INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

# Home Health Services

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# Revision History

| Version | Date | Reason for Revisions | Completed By |
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| 1.0 | Policies and procedures as of Oct. 1, 2015<br>Published: Feb. 25, 2016 | New document | FSSA and HPE |
| 1.1 | Policies and procedures as of April 1, 2016<br>Published: July 12, 2016 | Scheduled update | FSSA and HPE |
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| 8.0 | Policies and procedures as of April 1, 2025<br>Published: Dec. 9, 2025 | Scheduled update:<br>• Reorganized and edited text as needed for clarity<br>• Changed “plan of treatment” references to “plan of care” | FSSA and Gainwell |

| Version | Date | Reason for Revisions | Completed By |
|---|---|---|---|
| | | • Added PathWays to initial note<br>• Updated the *IHCP Coverage for Home Health Services* section<br>• Added reference to Telehealth Services Codes in the *Telehealth Services* section<br>• Added the *Traveling With a Member* section<br>• Updated the *Certification of Medical Necessity for Home Health Care* section<br>• Added the *Care Coordination Considerations* section and subsections<br>• Updated the *Home Health Prior Authorization Policies* section<br>• Updated the *Home Health PA Documentation* section<br>• Added the *Additional PA Requirements for Assisted Living Facility Residents* section<br>• Updated the *PA for Home Health Nursing and Home Health Aide Services* section<br>• Updated the *PA Exception for Hospital Discharge* section<br>• Reorganized and updated the *Home Health Billing Procedures* section and subsections<br>• Updated the *Electronic Visit Verification for Home Health Services* section | |

# Table of Contents

*Note: The information in this module applies to Indiana Health Coverage Programs (IHCP) services provided under the **fee-for-service (FFS)** delivery system.*

*For information about services provided through the **managed care** delivery system – including Healthy Indiana Plan (HIP), Hoosier Care Connect, Hoosier Healthwise and Indiana PathWays for Aging (PathWays) services – providers must contact the member's managed care entity (MCE) or refer to the MCE provider manual. MCE contact information is included in the IHCP Quick Reference Guide at in.gov/medicaid/providers.*

*For updates to the information in this module, see IHCP Bulletins at in.gov/medicaid/providers.*

# Introduction

In accordance with *Code of Federal Regulations 42 CFR 440.70*, the Indiana Health Coverage Programs (IHCP) defines "home health services" as services provided on a part-time and intermittent basis to Medicaid members of any age in the member's place of residence. A "place of residence" for home health services does not include a hospital, nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID). Members may receive home health services in any setting in which normal life activities take place other than a hospital, nursing facility, ICF/IID 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 members who are homebound.

# IHCP Coverage for Home Health Services

Home health services are available to IHCP members of any age when the services are:

- Medically necessary
- Ordered in writing by the member's qualified attending practitioner, who must be enrolled in the IHCP as one of the following licensed practitioners:
  - Physician
  - Nurse practitioner
  - Clinical nurse specialist
  - Physician assistant
- Performed on a part-time and intermittent basis, in accordance with a written plan of care that the qualified attending practitioner reviews every 60 days

The medical necessity for home health services must be certified by the member's qualified attending practitioner as described in the *Certification of Medical Necessity for Home Health Care* section.

Home health services require prior authorization as described in the *Home Health Prior Authorization Policies* section.

# Covered Services

Home health services include skilled nursing, home health aide services and skilled therapies (physical therapy, occupational therapy and speech-language pathology).

IHCP home health benefits include covered services performed by practitioners such as the following:

- Registered nurses (RNs)
- Licensed practical nurses (LPNs)
- Home health aides
- Physical therapists
- Occupational therapists
- Speech-language pathologists

## Telehealth Services

The IHCP covers telehealth services provided by home health agencies. See the *Telehealth and Virtual Services* module for more information. Healthcare Common Procedure Coding System (HCPCS) codes eligible for telehealth reimbursement can be found on *Telehealth Service Codes*, accessible from the *Code Sets* webpage at in.gov/medicaid/providers.

## Traveling With a Member

If a member requires home health services and is also expecting to travel for other services, the home health agency should include this information as part of a prior authorization (PA) request for home health services. With prior approval, staff within a home health agency are allowed to travel with a member if the staff person meets all state licensure requirements (and out-of-state licensure requirements, if traveling out of state). This policy applies to FFS coverage; policies may vary for managed care members.

The home health aide or nurse can accompany the member to medically necessary appointments but cannot drive the member. Nonemergency medical transportation (NEMT) is reimbursable only when provided by IHCP-enrolled transportation providers (provider type 26) and must be arranged through Verida for FFS members, as described in the *Transportation Services* module.

# Noncovered Services

The following services are **not covered** under the home health benefit:

- Transporting the member to grocery stores, pharmacies, banks and so forth
- Homemaker services (including shopping, laundry, cleaning, meal preparation and so on)
- Chores (including picking up prescriptions and running other errands)
- Sitter or companion services (including activity planning, escorting the member to events and so on)
- Respite care

> *Note: Although these services are not covered for home health billing, they may be covered for eligible members under an applicable IHCP Home- and Community-Based Services (HCBS) waiver program, or (in the case of transporting members to the pharmacy) as a Traditional Medicaid benefit.*

# Certification of Medical Necessity for Home Health Care

The medical necessity for home health services must be certified by the member's qualified attending practitioner – that is, the ordering physician, nurse practitioner, clinical nurse specialist or physician assistant who develops and, every 60 days, reviews the member's written plan of care.

