Home Health Services

The Division of Medicaid covers the following home health services:

1. Skilled Nursing Visit for intermittent or part-time nursing services provided by a registered nurse employed by a home health agency in accordance with Mississippi State Department of Health, Division of Health Facilities Licensure and Certification standards or a registered nurse when no home health agency exists in the area. The registered nurse must be a graduate of an approved school of professional nursing, who is licensed as a registered nurse by the State in which they practice.

2. Home Health Aide Visit for personal care services provided directly by an aide employed by a home health agency and in accordance with Mississippi State Department of Health, Division of Health Facilities Licensure and Certification standards. The home health aide must be an individual who has successfully completed a state-established or other home health aide training program approved by the State. Home Health aide services may be provided without a requirement for skilled nursing services and must be supervised by a registered nurse.

Home Health visits are limited to a combined total of thirty-six (36) visits per state fiscal year.

Home health services must be provided to a beneficiary at the beneficiary's place of residence defined as any setting in which normal life activities take place, other than:

1. A hospital,

2. Nursing facility,

3. Intermediate care facility for individuals with intellectual disabilities except when the facility is not required to provide the home health service; or

4. Any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

Home health services must be provided in accordance with the beneficiary's physician's orders as part of a written plan of care, which must be reviewed every sixty (60) days. The beneficiary's attending physician must document that a face-to-face encounter occurred no more than ninety (90) days before or thirty (30) days after the start of home health services. The face-to-face encounter must be related to the primary reason the beneficiary requires the home health service.

The home health agency providing home health services must be certified to participate as a home health agency under Title XVIII (Medicare) of the Social Security Act, and comply with all

State of Mississippi

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-OTHER TYPES OF CARE

For those home health agencies not covered by the common audits agreement with Medicare intermediaries, the Office of Compliance and Financial Review of the Division of Medicaid shall be responsible for performance of field reviews and field audits. The Office of Reimbursement of the Division of Medicaid will be responsible for performance of desk reviews.

D. Retention

All audit reports received from Medicare intermediaries or issued by the Division of Medicaid will be retained for a period of at least five (5) years.

E. Overpayment

Overpayments as determined by desk review or audit will be reimbursable to the Division of Medicaid. All overpayments shall be reported to HHS as required.

F. Appeal Procedures – Desk Reviews

A provider who disagrees with the results of their original desk review may request a reconsideration. The request for reconsideration must be made in writing to the Division of Medicaid and must include the reason for the request and any supporting documentation, and must be made within thirty (30) calendar days after receipt of the notification of the desk review results. Notices and responses shall be delivered by certified mail, return receipt requested, overnight delivery by a private carrier, or by hand delivery, and shall be deemed to have been received, if by certified mail or overnight mail, on the day the delivery receipt is signed, or if by hand delivery, on the date delivered. The written request for reconsideration should include the provider's name, provider number, cost reporting period, and a detailed description of the adjustment(s) or issues to be reconsidered. If the provider does not request a reconsideration, the Division of Medicaid will consider the provider's nonresponse as acceptance of the final desk review results. Therefore, no administrative hearing request will be considered.

If the reconsideration is submitted on a timely basis and includes all required information, the Division of Medicaid will review the reconsideration request and respond to the provider within thirty (30) calendar days of the date of receipt of all the required information.

If the provider disagrees with the results of the reconsideration, the provider may request an administrative hearing by the Division of Medicaid as described in Miss. Admin. Code Part 300, within thirty (30) calendar days of the receipt date of the final reconsideration letter.

Unless a timely and proper request for an administrative hearing is received by the Division of Medicaid from the provider, the findings of the Division of Medicaid shall be considered a final and binding administrative determination. Any administrative hearing will be conducted in accordance with the procedures for administrative hearings as adopted by the Division of Medicaid.

G. Final Cost Reports

The final cost reports received from Medicare intermediaries will be used as received from the intermediary to adjust rates. Providers may not appeal to the Division of Medicaid regarding the results of final cost reports. Appeals should be made to the Medicare intermediary under the procedures established by the