TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Proposed Rule
LSA Document #17-342

DIGEST

Amends 405 IAC 1-4.2-2 to clarify policy language regarding a member's place of residence and to clarify that home health services cannot be limited to services furnished to members who are homebound. Amends 405 IAC 5-16-2 to add the requirement for documentation of a face-to-face encounter for home health services in accordance with 42 CFR 440.70(f). Amends 405 IAC 5-16-3 to add the requirement for therapy services to be ordered in writing in accordance with 405 IAC 5-22-6(b)(1). Amends 405 IAC 5-16-3.1 to clarify therapy services must be ordered or prescribed in writing by a provider in accordance with 405 IAC 5-22-6(b)(1), and to add that home health services are reimbursable only if the treating physician certifying the need for home health services documents that a face-to-face encounter with the individual occurred. Effective 30 days after filing with the Publisher.

IC 4-22-2.1-5 Statement Concerning Rules Affecting Small Businesses

405 IAC 1-4.2-2; 405 IAC 5-16-2; 405 IAC 5-16-3; 405 IAC 5-16-3.1

SECTION 1. 405 IAC 1-4.2-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-4.2-2 Definitions

Authority: IC 12-15-5-11; IC 12-15-21
Affected: IC 12-15-13-2; IC 12-15-34-1

Sec. 2. ~~(a)~~ The **following** definitions in this section apply throughout this rule:

~~(b)~~ **(1)** "HHA" means a home health agency as defined in IC 12-15-34-1 that is licensed by ISDH to provide home health services and is enrolled as a provider.

~~(c)~~ **(2)** "Home health care" means health care provided to Medicaid members ~~who are medically confined to the home as certified by the attending or primary physician.~~ **in the member's place of residence as follows:**

(A) A place of residence for home health services does not include a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities.

(B) Nothing in this subdivision should be read to prohibit a member from receiving home health services in any setting in which normal life activities take place, other than a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. Home health services cannot be limited to services furnished to members who are homebound.

~~(d)~~ **(3)** "Hours worked" means the number of total hours paid for HHA personnel, less the number of hours paid for vacation, holiday, and sick pay.

~~(e)~~ **(4)** "Overhead cost rate" means the flat, statewide rate for all allowable costs not reimbursed through the staffing rate.

~~(f)~~ **(5)** "Semivariable cost" means that portion of the overhead cost that is reallocated from the overhead cost to the staffing cost. It consists of the following:

~~(1)~~ **(A)** Direct supervision.

~~(2)~~ **(B)** Routine medical supplies.

~~(3)~~ **(C)** Transportation.

~~(4)~~ **(D)** Any other semivariable expenses that must be covered by Medicaid under federal law.

~~(g)~~ **(6)** "Staffing cost rate" means the service-specific wage and benefit rate paid per billable hour and based upon standard personnel-related costs that are a function of staff time spent in the performance of patient care activities.

~~(h)~~ **(7)** "Telehealth services" means the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision, and information across a distance.

(Office of the Secretary of Family and Social Services; 405 IAC 1-4.2-2; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3375; filed Jan 9, 1997, 4:00 p.m.: 20 IR 1116; filed Oct 8, 1998, 12:23 p.m.: 22 IR 433; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 18, 2007, 11:38 a.m.: 20070718-IR-405070031FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Sep 19, 2014, 3:22 p.m.: 20141015-IR-405140194FRA; filed Aug 1, 2016,

3:44 p.m.: 20160831-IR-405150418FRA; errata filed Oct 6, 2016, 2:59 p.m.: 20161019-IR-405160452ACA)

SECTION 2. 405 IAC 5-16-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-16-2 Home health agency services

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 2. **(a)** Medicaid reimbursement is available to home health agencies for:
(1) skilled nursing services provided by a registered nurse or licensed practical nurse;
(2) home health aide services;
(3) physical, occupational, and respiratory therapy services;
(4) speech pathology services;
(5) renal dialysis; and
(6) telehealth services;
when such services are provided within the limitations listed in sections 3 and 3.1 of this rule.

