techniques such as from bed to chair, needed for safe transfer
 - Proper body alignment, positioning, and timing techniques for a bedridden beneficiary
 - Ambulation with prescribed assistive devices (such as crutches, walker, or cane) which are needed due to a recent functional loss
 - Use and care of braces, splints, and orthotics and associated skin care
 - Preparation and maintenance of a therapeutic diet
 - Proper administration of oral medication, including signs of side effects, and avoidance of interaction with other medications and foods

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- Proper care and application of any special dressings or skin treatments (such as dressings or treatments needed due to severe or widespread fungal infections, active and severe psoriasis or eczema, or skin deterioration from radiation treatments)

Occupational Therapy

Occupational therapy must be restorative and rehabilitative and provided by a registered occupational therapist. It may only be provided following physical debilitation due to acute physical trauma or physical illness and is limited to six months duration for non-KBH beneficiaries. This service is limited to one unit per day and other limitations of the Acute Care Home Health Service Plan.

Physical Therapy

Physical therapy must be restorative and rehabilitative and provided by a registered physical therapist. Physical therapy can only be provided following physical debilitation due to acute physical trauma or physical illness and is limited to six months duration for non-KBH beneficiaries. This service is limited to one unit per day and other limitations of the Acute Care Home Health Service Plan.

Respiratory Therapy

Respiratory therapy is limited to KBH beneficiaries. The limit is one unit per day.

Speech Therapy

Speech therapy must be restorative and rehabilitative and provided by a licensed speech language pathologist. Speech therapy can only be provided following physical debilitation due to acute physical trauma or physical illness and is limited to six months duration for non-KBH beneficiaries. This service is limited to one unit per day and other limitations of the Acute Care Home Health Service Plan.

Restorative Aide

Restorative aides may only provide restorative and rehabilitative physical therapy services under the physical therapy plan of care developed by a registered physical therapist. Restorative aide services may not be billed on the same date of service as a home health aide service. Restorative aide services may only be provided following physical debilitation due to acute physical trauma or physical illness and is limited to six months duration for non-KBH beneficiaries. One unit of restorative aide service is allowed per day.

Venipuncture

Venipuncture service should rarely, if ever, be provided as a stand-alone service and will generally be included with other services during a home visit.

Demonstration Criteria for Provider Type and Specialty (PT/PS) 05-051

1. Providers must meet all of the regulatory requirements and conditions of participation and operate as a Medicare-certified home health agency, with a provider type (PT) 05 and provider specialty (PS) 050.
2. Providers must be able to demonstrate that the equipment used to render home telehealth services meet program specifications (real-time, interactive, audio and video telecommunication).
3. Providers must submit literature to the fiscal agent's Provider Enrollment team pertaining to the telecommunication equipment the agency has chosen that will allow thorough physical assessments such as: assessment of edema, rashes, bruising, skin conditions, and other significant changes in health status.

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4. Providers must be able to obtain and maintain telecommunication devices to render home telehealth visits.
5. When the provider has satisfied all the enrollment/demonstration requirements and a site visit is performed by the state program manager, KMAP will approve enrollment of PT/PS 05-051.
6. Providers are eligible for reimbursement of home telehealth services that meet the following criteria:
 - Prescribed by a physician
 - Considered medically necessary
 - Signed beneficiary consent for telehealth services
 - Skilled nursing service
 - Does not exceed program limitations (limited to two visits per week for non-HCBS beneficiaries)

Upon completion of the enrollment process and approval of the telehealth demonstration, home health agencies should refer to home telehealth prior authorization criteria as noted in this appendix for further guidance.

Note: Providers must obtain PA for beneficiary participation in the demonstration process, as PA is required for all fee-for-service home health visits.