A face-to-face encounter with the certifying practitioner is required at the initiation of home health services. It is also required if there has been an interruption in home health services. (An interruption of home health services is considered 60 days or more from the end of the last authorization period.) For the initial certification, this face-to-face encounter must occur no more than **90 days before or 30 days after** the start of services.

For long-term home health services, a face-to-face encounter with the certifying practitioner is required on a rolling 12-month basis that is within 90 days before or 30 days after the anniversary date of the previous year's face-to-face encounter.

The face-to-face encounter may occur in person or through telehealth, in accordance with the policies and procedures described in the *Telehealth and Virtual Services* module. A face-to-face encounter with a qualified attending practitioner for the purpose of certifying or recertifying the need for home health services is a reimbursable evaluation and management (E/M) service.

Documentation of the face-to-face encounter, in accordance with *42 CFR 440.70(f),* is required for IHCP coverage of home health services. The qualified attending practitioner must include the following when documenting the face-to-face encounter:

- The date the practitioner saw the patient
- Detailed clinical findings from the visits
- Clear connections between clinical findings and home health care needs
- Practitioner signatures and dates on all required documents

The practitioner must provide this *written* documentation of the face-to-face encounter to the home health agency, which is then responsible for submitting the documentation to the payer's PA contractor. It is *not* acceptable for the practitioner to *verbally* communicate the encounter to the home health agency, and have the home health agency then document the encounter as part of the certification for the provider to sign.

> *Note: The face-to-face encounter requirements for coverage of home health services apply to all initial orders. Members will also need an annual face-to-face encounter with their certifying practitioner after the initial encounter. The face-to-face encounter requirements do **not** apply to reorders for the medical necessity of continued home health services within a continuous one-year period, unless there is an increase in home health hours.*
>
> *IHCP HCBS programs and benefits are outside the scope of this regulation and are not subject to the face-to-face encounter requirements.*

Certification requirements for the medical equipment and supplies used for home health services can be found in the *Durable and Home Medical Equipment and Supplies* module.

# Indicators for Home Health Services

At least one indicator from each of the following two categories must be present for a member to be eligible for home health services:

**Category I: Member**

- The member is at risk of respiratory failure, severe deterioration or hospitalization without constant monitoring.
- The member requires total care – monitoring 24 hours per day.
- The member desires to stay in the home, rather than in a long-term care (LTC) facility.
- The medical condition of the member has deteriorated, creating the need for more intense short-term care (practitioner's statement required).

**Category II: Caregiver**

- The member does not have a primary caregiver or access to other care.
- The caregiver is employed and absent from the home or is unable to provide the necessary care.
- The caregiver has additional child-care responsibilities, disallowing the time needed to care for the member (three or more children under 6 years of age, or four or more children under the age of 10).
- The caregiver has additional children with special needs to care for (one or more children with special healthcare needs requiring extensive medical and physical care).
- A caregiver is experiencing a major illness or injury, with expectation of recovery.
- There is a temporary but significant change in the availability of a caregiver – for example, military service.
- There is a significant permanent change in a caregiver's status – for example, death or divorce with loss of one caregiver.

# Care Coordination Considerations

The following sections provide information for providers to keep in mind when coordinating care of members.

## *Coordinating Home Health Services With Attendant Care and Structured Family Caregiving for HCBS Waiver Members*

The following clarification is provided so that providers do not duplicate services for home health members who are also eligible for Attendant Care or Structured Family Caregiving services under an HCBS waiver:

- Home health services may be provided on the same day as Structured Family Caregiving if the services are not rendered at the same time (simultaneously).
- Home health services may be provided on the same day as Attendant Care services if the services are not rendered at the same time (simultaneously).
- For members receiving both Structured Family Caregiving and home health services, the direct care provider for each service cannot be the same individual.

- Home health services are not reimbursable if the individual's primary caregiver (whether paid or unpaid) is a paid provider of *another* Medicaid service – including Attendant Care and other HCBS waiver services – for that same individual. This is because home health reimbursement is allowable only when the primary caregivers are unavailable, and the caregiver cannot make themselves unavailable to allow the individual to qualify for home health services.

- Home health providers that provide services to a member residing in an assisted living facility must verify that the home health services are not duplicative of the services the assisted living facility is required to provide under room and board (see the *Additional PA Requirements for Assisted Living Facility Residents* section).

### *Home Health Services in Addition to Hospice Per Diem*

The IHCP has directed that a member age 21 or older who is enrolled in the IHCP hospice benefit cannot concurrently receive IHCP home health services (outside those that are reimbursed under the hospice per diem) for treatment of the terminal diagnosis or related conditions.

A member age 20 or younger who elects IHCP hospice benefits may receive coverage for concurrent curative treatment of the terminal illness, including through home health services, in conjunction with hospice services.

State statutes require that the Medicaid hospice benefit mirrors the Medicare hospice program with regard to hospice covered services and reimbursement methodology. As such, this policy also applies when the individual is receiving hospice services under the Medicare hospice program.

For additional information, providers may refer to *Section 5: Hospice Authorization* of the *Hospice Services* provider reference module.