(b) Documentation of a face-to-face encounter in accordance with 42 CFR 440.70(f) is required.

(Office of the Secretary of Family and Social Services; 405 IAC 5-16-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3325; filed Aug 27, 1999, 10:15 a.m.: 23 IR 16; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Sep 19, 2014, 3:22 p.m.: 20141015-IR-405140194FRA)

SECTION 3. 405 IAC 5-16-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-16-3 Prior authorization for home health agency services; generally

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 3. (a) All home health services require prior authorization by the office, except the following:
(1) Services provided by a registered nurse, licensed practical nurse, or home health aide, which have been ordered in writing by a physician prior to the patient's discharge from a hospital, and that do not exceed one hundred twenty (120) units within thirty (30) calendar days of discharge from a hospital. These services may not continue beyond thirty (30) calendar days unless prior authorization is received.
(2) Any combination of therapy services ordered in writing by a ~~physician~~ **provider in accordance with 405 IAC 5-22-6(b)(1)** prior to the patient's discharge from a hospital and that do not exceed thirty (30) units within thirty (30) calendar days of discharge from a hospital. These services may not continue beyond thirty (30) calendar days unless prior authorization is received.

(b) Prior authorization requests for home health agency services may be submitted by an authorized representative of the home health agency. Written prior authorization forms must contain the information specified in 405 IAC 5-3-5. Telephone requests for the prior authorization of services will be conducted in accordance with 405 IAC 5-3-2 and 405 IAC 5-3-6.

(c) The following information must be submitted with the written prior authorization request form and may also be requested as written documentation to supplement telephone requests for prior authorization:
(1) Copy of the written plan of treatment, signed by the attending physician.
(2) Estimate of the costs for the required services as ordered by the physician and set out in the written plan of treatment. The cost estimate must be provided on or with the plan of treatment and signed by the attending physician.
(3) Documentation of a face-to-face encounter in accordance with 42 CFR 440.70(f) is required.

(d) Prior authorization will include consideration of the following, if applicable:
(1) Review of the information provided in the **written Medicaid** prior **review and** authorization form, or telephone request for prior authorization, and any additional required or requested documentation.

(2) Review of the following factors when determining the appropriate services, units of service, and length of period for prior authorized services for home care members:
(A) Severity of illness and symptoms.
(B) Stability of the condition and symptoms.
(C) Change in medical condition that affects the type or units of service that can be authorized.
(D) Treatment plan, including identified goals.
(E) Intensity of care required to meet needs.
(F) Complexity of needs.
(G) Amount of time required to complete treatment tasks.
(H) Rehabilitation potential.
(I) Whether the services required in the current care plan are consistent with prior care plans.
(J) Need for instructing the member on self-care techniques in the home or need for instructing the caregiver on caring for the member in the home, or both.
(K) Other caregiving services received by the ~~recipient,~~ **member,** including, but not limited to, services provided by Medicare, Medicaid Waiver Programs, CHOICE, vocational rehabilitation, and private insurance programs.
(L) Caregivers available to provide care for the member, including consideration of the following:
(i) Number of caregivers available.
(ii) Whether the caregiver works outside the home.
(iii) Whether the caregiver attends school outside of the home.
(iv) Reasonably predictable or long term physical limitations of the caregiver that limit the ability of the caregiver to provide care to the member.
(v) Whether the caregiver has additional child care responsibilities.
(vi) How and when the units of service requested will be used to assist the caregiver in meeting the member's medical needs.
(M) Whether the member works or attends school outside of the home, including what assistance is required.
(N) Special situations when additional home health units may be authorized on a short term basis, including the following:
(i) Significant deterioration in the condition of the member, particularly if additional units will prevent an inpatient or extended inpatient hospital admission.
(ii) Major illness or injury of the caregiver with expectation of recovery, including, but not limited to:
(AA) illness or injury that requires an inpatient acute care stay;
(BB) chemotherapy or radiation treatments; or
(CC) a broken limb, which would impair the caregiver's ability to lift the member.
(iii) Temporary, but significant, change in the home situation, including, but not limited to:
(AA) a caregiver's call to military duty; or
(BB) temporary unavailability due to employment responsibilities.
(iv) Significant permanent change in the home situation, including, but not limited to, death or divorce with loss of a caregiver. Additional units of service may be authorized to assist in providing a transition.

