



MISSISSIPPI DIVISION OF
MEDICAID

Mississippi Medicaid
Provider Reference Guide
For Part 215
Home Health Services

*This is a companion document to the
Mississippi Administrative Code Title 23
and must be utilized as a reference only.*

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HOME HEALTH SERVICES INTRODUCTION

Medicaid, as authorized by Title XIX of the Social Security Act, is a federal and state program of medical assistance to qualified individuals. Each state designates a state agency as the single state agency for the administration of Medicaid. State law has designated the Division of Medicaid, Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

Medicaid provides financial assistance for home health services. To qualify for home health services, a beneficiary must be essentially homebound, under the care of a physician and in need of home health services on an intermittent basis. The beneficiary's residence shall not include a hospital, skilled nursing facility, or a mental or criminal institution.

A home health provider's participation in the Mississippi Medicaid program is entirely voluntary. However, if a provider does choose to participate in the Home Health Program, that agency must be certified to participate as a home health agency under Title XVIII (Medicare) of the Social Security Act, furnish the Division of Medicaid (DOM) with a copy of its certification letter and/or recertification letter, meet all applicable state and federal laws and regulations, provide DOM with a copy of its certificate of need approval when applicable, and execute a participation agreement with DOM.

The Division of Medicaid is responsible for formulating program policy. DOM staff is directly responsible for the administration of the program. Under the direction of DOM, the fiscal agent is responsible for processing claims, issuing payments to providers, and for notifications regarding billing. Medicaid policy as it relates to these factors is initiated by DOM.

CRITERIA FOR COVERAGE

The following services are covered in the Home Health program when they are provided to eligible beneficiaries in their place of residence and are ordered by a physician. Certain home health services must be reviewed and approved for medical necessity by the Division of Medicaid's Utilization Management and Quality Improvement Organization (UM/QIO).

- Twenty-five (25) home health visits are allowed per Medicaid fiscal year. For beneficiaries over age twenty-one the home health visits may be a combination of skilled nurse or home health aide visits. For beneficiaries under age twenty-one (21) the visits may be a combination of skilled nurse, home health aide, physical therapy (physical therapist or physical therapist assistant) and speech therapy visits. Additional visits are available for children under age 21 through the Expanded EPSDT Program when approved for medical necessity by the UM/QIO.

- Home health agencies should bill using only the following revenue codes:
 - o 270 – Medical/Surgical Supplies and Devices
 - o 421 – Physical Therapy (beneficiaries under age 21)
 - o 441 – Speech-Language Pathology (beneficiaries under age 21)
 - o 551 – Skilled Nursing
 - o 571 – Home Health Aide

- Reimbursement for the cost of medical supplies reported in the medical supplies cost center of the Medicare cost report, which are directly identifiable supplies furnished to individual patients and for which a separate charge is made, will be included in the payment for the visit. Medical supplies must be relevant to the beneficiary's home health plan of care. Medical supplies are medically necessary disposable items, primarily serving a medical purpose, having therapeutic or diagnostic characteristics enabling a patient to effectively carry out a physician's prescribed treatment for illness, injury or disease, and are appropriate for use in the patient's home. Although separate payment will not be made in addition to the visits, home health agencies must report the related charges for supplies under revenue code 270 on the UB04 claim form. Routine medical supply charges should not be reported under revenue code 270 because the costs of these items are reported in the administrative and general cost center on the Medicare cost report. DOM will not reimburse for Durable Medical Equipment (DME), orthotics or prosthetics supplied through a home health agency.

WAIVER SERVICES

Mississippi Medicaid currently operates Home and Community Based Waiver Programs. The Elderly and Disabled Waiver allow beneficiaries expanded home health services when approved for medical necessity by the waiver case manager. Beneficiaries enrolled in other waivers may receive home health services under the State Medicaid plan in accordance with policy.

Processes and services related to waiver services must be handled according to procedures set forth by the Home and Community-Based Waiver Program manual.

DURABLE MEDICAL EQUIPMENT, ORTHOTICS, OR PROSTHETICS

DOM will not reimburse for Durable Medical Equipment (DME), Orthotics, or Prosthetics supplied through a home health agency. Should a beneficiary receiving care through a home health agency need DME, access must be attained through the Medicaid Durable Medical

Equipment Program. Home health agencies may not supply or bill for DME, orthotics, or prosthetics.

CERTIFICATION REQUIREMENTS

As a condition for reimbursement, DOM requires that certain home health services be certified through the Division of Medicaid's Utilization Management and Quality Improvement Organization (UM/QIO). Failure to obtain certification will result in denial of payment to the providers billing for services. All procedures and criteria set forth by the UM/QIO are applicable to home health agencies and ordering physicians and are approved by the Division of Medicaid.

The designated UM/QIO will determine the medical necessity and the quality of services to be provided in the home, the appropriateness of the agency, the types of services, and the number of visits reasonably required to treat the beneficiary's condition.

Beginning with visit 26, the UM/QIO will certify all home health skilled nursing, speech therapy, physical therapy and home health aide services rendered for beneficiaries under age twenty-one (21) except those rendered to beneficiaries who reside in a hospice or have Medicare Parts A & B. No certification is required for the initial 25 visits for children and adults.