## Home Health Care Hourly Determination Guidelines

The following guidelines are used to determine the appropriate number of hours authorized for home health services. These are guidelines only and do not override medical decisions based on individual case review.

Factors for consideration when determining the hours of service to be approved include the following:

- Severity of illness and symptoms
- Stability of condition and symptoms
- Change in medical condition that affects the type or units of service that can be authorized
- Plan of care, including identified goals
- Intensity of care required to meet needs
- Complexity of needs
- Amount of time required to complete treatment tasks
- Whether the services required in the current plan of care are consistent with prior plans of care
- 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
- Other home care services currently being used, including but not limited to Medicare, Medicaid waiver programs, Community and Home Option to Institutional Care for the Elderly and Disabled (CHOICE), vocational rehabilitation, and private insurance

- Whether the member works or attends school outside the home, including what assistance is required
- Caregivers available to provide care for the member, including the following considerations:
  - Number of caregivers available
  - Whether the caregiver works outside the home, whether that work is performed in-person or remotely
  - Whether the caregiver attends school outside the home, whether attending in-person or remotely
  - Whether the caregiver has additional childcare responsibilities
  - Physical limitations of available caregivers that limit their ability to provide care to the member
  - Number of hours requested, compared to availability of caregiver time (The provider is responsible for coordinating home care services with the caregiver's work or school schedule to meet the member's needs.)

Special situations may occur where additional home health hours may be authorized on a short-term or temporary basis. These situations are evaluated individually, on a case-by-case basis. Examples of these situations include the following:

- Significant deterioration in the member's condition, particularly if additional hours will prevent an inpatient or extended inpatient hospital admission
- Major illness or injury of the caregiver with expectation of recovery, including, but not limited to:
  - Illness or injury that requires an inpatient acute-care stay
  - Chemotherapy or radiation treatments
  - A broken limb, which would impair the caregiver's ability to lift the member
- Temporary but significant change in the home situation, including but not limited to:
  - A caregiver's call to military duty
  - Temporary unavailability due to employment responsibilities
- 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 for a short period of time to assist in providing a transition.

## Up to 12 (or 16) Hours a Day of Home Health Services

Members requiring 24-hour monitoring may be authorized for up to **12 hours** a day of skilled nursing or home health aide services to prevent deterioration in life sustaining systems. Examples of these conditions include but are not limited to:

- Severe respiratory conditions resulting from:
  - Pulmonary disorders, such as bronchopulmonary dysplasia
  - Cystic fibrosis, bronchitis or asthma
  - Central nervous system disorders
  - Cardiovascular disorders, such as cardiac anomalies
  - Neuromuscular disorders, such as muscular dystrophy and Guillain-Barré syndrome
- Dependency on mechanical ventilator assistance
- Tracheostomy

Special situations may occur where home health hours may be approved for up to **16 hours** per day of skilled care on an ongoing basis, although each individual situation must be evaluated with a PA request. These special situations include but are not limited to:

- A single caregiver is available, and that caregiver also works full-time (or a significant number of part-time hours), whether that work is performed in-person or remotely. This situation applies in cases where there is only one adult caregiver in the home and in situations where there may be two adults present, but one is unable to provide any care (or only a very limited amount of care) due to physical disability or severe physical limitations.
- The caregiver has significant additional childcare responsibilities. Significant is defined as any of the following:
  - Three or more children under the age of 6
  - Four or more children under the age of 10
  - One or more children with special medical care needs requiring extensive medical and physical care above and beyond the needs of the average well child

## *Eight Hours a Day of Home Health Services*

Members who require extensive care and daily monitoring of their medical/physical conditions, but who do not possess the same degree of potential to deteriorate quickly into life-threatening situations as do members requiring 24-hour monitoring, may receive up to **eight hours** of home health care daily. An additional hour or two may be allowed for transportation to and from work in situations where the caregivers work full-time outside the home.

Examples of these situations include but are not limited to:

- Chronic, debilitating conditions, such as quadriplegia or severe forms of cerebral palsy, muscular dystrophy, spina bifida or other congenital anomalies
- Conditions that require equipment or treatment needs with potential for serious complications – for example, central lines, Hickman catheters, or nutrition provided by hyperalimentation or gastrostomy tube feedings
- Conditions that require frequent treatments, such as physical or occupational therapy
- Members requiring skilled nursing assistance to attend school
- Members receiving multiple medications that require monitoring for severe side effects or responses

## *Three to Seven Hours a Day of Home Health Services*

Members without the severity of conditions noted in the previous sections, but who require primarily heavy physical care with some skilled nursing monitoring to avoid deterioration, may receive **three to seven hours** of home health care per day. These members are generally stable but with chronic conditions such as congenital anomalies, neuromuscular disorders, central nervous system disorders or other disorders that severely disrupt the capacity to care for oneself.

Consideration may be given to paraplegics, quadriplegics or other members with disabilities that render them unable to provide self-care, such as bathing or dressing, but who are able to drive mechanically altered vehicles to maintain meaningful employment and a relationship with the community. Such adults may be considered for assistance from a home health aide for up to four hours per day. The agency may split the hours between morning and evening to attend to the bedtime needs of the member. This service is subject to medical necessity, and documentation must demonstrate the need.

