Rules of
Department of Social Services
Division 70—MO HealthNet Division
Chapter 90—Home Health Program

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 90—Home Health Program

13 CSR 70-90.010 Home Health-Care Services

PURPOSE: This rule provides the regulatory basis for payment for home health-care services provided to MO HealthNet-eligible participants.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) An otherwise eligible MO HealthNet participant is eligible for MO HealthNet reimbursement on his/her behalf for home health services if all the conditions of subsections (1)(A)–(C) are met.

(A) The services are prescribed by the participant's physician, who documents a face-to-face patient encounter occurred in accordance with 42 CFR 440.70(f). If a Medicare face-to-face encounter document has already been provided for the same participant episode of care, it will suffice as the MO HealthNet face-to-face documentation requirement;

(B) The services are provided in accordance with a plan of care which clearly documents the need for services and is reviewed by the physician at least every sixty (60) days; and

(C) The services are provided in the participant's place of residence as specified in 42 CFR 440.70(c) by a qualified person in the employ of or under contract to a Medicare-certified home health agency which is also licensed by Missouri and enrolled with the MO HealthNet program. 42 CFR 440.70 is published by the Federal Register, at https://www.ecfr.gov/. A copy of 42 CFR 440.70 on November 12, 2019, is incorporated by reference and made a part of this rule, as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Ct., Jefferson City, MO 65109, at its website at https://dssruletracker.mo.gov/dss-proposed-rules/welcome.action. This rule does not incorporate any subsequent amendments or additions.

(2) Home health services include the following services and items:

(A) Intermittent skilled nursing care which is reasonable and necessary for the treatment of an injury or illness;

(B) Physical, occupational, or speech therapy when the following conditions are met:

1. The participant is an eligible child, pregnant woman, or blind person; and

2. Physical, occupational, or speech therapy reasonable and necessary for restoration to an optimal level of functioning following an injury or illness, in accordance with limitations set forth in section (8) of this rule;

(C) Intermittent home health aide; and

(D) Supplies identified as specific and necessary to the delivery of a participant's nursing care and prescribed in the plan of care. Supplies are health care related items that are consumable or disposable, or cannot withstand repeated use by more than one (1) individual, that are required to address an individual medical disability, illness, or injury. Medical supplies are classified as—

1. Routine—medical supplies used in small quantities for patients during the usual course of most home visits; or

2. Non-routine—medical supplies needed to treat a patient's specific illness or injury in accordance with the physician's plan of care and meet further conditions discussed in more detail below.

(3) To qualify as skilled nursing care or as physical, occupational, or speech therapy under subsection (2)(A) or subsection (2)(B) and to be reimbursable under the MO HealthNet Home Health Program, a service must meet the following criteria:

(A) The service must require performance by an appropriate licensed or qualified professional to achieve the medically desired result. Determination that a professional is required to perform a service will take into account the nature and complexity of the service itself and the condition of the patient as documented in the plan of care;

(B) The service must generally consist of no more than one (1) visit per discipline per day, as further defined in section (5); and

(C) The service must constitute active treatment for an illness or injury and be reasonable and necessary. To be considered reasonable and necessary, services must be consistent with the nature and severity of the individual's illness or injury, his/her particular medical needs, and accepted standards of medical practice. Services directed solely to the prevention of illness or injury will neither meet the conditions of subsection (2)(A) or subsection (2)(B), nor be reimbursed by the MO HealthNet Home Health Program.

(4) Necessary items of durable medical equipment and appliances prescribed by the physician as a part of the home health service are available to participants of home health services through the MO HealthNet Durable Medical Equipment Program subject to the limitations of amount, duration, and scope where applicable.

(5) The services of a home health aide must be reasonable and necessary to maintain the participant at home, be based on the participant's illness or injury, and there must be no other person available who could and would perform the services. The duties of the aide shall include the performance of procedures such as, but not limited to, the extension of covered therapy services, personal care, ambulation, and exercise and certain household services essential to health care. The services of the aide must be supervised by a registered nurse or other appropriate professional staff member, whose visits will not be separately reimbursed unless a covered skilled nursing or therapy service as prescribed on the plan of care is performed concurrently. Participants eligible for the State Plan Personal Care Program in need of the services covered in this section who will not concurrently receive home health skilled nursing or physical, occupational, or speech therapy, must receive any services in this section that are covered under the State Plan Personal Care program through the State Plan Personal Care Program.

(6) The unit of service for both professional and home health aide services is a visit. A visit is a personal contact for a period of time, not to exceed three (3) continuous hours, in the patient's place of residence, made for the purpose of providing one (1) or more covered home health services. The combined total of all skilled nurse and home health aide visits reimbursed on behalf of a MO HealthNet participant may not exceed one hundred (100) visits per calendar year.

(A) Where two (2) or more staff are visiting concurrently to provide a single type of service, or where one (1) staff provides more than one (1) type of service or where one (1) staff is present in the home only to supervise another, only one (1) visit is reimbursable by MO HealthNet.

(B) Unless the plan of care documents a specific need for more than one (1) visit per day, MO HealthNet will reimburse only one (1) visit per day for each of the following:

skilled nurse, home health aide, physical therapist, occupational therapist, or speech therapist.

(C) When more than one (1) visit per day is medically required and documented by the plan of care, each single visit will be counted toward the combined total limit of one hundred (100). Documentation submitted with a claim supporting extended daily visits, multiple visits per day, or both does not override the one hundred (100) visit per calendar year limitation. For example: A patient requires a visit for a procedure that takes one (1) hour in the morning and requires another visit for a procedure that takes one (1) hour in the afternoon. Each visit may be reimbursed, but two (2) visits will be counted toward that participant's total home health visits for that year.