(Office of the Secretary of Family and Social Services; 405 IAC 5-16-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3325; filed Aug 27, 1999, 10:15 a.m.: 23 IR 17; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA)

SECTION 4. 405 IAC 5-16-3.1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-16-3.1 Home health agency services; limitations

Authority: IC 12-15
Affected: IC 12-13-7-3; IC 12-15-13-6

Sec. 3.1. (a) In addition to the prior authorization requirements as outlined in section 3 of this rule, services provided by a registered nurse, licensed practical nurse, home health aide, or renal dialysis aide employed by a home health agency must be as follows:
(1) Prescribed or ordered in writing by a physician.
(2) Provided in accordance with a written plan of treatment developed by the attending physician.
(3) Intermittent or part time, except for ventilator-dependent patients who have a developed plan of home health care.

(4) Health-related nursing care. Homemaker, chore services, and sitter/companion service are not covered, except as specified under applicable Medicaid waiver programs.
(5) Medically necessary.
(6) Less expensive than any alternate modes of care.

(b) In addition to the prior authorization requirements as outlined in section 3 of this rule, physical therapy, occupational therapy, respiratory therapy, and speech pathology must be as follows:
(1) Provided by an appropriately licensed, certified, or registered therapist employed or contracted by the home health agency.
(2) Ordered or prescribed in writing by a ~~physician.~~ **provider in accordance with 405 IAC 5-22-6(b)(1).**
(3) Provided in accordance with a written plan of treatment developed cooperatively between the therapist and the attending physician.
(4) Medically necessary. Educational activities, such as the remediation of learning disabilities, are not covered by Medicaid.
(5) Provided in accordance with 405 IAC 5-22.

(c) Nursing services, which do not meet the definition of emergency services at 405 IAC 5-2-9, are covered without prior authorization when provided to a member for whom home health services have been currently authorized when the attending physician orders a one (1) time home visit due to a change in the patient's medical condition to prevent deterioration of the patient's medical condition, for example, reanchoring a foley catheter, obtaining a laboratory specimen, administering an injection, or assessing a reported change with signs and symptoms of potential for serious deterioration.

(d) In addition to the limitations as outlined in subsection (a) and section 3 of this rule, telehealth services provided by a home health agency are subject to the following requirements:
(1) The member must be receiving home health services.
(2) To initially qualify for telehealth services, the member must have had two (2) or more of the following events related to one (1) of the conditions listed in subdivision (3) within the previous twelve (12) months:
(A) An emergency room visit.
(B) An inpatient hospital stay.
(3) The member must have one (1) or more of the following conditions:
(A) Chronic obstructive pulmonary disease.
(B) Congestive heart failure.
(C) Diabetes.
Additional qualifying conditions may be added by the office upon satisfying the notice requirements set forth in IC 12-15-13-6.
(4) An emergency room visit resulting in an inpatient hospital admission does not constitute two (2) separate events for purposes of meeting the requirements of subdivision (2).
(5) In any telehealth encounter, a licensed registered nurse must perform the reading of transmitted health information provided to the member in accordance with the written order of the physician.

(e) Home health services are reimbursable only if the treating physician certifying the need for home health services documents that there was a face-to-face encounter with the individual as outlined in section 2(b) of this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 5-16-3.1; filed Aug 27, 1999, 10:15 a.m.: 23 IR 18; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Sep 19, 2014, 3:22 p.m.: 20141015-IR-405140194FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA)

Notice of Public Hearing

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