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

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 90—Home Health Program

13 CSR 70-90.010 Home Health-Care Services

PURPOSE: This rule provides the regulatory basis for Title XIX Medicaid vendor payment for home health-care services provided to Medicaid-eligible individuals.

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. Therefore, the material which is so incorporated is on file with the agency who filed this rule, and with the Office of the Secretary of State. Any interested person may view this material at either agency's headquarters or the same will be made available at the Office of the Secretary of State at a cost not to exceed actual cost of copy reproduction. The entire text of the rule is printed here. This note refers only to the incorporated by reference material.

(1) An otherwise eligible Medicaid recipient is eligible for Medicaid reimbursement on his/her behalf for home health services if all the conditions of subsections (1)(A)–(D) are met—

(A) The recipient requires—

1. Intermittent skilled nursing care which is reasonable and necessary for the treatment of an injury or illness;

2. Physical or occupational 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; or

3. 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.

(B) The recipient is confined to his/her home in accordance with section (3);

(C) The services are prescribed by a physician and 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

(D) The services are provided in the recipient's place of residence 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 Medicaid program.

(2) To qualify as skilled nursing care or as physical, occupational or speech therapy under paragraphs (1)(A)1.–3. and to be reimbursable under the Medicaid 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 (6); 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 paragraphs (1)(A)1.–3. nor be reimbursed by the Medicaid Home Health Program.

(3) A recipient will be considered to be confined to his/her home in accordance with subsection (1)(B), if s/he has a condition due to an injury or illness which restricts his/her ability to leave his/her place of residence except with the aid of supportive devices, the use of special transportation or the assistance of another person, or if s/he has a condition which is such that leaving his/her home or traveling to obtain the needed healthcare is medically contraindicated. A recipient will not need to be bedridden in order to meet this requirement. Further, a recipient may be considered homebound even if s/he occasionally leaves home for nonmedical purposes, as long as these absences are infrequent, or relatively short duration, and do not indicate that the recipient has the capacity to obtain the needed care on an outpatient basis in a physician's office, outpatient clinic or other health-care facility. In addition, children at serious risk of early developmental delay due to low birth weight or lack of normal expected physiological development, for whom a vigilant and responsive family environment is critical for treatment, will be considered homebound when the skilled intervention of a nurse is required on-site to create and sustain this environment. This nursing care must otherwise meet the requirements of this rule and must not duplicate services which could effectively be provided in a physician's office or clinic.

(4) Services included in Medicaid home health coverage are those set forth in paragraphs (1)(A)1.–3. and, in addition, the intermittent services of a home health aide and the provision of nonroutine supplies identified as specific and necessary to the delivery of a recipient's nursing care and prescribed in the plan of care. These additional services are covered only if all the conditions of subsections (1)(A)–(D) are met. Necessary items of durable medical equipment prescribed by the physician are available to recipients of home health services through the Medicaid 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 needed concurrently with skilled nursing or physical, occupational or speech therapy services which meet the requirements in subsections (1)(A)–(D). The services of the aide must be reasonable and necessary to maintain the recipient at home 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.

(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 Medicaid recipient 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 Missouri Medicaid.

(B) Unless the plan of care documents a specific need for more than one (1) visit per

day, Medicaid 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 recipient's total home health visits for that year.

(7) To be reimbursed by Medicaid, all home health services and supplies must be provided in accordance with a written plan of care authorized by the recipient'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 Sections 13.14C, 13.14D, 14.2, 14.3, 14.4, and 14.5 of the home health provider manual, which are incorporated by reference in this rule and available through the Department of Social Services, Division of Medical Services website at www.dss.mo.gov/dms. Paper copies of plans of care and interim orders must be submitted with paper claims. Information from the plan of care and interim order(s) must be included in the appropriate data fields when the provider is submitting an electronic claim. 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 recipient'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 recipient's physician; and

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

(B) Therapy services may be delivered for one (1) certification period (up to sixty-two (62) 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 recipient 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 Division of Medical Services, 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 recipient'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;

3. The services must be provided with the expectation, based on the assessment made by the attending physician of the recipient'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; and

4. The recipient continues to be medically homebound as defined in section (3) of this rule.

AUTHORITY: sections 208.153 and 208.201, RSMo 2000. 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.*

**Original authority: 208.153, RSMo 1967, amended 1973, 1989, 1990, 1991 and 208.201, RSMo 1987.*

13 CSR 70-90.020 Home Health-Care Services Reimbursement

PURPOSE: This rule establishes the methodology where a Medicaid maximum allowable fee for service is determined on an annual basis by the Division of Family Services.

(1) Reimbursement. Title XIX Medicaid 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;

(B) The Title XVIII interim Medicare rate in effect as of the date of service for the billing provider as determined by the Medicare fiscal intermediary; or

(C) The Medicaid maximum allowable fee for service.

AUTHORITY: sections 207.020, RSMo Supp. 1993, 208.152, RSMo Supp. 1992, 208.153, RSMo Supp. 1991 and 208.201, RSMo Supp. 1987. 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.*

**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, 1981, 1986, 1988, 1990, 1992; 208.153, RSMo 1967, amended 1973, 1989, 1990, 1991; and 208.201, RSMo 1987.*