# Home Health Prior Authorization Policies

All home health services require prior authorization (PA), except as outlined in *PA Exception for Hospital Discharge* section. For specific PA criteria for home health services, see *Indiana Administrative Code 405 IAC 5-16*.

An authorized representative of the home health agency submits PA requests for home health agency services, along with supporting documentation, to the IHCP PA contractor. An increase in home health services also requires a written request for a PA revision, with supporting documentation of medical necessity.

Providers can submit PA requests electronically, using the provider portal offered by the PA contractor or via 278 electronic transaction. Providers can also complete the *Indiana Health Coverage Programs Prior Authorization Request Form*, which is available on the *Forms* webpage at in.gov/medicaid/providers, and submit it to the PA contractor by mail or fax. PA requests may also be made by phone, although supporting documentation will continue to be required, in addition to the phone call. See the *IHCP Quick Reference Guide* for PA contractor contact information, including phone and fax number, mailing address, and portal link.

See the *Prior Authorization* module for detailed information on submitting PA requests.

## *Home Health PA Documentation*

The following documentation (list updated effective April 1, 2025) must be submitted with the PA request for all home health services:

- Documentation of a face-to-face encounter with the qualified attending practitioner, as described in the *Certification of Medical Necessity for Home Health Care* section
  - This item is required with the initial PA request and annually thereafter. It is also required with requests for a PA revision to increase services and with requests for resumption of services after an interruption of 60 days or more beyond the PA expiration date.
  - This item is not required with requests for continuation of existing services within an uninterrupted 12-month period.
- A completed *Home Health CMS 485* form
  - This form can be found on the *Forms* webpage at in.gov/medicaid providers (under the *Medical Clearance Forms and Certifications of Medical Necessity* section).
- Comprehensive home health assessment, completed by the qualified attending practitioner, which must include the following:
  - List of all other supportive services and therapies the member is receiving, including but not limited to:
    - Medicaid HCBS waiver services, such as Structured Family Caregiving and Attendant Care
    - Other shift/hour services, such as applied behavior analysis (ABA) therapy
  - Indication of whether the agency staff providing home health services is also the parent or legally responsible individual for the member:

    *Note: Certified home health aides, registered nurses, licensed practical nurses and licensed therapists who are employed by the home health agency may provide IHCP-reimbursable home health services, within their scope of practice, to eligible members living in their home and for whom they are legally responsible.*
  - All information indicated in *42 CFR 484.55(c)*, including incorporation of data items from the current version of the Start-of-Care Outcome and Assessment Information Set (OASIS)

- Copy of the written plan of care that was developed by the qualified attending practitioner, home health agency personnel and (if applicable) therapists and that:
  - Has been signed by the qualified attending practitioner completing the assessment
  - Is current through the date of request
  - Includes the following:
    - Start of care date
    - Progress notes regarding the necessity, effectiveness and goals of therapy services
    - Mental status
    - Types of services and equipment required
    - Frequency of visits
    - Prognosis
    - Rehabilitation potential
    - Functional limitations
    - Activities permitted
    - Nutritional requirements
    - Medications and treatments
    - Safety measures to protect against injury
    - Instructions for timely discharge or referral
    - Other relevant information

> *Note: Copies of the plan of care must also be kept on file with the home health agency and at the member's home.*
>
> *Documenting acceptance of the plan of care is the home health agency's responsibility and at their discretion of how best to ensure documented acceptance in case of an audit. Per IDOH guidance, the expectation is that members are involved in, aware of, acknowledge and are given a copy of the plan of care.*
>
> *The qualified attending practitioner must review the plan of care every 60 days and reorder the service if medically necessary. Documentation of this review and reorder must be kept on file with the home health agency and made available for postpayment review.*

- Estimate of costs for the required services as ordered by the physician or other qualified practitioner and set out in the written plan of care:
  - The cost estimate must be provided with the plan of care and signed by the attending practitioner
  - The estimate must reflect the cost of each service requested, plus the overhead rate, for the total time period requested in the PA, as reflected on the plan of care.
- Number of nonpaid caregivers that assist in member care (even if the number is zero), and availability of each nonpaid caregiver, including the following:
  - Whether the caregiver works outside the home, whether that work is performed in-person or remotely
  - Whether the caregiver attends school outside of the home, whether attending in-person or remotely
  - Whether the caregiver has additional childcare responsibilities
  - Reasonably predictable or long-term physical limitations of that limit the caregiver's ability to provide care to the member

- Work documentation for each nonpaid parent/caregiver who is employed, to include:
  - Current work confirmation letter that:
    - Is on company letterhead
      - Alternatively, the information can be provided in a company email from a supervisor, that includes the supervisor's contact information.
    - Is completed and signed by a manager, supervisor or Human Resources (HR) representative
      - If self-employed, the letter must be signed by the employee.
    - Includes a schedule or calendar of the employee's work time, including overtime
      - If work hours are irregular and cannot be broken down into specific days and times (due to the nature of the job, such as on-call staff working in the service industry or factory), the letter should describe the weekly work hours with as much detail as possible.