(7) To be reimbursed by MO HealthNet, all home health services and supplies must be provided in accordance with a written plan of care authorized by the participant's physician. The criteria for the development of the written plan of care and changes to the written plan of care through interim order(s) are described in the *MO HealthNet Division Home Health Provider Manual*. The *MO HealthNet Division Home Health Provider Manual* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at http://manuals.momed.com/manuals/, December 10, 2019. This rule does not incorporate any subsequent amendments or additions. Plans of care and interim order(s) are to be maintained in the client record.

(8) Skilled therapy services will be considered reasonable and necessary for treatment if the conditions of paragraphs (8)(A)1.–4. are met.

(A) The services—

1. Must be consistent with the nature and severity of the illness or injury and the participant's particular medical needs;

2. Must be considered, under accepted standards of medical practice, to be specific and effective treatment for the patient's condition;

3. Must be provided with the expectation of good potential for rehabilitation, based on assessment made by the participant's physician; and

4. Are necessary for the establishment of a safe and effective maintenance program, or for teaching and training a caregiver.

(B) Therapy services may be delivered for one (1) certification period (up to sixty (60) days), if services are initiated within sixty (60) days of onset of the condition or within sixty (60) days from date of discharge from the hospital, if the participant was hospitalized for the condition. Prior authorization to continue therapy services beyond the initial certification period may be requested by the home health provider. Prior authorization requests will be reviewed by the MO HealthNet Division, and approval or denial of the continuation of services will be based on the following criteria:

1. The service must be consistent with the nature and severity of the illness or injury and the participant's particular medical needs;

2. The services are considered, under accepted standards of medical practice, to be specific and effective treatment for the patient's condition; and

3. The services must be provided with the expectation, based on the assessment made by the attending physician, that the participant's condition will improve materially in a reasonable and generally predictable period of time, or are necessary to the establishment of a safe and effective maintenance program.

AUTHORITY: sections 208.153, 208.201, and 660.017, RSMo 2016, and section 208.152, RSMo Supp. 2019. This rule was previously filed as 13 CSR 40-81.056. Original rule filed April 14, 1982, effective July 11, 1982. Rescinded and readopted: Filed April 2, 1986, effective July 1, 1986. Amended: Filed Nov. 4, 1986, effective Feb. 1, 1987. Amended: Filed June 16, 1987, effective Nov. 1, 1987. Amended: Filed Dec. 5, 1988, effective Feb. 24, 1989. Amended: Filed April 4, 1989, effective June 29, 1989. Amended: Filed Dec. 13, 1991, effective May 14, 1992. Emergency amendment filed Nov. 18, 1993, effective Dec. 1, 1993, expired Dec. 9, 1993. Amended: Filed June 3, 1993, effective Dec. 9, 1993. Amended: Filed Jan. 15, 2004, effective Aug. 30, 2004. Emergency amendment filed Aug. 15, 2005, effective Sept. 1, 2005, expired Feb. 27, 2006. Amended: Filed June 1, 2005, effective Dec. 30, 2005. Amended: Filed June 1, 2006, effective Dec. 30, 2006. Amended: Filed Aug. 17, 2009, effective Feb. 28, 2010. Amended: Filed April 1, 2010, effective Nov. 30, 2010. Amended: Filed May 1, 2015, effective Nov. 30, 2015. Amended: Filed Dec. 10, 2019, effective June 30, 2020.*

**Original authority: 208.152, RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978, 1978, 1981, 1986, 1988, 1990, 1992, 1993, 2004, 2005, 2007, 2011, 2013, 2014, 2015, 2016, 2018; 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*

13 CSR 70-90.020 Home Health-Care Services Reimbursement

PURPOSE: This rule establishes the methodology where a MO HealthNet maximum allowable fee for service is determined on an annual basis by the MO HealthNet Division.

(1) MO HealthNet reimbursement for covered home health services provided to eligible individuals shall be made at the lower of—

(A) The provider's billed charge for the service; or

(B) The MO HealthNet maximum allowable fee for service. The fee schedule is available at www.dss.mo.gov/mhd/providers/index.htm.

(2) MO HealthNet reimbursement for covered non-routine supplies is the lower of—

(A) The provider's billed charge for the non-routine supply; or

(B) The home health non-routine supply cost. The home health non-routine supply cost is defined as the invoiced acquisition cost of the supply multiplied by two (2) to cover the cost for overhead (including taxes and shipping). Invoiced acquisition cost is defined as the amount shown on the invoice received for purchase of the supply which must include any reduction in cost the provider receives (i.e., discounts, allowances) and does not include shipping or sales tax.

AUTHORITY: sections 208.153 and 208.201, RSMo Supp. 2013, and section 208.152, RSMo Supp. 2014. This rule was previously filed as 13 CSR 40-81.057. Original rule filed May 11, 1984, effective Aug. 11, 1984. Amended: Filed Dec. 18, 1991, effective Aug. 6, 1992. Amended: Filed Aug. 17, 2009, effective Feb. 28, 2010. Amended: Filed May 1, 2015, effective Nov. 30, 2015.*

**Original authority: 207.020, RSMo 1945, amended 1961, 1965, 1977, 1981, 1982, 1986, 1993; 208.152, RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978, 1978, 1981, 1986, 1988, 1990, 1992, 1993, 2004, 2005, 2007; 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007; and 208.201, RSMo 1987, amended 2007.*