SUBMITTING A CERTIFICATION REQUEST

Processes related to certification and recertification for home health services must be handled according to the procedures set forth by the UM/QIO provider manual for home health agencies.

REVIEW OUTCOMES

The UM/QIO will issue a Notice of Review Outcome to the provider at the completion of the review process. If the criteria are met for home health, a Treatment Authorization Number (TAN) will be assigned for billing of services. If the criteria are not met or the review outcome results in less visits being approved than requested or a denial, written notification is sent to the beneficiary/ representative, home health agency and the physician.

Procedures related to certification for home health services must be handled according to the procedures set forth by the UM/QIO.

RECONSIDERATIONS

When the UM/QIO is unable to determine medical necessity, the review outcome may result in fewer visits being approved than requested or in a denial. If the beneficiary, home health agency, or physician disagrees with the determination, and wishes to request a reconsideration, the request must be submitted to the UM/QIO within 30 days of the date of notice.

ADMINISTRATIVE APPEALS

If a determination has been upheld through the reconsideration process to the UM/QIO, the beneficiary may make an administrative appeal to the Division of Medicaid. Administrative appeals shall be made available to any beneficiary who requests such a review because Medicaid services are denied, or reduced as a result of the UM/QIO review.

The beneficiary or beneficiary's legal representative must request the appeal in writing within thirty (30) days from the date the UM/QIO mails the appropriate notice to the beneficiary of its decision regarding services. Administrative appeals cannot be made by the home health agency or physician.

PHYSICIAN RESPONSIBILITIES

CERTIFICATION AND RECERTIFICATION STATEMENT

The physician has a major role in determining utilization of health services furnished by providers. He/she must provide a statement of certification that shows the medical necessity for home health services, the type of services required, and the period of time home health services will be needed. This written statement must be provided to the home health agency and retained in the beneficiary's record and submitted to the Division of Medicaid's Utilization Management and Quality Improvement Organization (UM/QIO) as required for the review process in determining the need for admission to the home health program. It is mandatory that an individual requiring a level of care which would make him/her eligible for home health benefits be seen by the specializing physician or the primary care physician at least once every sixty (60) days. The physician must provide a written recertification statement stating there is a continuing need for home health services and approximately how long services will be needed. The certification and the recertification statements must be signed by the attending physician and kept in the beneficiary's record.

DOCUMENTATION REQUIREMENTS

Providers must maintain proper and complete documentation to verify the services and medical supplies provided. The provider has full responsibility for maintaining documentation to justify the services and medical supplies provided.

DOM, the fiscal agent, Medicaid fraud control unit, state auditor, U. S. Department of Health and Human Services, Office of the Inspector General, and any of their designated

representatives, have the authority to request any beneficiary records at any time to conduct a random sampling review and/or document any services billed by the home health provider.

If a home health agency's records do not substantiate services paid for under the Mississippi Medicaid program, as previously noted, the agency will be asked to refund to the Mississippi Medicaid program any money received for such non-substantiated services. If a refund is not received within sixty (60) days, a sum equal to the amount paid for such services will be deducted from any future payments that are deemed to be due the provider.

A home health provider who knowingly or willfully makes, or causes to be made, false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under federal and state laws. A false attestation can result in civil monetary penalties as well as fines, and may automatically disqualify the home health provider as a provider of Medicaid services.

HOME HEALTH SERVICES PROVIDED IN ANOTHER STATE

If the home health agency is determined eligible for a temporary number, the provider must complete a provider enrollment packet and meet all home health agency requirements. The provider enrollment packet can be downloaded at <https://msmedicaid.acs-inc.com/msenvision>; click on provider, provider enrollment then download enrollment package or request an application by calling ACS Provider Enrollment at 1-800-884-3222. The completed enrollment packet, claims for dates of services, verification in writing of the agency's Medicaid rates for their state, and other required information must be mailed to:

Division of Medicaid
Bureau of Reimbursement
550 High Street
Jackson, MS 39201

DOM will issue a rate letter assigning a temporary provider number for specific dates of services and the rates for disciplines in question. In addition, the letter would include the effective date and close date for the temporary provider number. Rate assignment is calculated by using the lesser of the assigned rates for the requesting state or Mississippi Medicaid ceilings.

It is required that certain home health services be certified by the Division of Medicaid's Utilization Management and Quality Improvement Organization (UM/QIO). DOM will initiate a review for medical necessity and forward claims to the appropriate source.

MORATORIUM

The State of Mississippi currently has a moratorium on home health agencies. New applications for enrollment are not accepted. Applications are only processed for current home health agencies when there is a change of ownership.

DUAL ELIGIBLES

Medicare is the primary payor for dually eligible beneficiaries, and providers are obligated to comply with the requirements covering the coordination between the two programs. Persons eligible for Medicare and Medicaid are entitled to all services available under both programs, but a claim must be filed with Medicare if Medicare covers the services. A patient may not receive home visits under both programs simultaneously. For information on “Medicaid Cost Sharing for Medicare/Medicaid Dually Eligibles” for Medicare Part A crossover claims, refer to Administrative Code Part 200, Chapter 2.

Twenty-five home health visits per fiscal year limit is applicable for beneficiaries age 21 and over. For beneficiaries under age 21, the UM/QIO may approve medically necessary visits beyond the limit of twenty-five (25).