    > *Note: If a work confirmation letter cannot be obtained, two months of the most recent paystubs may be provided as an alternative.*

  - Travel time to and from work (with map or other documentation to support travel time)
- School documentation for each nonpaid parent/caregiver who is in school, including but not limited to:
  - Official or unofficial transcript and/or class schedule, including the following information:
    - Name and contact information of the institution
    - Class times and locations (for dates of service)
  - Travel time to and from class, if class is conducted in-person
  - Office hours of instructors, if the caregiver requires the use of office hours

  > *Note: If the caregiver works while attending school, both the work and school documentation are required.*

- Amount of time required to complete treatment tasks (number of hours per day, number of visits per day, and number of days per week the service is to be provided)
- Intensity of care required to meet needs
- Documentation of whether the member works or attends school outside the home, including:
  - What assistance is required
  - Member school calendar and/or work schedule (as applicable)
- Number of hours per day and number of days per week the member receives *other* home health service, from non-Medicaid sources including (but not limited to) the following:
  - Medicare
  - CHOICE program
  - Medicaid waiver programs
  - Private insurance
  - Vocational rehabilitation
- Number of members receiving home health services within the same household, so that care can be coordinated to use services in the most efficient manner

  > *Note: A home care situation in which more than one member of a single household is receiving home health services is called a **multiple-member care situation**. In these situations, care must be coordinated in the most efficient manner. Multiple-member care situations must be reported on each member's individual PA request. See the Overhead Rate section for special billing for multiple-member care situations.*

### Additional PA Requirements for Assisted Living Facility Residents

For home health services provided to a member residing in an assisted living facility (ALF), the following additional requirements apply:

- The PA request must include place-of-service (POS) code 13 – *Assisted living facility*.
- To prevent any payment denials, the home health provider must verify with the ALF that the home health services are not duplicative of the services the facility is required to provide as part of its per diem reimbursement.

### Signature Requirements

An original signature or signature stamp is required on the *Indiana Health Coverage Programs Prior Authorization Request Form,* as well as on all state forms submitted with the PA request. The IHCP allows electronic signatures on supporting documents (such as qualified practitioner orders and plans of treatment) submitted with PA requests for home health and hospice services. See the *Prior Authorization* module for more information.

> *Note: Providers must clearly sign the plan of care that accompanies the PA request. Electronic, typed or stamped signatures must match the written signature on the plan of care. Signing providers must be within the scope of practice for their applicable licensure.*

## *PA for Home Health Nursing and Home Health Aide Services*

PA is required for all home health services rendered by RNs, LPNs or home health aides from agencies that are IHCP providers, *with the exception of* services that are ordered in writing by a qualified practitioner before the member's discharge from an inpatient hospital. Such services may continue without PA for up to a total of 120 hours delivered within 30 days of discharge. (See the *PA Exception for Hospital Discharge* section for details.)

Home health services provided by an RN, LPN or home health aide must meet the following criteria:

- Ordered in writing by a qualified practitioner within their scope of practice
- Provided in accordance with a written plan of care developed by the qualified attending practitioner
- Medically necessary
- Less expensive than any alternate mode of care
- Provided in accordance with all other requirements for nursing services as laid out in *405 IAC 5-22-2*

Written evidence of qualified practitioner involvement and personal patient evaluation are required to document the acute medical needs. A current plan of care and progress notes as to the necessity and effectiveness of nursing services must be attached to the prior authorization request and available for postpayment audit purposes.

PA requests for **home health aide** services are based on procedure code 99600 – *Unlisted home visit, service, or procedure.* For **home health nursing** (both LPN and RN) services, the PA request is based on procedure code 99600 along with modifier **TD** – *Registered nurse (RN)*. PA requests for home nursing do not need to indicate whether an RN or an LPN is to perform the service, because that level of detail is reported on the claim. When home health providers bill 99600 with either modifier **TE** –*Licensed practical nurse (LPN)* or modifier **TD** –*Registered nurse*, the IHCP Core Medicaid Management Information System (*Core*MMIS) uses the PA units approved for the nursing service as 99600 TD.

## PA for Home Health Therapy Services

PA is required for all home health therapy services, *with the exception of* occupational therapy, physical therapy and speech-language pathology services that are ordered in writing by a physician or other qualified practitioner before the member's discharge from an inpatient hospital, limited to a combined total of 30 units of service within 30 days of discharge. If additional services are required, PA must be obtained. (See the *PA Exception for Hospital Discharge* section for details.)

Occupational therapy, physical therapy and speech-language pathology services provided by a home health agency must meet the following criteria:

- Ordered in writing by a qualified practitioner within their scope of practice
- Provided by an appropriately licensed, certified or registered therapist employed or contracted by the home health agency
- Provided in accordance with a written plan of care developed cooperatively between the therapist and the qualified practitioner within their scope of practice
- Medically necessary
- Provided in accordance with all other requirements for these services (see the *Therapy Services* module)

Orders for therapy services must include the specific procedures and modalities to be used, and the amount, frequency and duration of each.

Written evidence of qualified practitioner involvement and personal member evaluation is required to document the acute medical needs. A current plan of care and progress notes about the necessity and effectiveness of therapy must be attached to the PA request, and a copy must be available for postpayment audit.

## PA Exception for Hospital Discharge

Providers can perform certain home health services without PA following a member's discharge from an inpatient hospital if a physician or other qualified practitioner orders the service in writing prior to the member's discharge:

- RN, LPN and home health aide services, not to exceed 120 units within 30 calendar days following the discharge
- Any combination of therapy services, not to exceed 30 units in 30 calendar days following the discharge

The hospital discharge date is counted as day 1.

Providers should use **occurrence code 42** with the corresponding date of discharge in the occurrence code and occurrence date fields of the institutional claim (fields 31a–34b on the *UB-04* claim form) to bypass PA requirements associated with the preceding parameters.

Home health services may not continue beyond the limits noted unless PA is obtained. When a provider bills for services exceeding the limitations established in the IAC, and the provider has not received PA for additional units, *Core*MMIS automatically denies or cuts back units on the remittance advice (RA).

# Home Health Billing Procedures

> *Note: These billing instructions do not apply to home-based services provided through an HCBS waiver program. See the Home- and Community-Based Services Billing Guidelines module for information about billing HCBS waiver services.*

To ensure appropriate reimbursement, Traditional Medicaid home health claims should be submitted as an institutional claim (*UB-04* claim form, IHCP Provider Healthcare Portal [IHCP Portal] institutional claim or the 837I electronic transaction). The institutional claim includes occurrence code fields for reporting overhead and procedure code fields for reporting the applicable services provided. Table 1 shows the occurrence code for the overhead and the procedure codes (and modifiers) related to each home health discipline, along with applicable billing units.

Table 1 – Codes and Billing Units for Reporting Home Health Services

| Code | Service Performed By | Billing Unit |
|---|---|---|
| Occurrence code 73 | [Overhead] | One unit per provider per member per day |
| Procedure code and modifier 99600 TD | Registered nurse | Hourly |
| Procedure code and modifier 99600 TE | Licensed practical nurse | Hourly |
| Procedure code 99600 | Home health aide | Hourly |
| Procedure code G0151 | Physical therapist | 15-minute increments |
| Procedure code G0152 | Occupational therapist | 15-minute increments |
| Procedure code G0153 | Speech-language pathologist | 15-minute increments |

Home health providers follow the general billing directions for completing the institutional claim, as described in the *Claim Submission and Processing* module, with the exception of the service date (as described in the following sections).

> *Note: All institutional claims, including home health claims, must include the National Provider Identifier (NPI) of the IHCP-enrolled attending provider.*

Submit home health claims electronically or mail them to the following address for processing:

**Gainwell – UB-04 Claims**
**PO Box 50448**
**Indianapolis, IN 46250-0418**

## *Overhead Rate*

Providers use the appropriate occurrence code and corresponding dates to indicate the appropriate overhead fee for a claim. Providers must bill home health overhead with occurrence code 73, indicating that one encounter with the member occurred on the date shown.

> *Note: Providers should not add the dollar figures associated with the overhead rates to the claim when calculating total charges. The RA or 835 transaction automatically reflects the appropriate overhead amounts.*

Home health agencies may report only one overhead per provider per member per day. Providers that submit more than one claim in a multiple-member care situation (home health services provided to multiple members in the same household) should attach the overhead to only one of the submitted claims. As long as the overhead is attached to only one member, it does not matter to which member it is attached.

Overheads are linked with reimbursement for services provided. If the therapist, home health aide, LPN or RN enters the home and the member refuses service, providers cannot bill for any unit of service. When the provider does not render a service, the IHCP does not reimburse the provider for overhead.

Providers should use the following guidance when billing the overhead occurrence code for nonconsecutive and consecutive dates of service on the *UB-04* claim form or the IHCP Portal institutional claim:

- If the dates of service billed are not consecutive:
  - On the *UB-04* claim form, for each nonconsecutive date of service billed, providers should enter the occurrence code and the corresponding date in the Occurrence Code and Date fields (31a–34b).
  - On the IHCP Portal institutional claim, for each nonconsecutive date of service billed, in the *Occurrence Codes* panel, providers should enter the occurrence code and the corresponding date, using the same date in both the From Date and To Date fields for each entry.
- If the dates of service billed are consecutive, and one encounter was provided every day:
  - On the *UB-04* claim form, providers should enter the appropriate occurrence code and the first and last dates of service being billed in the Occurrence Span Code, From, and Through fields (35a–36b).
  - On the IHCP Portal institutional claim, use the same occurrence code fields as are used for nonconsecutive dates, but use the From Date and To Date fields to indicate that the single code entry represents a span.

## Line-Item Service Details

Each line item identifies services billed using procedure codes and service dates. Providers must bill each date of service as a separate line item and bill each level of service, such as RN or LPN, provided on the same date as a separate line item.

When home health providers perform the same service for the same person multiple times on the same day (such as multiple RN visits on a single date of service), they must bill those services on the same claim form and on a single detail, with the total number of units of services provided. Billing separate lines for the same service with the same date of service causes claims to be denied as exact duplicates. See the *Multiple-Visit Billing* section for more information.

For each line item, providers must enter the HCPCS/ Current Procedural Terminology (CPT®[1]) procedure codes (and modifiers, if needed) for the services provided. The Family and Social Services Administration (FSSA) sets the rate for each procedure code.

The procedure code description defines the unit of service. The billing units of home health visits for therapists, home health aides, LPNs and RNs are as follows:

- **For therapy visits** – Therapy codes are measured as one unit equals 15 minutes. If the therapist is in the home eight minutes or more, the provider can round the visit up to the 15-minute unit of service. If the therapist is in the home for less than eight minutes, the provider cannot round this up and, therefore, cannot bill for it.
- **For home health aide, LPN or RN visits** – Nursing services are measured as one unit equals one hour. If the home health aide, LPN or RN is in the home for fewer than 29 minutes, providers can bill for the entire first hour only if they provided a service. For subsequent hours in the home, providers should:
  - Round up any partial unit of service of 30 minutes or more to the next highest unit.
  - Round down any partial unit of service of 29 minutes or less to the next lowest unit.

  (For example, 85 minutes spent on billable patient care activities is rounded down to one unit, and 95 minutes spent on billable patient care activities is rounded up to two units.)

[1] *CPT copyright 2025 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

Although reimbursement is based on procedure code only, each line item must also include an appropriate revenue code. Table 2 lists applicable revenue codes and the corresponding procedure codes.

Table 2 – Revenue Codes and Corresponding Procedure Codes for Home Health Services

| Revenue Code | Procedure Codes |
|---|---|
| 420 | G0151 |
| 421 | G0151 |
| 422 | G0151 |
| 423 | G0151 |
| 424 | 97161–97163 |
| 429 | G0151 |
| 430 | G0152 |
| 431 | G0152 |
| 432 | G0152 |
| 433 | G0152 |
| 434 | 97165–97167 |
| 439 | G0152 |
| 440 | G0153 |
| 441 | G0153 |
| 442 | G0153 |
| 443 | G0153 |
| 444 | 92521–92524 |
| 449 | G0153 |
| 552 | 99600 TD, 99600 TE |
| 559 | 99601, 99602 |
| 572 | 99600 |

If the therapist, home health aide, LPN or RN enters the home and the member refuses service, providers cannot bill for any unit of service. When the provider does not render a service, the IHCP does not reimburse the provider, including for overhead.

## *Multiple-Visit Billing*

When providers make multiple visits for the same prior-authorized service to a member during a single day, providers should bill all visits on the same claim form and on one detail with the total number of units of service provided. If providers bill these services on separate claim forms or on separate claim details, the IHCP denies one or more of the services as a duplicate service.

If additional hours of the same service are identified after a claim has been adjudicated and paid, providers must submit a paid claim adjustment. Procedures for submitting a paid claim adjustment are in the *Claim Adjustments* module.

Home health agency providers should be aware that rotating personnel in the home merely to increase billing is not appropriate.

> *Example:* A home health agency sent an RN to a member's home in the morning and an LPN to the same home in the evening of March 15, 2023. The first nurse performed two hours of RN services in the morning, and the second nurse performed two hours of LPN services in the evening of March 15, 2023.

**Detail 1:** Revenue code 552 with CPT code 99600 TD. The date of service is 3/15/23 and the unit of service is 2.

**Detail 2:** Revenue code 552 with CPT code 99600 TE. The date of service is 3/15/23 and the unit of service is 2.

## Registered Nurse Delegation to Home Health Aides

The IHCP has specific guidelines for tasks that are to be performed by RNs versus those performed by home health aides. Home health agency providers are expected to staff according to these guidelines. For federal and state regulations related to home health aide services, see *42 CFR 484.36* and *410 IAC 17-14-1(g)-(n)*.

The IHCP may grant PA for skilled services under the home health benefit; however, the home health agency must bill the IHCP for services that were provided as follows: **The skilled nurse renders home health aide services because the agency was unable to contract a home health aide.**

The agency must then document that the nurse rendered the home health aide service. The agency must bill the IHCP using the appropriate code for home health aide services. If the postpayment review identifies that the agency billed for skilled nursing services rather than for home health aide services, the IHCP recoups the overpayment.

## Initial Evaluations for Physical Therapy, Occupational Therapy and Speech-Language Pathology in Home Settings

Home health providers should use the CPT procedure code and corresponding revenue code listed in the following table, as appropriate, when billing for initial evaluations for physical therapy, occupational therapy or speech-language pathology in home settings. Although PA is generally not required for initial evaluations for therapy services, PA **is** required if initial evaluation is performed in the home.

Table 3 – Codes for Billing Initial Evaluations for Physical Therapy, Occupational Therapy and Speech-Language Pathology in Home Settings

| Therapy Service | Procedure Code and Description | Revenue Code and Description |
|---|---|---|
| Physical | 97161 – *Physical therapy evaluation, low complexity*<br>97162 – *Physical therapy evaluation, moderate complexity*<br>97163 – *Physical therapy evaluation, high complexity* | 424 – *Evaluation or re-evaluation* (for physical therapy) |
| Occupational | 97165 – *Occupational therapy evaluation, low complexity*<br>97166 – *Occupational therapy evaluation, moderate complexity*<br>97167 – *Occupational therapy evaluation, high complexity* | 434 – *Evaluation or re-evaluation* (for occupational therapy) |
| Speech-Language | 92521 – *Evaluation of speech fluency (eg, stuttering, cluttering)*<br>92522 – *Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)*<br>92523 – *Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)*<br>92524 – *Behavioral and qualitative analysis of voice and resonance* | 444 – *Evaluation or re-evaluation* (for speech-language pathology) |

# Home Infusion and Enteral Therapy Services

Home infusion includes the following:

- Enteral feeding within, or by way of, the intestine
- Enteral tube feeding that includes the provision of nutritional requirements through a tube into the stomach or small intestine
- Parenteral therapy that includes any route other than the alimentary canal, such as intravenous, subcutaneous, intramuscular or mucosal
- Total parenteral nutrition therapy (TPN)

## Billing for Home Infusion and Enteral Therapy

The following provider types may bill for home infusion and enteral therapy services and supplies:

- DME and home medical equipment (HME) providers
- Home health agencies
- Pharmacies

Providers should bill separately for the following three components of home infusion and enteral therapy:

- **DME and HME providers** bill all supplies, equipment and formulas required to administer home infusion and enteral therapy on a professional claim (*CMS-1500* claim form, IHCP Portal professional claim or 837P transaction) using the appropriate HCPCS code.
- **Home health agencies** bill only for services provided in the home by an RN or LPN on an institutional claim (*UB-04* claim form or electronic equivalent) using the appropriate HCPCS codes.
- **Pharmacies** bill for compound drugs or any drugs used in parenteral therapy on an *Indiana FSSA Drug Claim Form* or electronic equivalent using the appropriate National Drug Code (NDC).

A home health agency may bill all three components using the proper billing forms and appropriate codes if the agency maintains multiple enrollments as a home health agency, a pharmacy, and a DME or HME provider.

## Billing for Home Uterine Monitoring Device

Home health agencies can bill for infusion therapy using a home uterine monitor with the following procedure codes:

- 99601 – *Home infusion/specialty drug administration, per visit (up to two hours)*
- 99602 – *Home infusion/specialty drug administration, per visit (up to two hours); each additional hour*

Providers are allowed to bill one unit of service daily and should use revenue code 559 when billing 99601 or 99602.

Codes 99601 and 99602 cover the following items:

- Home uterine monitor
- Skilled nursing services that include the following:
  - Initial nursing assessment
  - Instructions given to the patient about the proper use of the monitor
  - Home visits to monitor signs and symptoms of preterm labor
  - Twenty-four-hour telephone support for troubleshooting the monitoring equipment and for reporting patient symptoms

Any costs involved in transmitting reports to the attending practitioner electronically, such as fax or telephone modem, are included in the payment. In addition, all supplies for each therapy are bundled into a daily rate, and home health agencies are not allowed to bill separately for any supplies associated with these therapies. Home health agencies are also not allowed to bill an overhead charge when daily infusion services do not include an actual encounter in the home.

# Home Health Reimbursement

Pursuant to *405 IAC 1-4.2,* home health providers are reimbursed for covered and prior-authorized services provided to IHCP members through standard, statewide rates computed by adding together the following two costs:

- Overhead cost rate
- Staffing cost rate multiplied by the number of hours spent performing billable patient care activities

When home health rate changes occur, the IHCP announces the updated rates in a bulletin. To view bulletins, providers can go to the *IHCP Bulletins* webpage at in.gov/medicaid/providers and search by keywords "home health" in the Search Provider References field to find the most current publication containing home health rates. If needed, check the IHCP Bulletin Archive for bulletins published before 2020.

See Table 1 for information about billing home health services. For coverage and rate information, see the Professional Fee Schedule, accessible from the *IHCP Fee Schedules* webpage at in.gov/medicaid/providers.

# Electronic Visit Verification for Home Health Services

The *21st Century Cures Act* directs Medicaid programs to require home health service providers to use an electronic visit verification (EVV) system to document services rendered. The IHCP requires the use of an EVV system to document home health services for all members, whether enrolled under the fee-for-service or managed care delivery system.

The IHCP has contracted with Sandata to provide a federally compliant EVV system that interfaces with *Core*MMIS. The state-sponsored Sandata EVV system also offers aggregator functionality to accept data from *alternate* EVV systems that providers may already be using or will opt to use in the future.

Agencies using the Sandata state-sponsored EVV solution must complete self-paced training. The self-paced training is accessible from the *IN FSSA Sandata EVV Training* webpage at sandata.zendesk.com. Upon completion of the training, providers will receive a certificate of completion and must send this document, along with their IHCP Provider ID, to inxixevv@gainwelltechnologies.com.

Agencies that opt to use an alternate EVV system should complete all required fields in an online registration form. Sandata will confirm receipt of request and respond with any follow-up questions as needed. Providers that use an alternate EVV system of their choice are responsible for ensuring that the system selected complies with federal requirements, including documentation of the following information:

- Type of service performed
- Individual receiving the service (including IHCP Member ID and the associated Payer ID)
- Date of the service
- Location of service delivery
- Individual providing the service
- Time the service begins and ends

> *Note: When creating client records on the EVV, providers must select the correct Payer ID for the individual. For FFS members, the Payer ID is INFSSA. Each managed care entity has its own Payer ID. Failing to use the correct Payer ID will prevent EVV records from matching to claims appropriately and will ultimately result in claim denials.*

Providers are reminded that they cannot bill partial units of service. Providers must round partial units of service to the nearest whole unit, as described in the *Line-Item Service Details* section, when calculating reimbursement. If the home health aide, LPN or RN is in the home for fewer than 29 minutes, providers can bill for the entire first hour, if and only if a service was provided. After the first hour, normal rounding rules apply. The Sandata Aggregator recognizes this billing parameter.

For more information on EVV and related training, see the *Electronic Visit Verification* and *Electronic Visit Verification Training* webpages at in.gov/medicaid/providers.