



Administrative Code

Title 23: Medicaid Part 215 Home Health Services

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Title 23: Division of Medicaid

Part 215: Home Health Services

Part 215 Chapter 1: Home Health Services

Rule 1.1: Definitions

The Division of Medicaid defines:

- A. Home health services as skilled nursing visits, home health aide visits, and durable medical equipment, supplies and appliances provided to a beneficiary:
 - 1. At the beneficiary's place of residence,
 - 2. Ordered by the beneficiary's physician or non-physician practitioner (NPP) as part of a written plan of care reviewed by the physician or NPP every sixty (60) days.
- B. Residence as 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.
- C. Durable medical equipment, supplies and appliances in Miss. Admin Code Title 23, Part 209.
- D. Out-patient setting as any setting where a beneficiary receives services and is not admitted as a resident or inpatient.
- E. Order as the certification of need for home health services.
- F. Recertification as the certification of continued need for home health services.
- G. A face-to-face encounter, for home health services, as an in person visit, including telehealth, which occurs between a physician or allowed non-physician practitioner and a beneficiary for the primary reason the beneficiary requires home health services and must occur no more than ninety (90) days before or thirty (30) days after the start of home health services.
- H. Allowed non-physician practitioner (NPP) as a:
 - 1. Nurse practitioner or clinical nurse specialist working in collaboration with the beneficiary's physician, or
 - 2. Physician assistant under the supervision of the beneficiary's physician.

Source: 42 C.F.R. § 440.70; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 07/01/2021; Revised and renamed rule eff. 09/01/2018.

Rule 1.2: Provider Enrollment Requirements

Home health providers, including out-of-state providers, must meet all of the applicable requirements set forth in Miss. Admin. Code Title 23, Part 200, Chapter 4.

Source: 42 C.F.R. § 440.70, 42 C.F.R. Part 455, Subpart E; 42 C.F.R. Part 484; Miss. Code Ann. § 43-13-121.

History: Revised eff. 08/01/2026. Revised eff. 09/01/2018.

Rule 1.3: Covered Services

A. The Division of Medicaid covers the following home health services:

1. Skilled nursing visits.
 - a) Intermittent or part-time skilled nursing services must be provided during the visit by a registered nurse (RN) or a licensed practical nurse (LPN) under the supervision of a RN employed by a home health agency in accordance with Mississippi State Department of Health, Division of Health Facilities Licensure and Certification (MSDH-DHFLC) standards or an RN when no home health agency exists in the area.
 - b) The RN must be a graduate of an approved school of professional nursing, who is licensed as an RN by the State in which they practice.
2. Home health aide visits for home health aide services.
 - a) Home health aide services must be provided directly by an aide employed by a home health agency and in accordance with MSDH-DHFLC standards.
 - b) 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 MSDH-DHFLC.
 - c) A supervisory visit must be made every sixty (60) days by an RN.
 - d) Home health aide services may be provided without the requirement of receiving skilled nursing services.
3. Durable medical equipment, medical supplies and appliances as described in Miss. Admin. Code Title 23, Part 209.

B. The Division of Medicaid covers up to thirty-six (36) home health visits per state fiscal year.

- C. Home health services must be medically necessary and reasonable for the treatment of the beneficiary's disability, illness, or injury.
- D. To receive home health services a beneficiary must:
 - 1. Be unable to travel to an outpatient setting for the needed services, or
 - 2. Have a condition that is so fragile or unstable that the beneficiary cannot receive the services in an outpatient setting, and
 - 3. Be seen by a physician or allowed non-physician practitioner (NPP) at least every sixty (60) days for the purpose of recertification of home health services.
- E. 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.
- F. The beneficiary's physician or allowed NPP, 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.
- G. Home health services must be provided in accordance with an order written by a physician, nurse practitioner, or physician assistant working in accordance with State law as part of a written plan of care, which must be reviewed every sixty (60) days.
- H. Recertification must occur at the time the plan of care is reviewed, and must be signed and dated by the physician or allowed NPP who reviews the plan of care.
- I. The home health agency providing home health services must be certified to participate as a home health agency under Medicare, and comply with all applicable state and federal laws and requirements.
- J. Home health services are covered for beneficiaries eligible for both Medicare and Medicaid if:
 - 1. The beneficiary is not receiving and does not qualify for home health services covered under Medicare,

2. The beneficiary is eligible for home health services provided by Medicaid,
 3. The home health services are medically necessary, and
 4. All requirements of Miss. Admin. Code Title 23, Part 215 are met.
- K. The Division of Medicaid covers home health services furnished to a beneficiary in another state to the same extent that home health services are covered in-state if:
1. Home health services are needed because of a medical emergency,
 2. It would cause the beneficiary's condition to decline if they were required to return to Mississippi in order to receive necessary home health services,
 3. The Division of Medicaid determines, on the basis of medical advice, the medically necessary home health services or necessary supplementary resources are more readily available in the other state,
 4. It is general practice for beneficiaries in a particular locality to use resources in another state, or
 5. The beneficiary has not been a resident for more than thirty (30) days in the state where the home health agency operates.
- L. The Division of Medicaid requires the following guidelines for an out of state home health agency:
1. If the beneficiary has been a resident for more than thirty (30) days in the state where the home health agency operates, the beneficiary would be considered a resident of that state and the Mississippi Division of Medicaid would not reimburse for services provided, or
 2. If the beneficiary has not been a resident for more than thirty (30) days in the state where the home health agency operates, the Mississippi Division of Medicaid would reimburse for services.
- M. Out-of-state providers are required to request a provider number and meet all home health agency requirements.

Source: 42 C.F.R. § 440.70; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with MS SPA 24-0006 (eff. 07/01/2024) eff. 11/01/2024; Revised eff. 07/01/2021; Revised eff. 07/01/2019.

Rule 1.4: Non-Covered Services

The Division of Medicaid does not cover:

- A. Home health services provided to a beneficiary who can receive the services in an outpatient setting including, but not limited to:
 - 1. Outpatient hospital,
 - 2. Free-standing clinic, or
 - 3. Nursing facility.
- B. Services that are not medically necessary.
- C. Services that are not part of a written plan of care reviewed and recertified every sixty (60) days by a physician or non-physician practitioner (NPP).
- D. Services provided by a home health agency that has not met the requirements for participation in Medicare.
- E. Services that have not been ordered by a physician or (NPP).
- F. Services provided in another state where the beneficiary has been a resident for more than thirty (30) days.
- G. The following services under the home health benefit:
 - 1. Physical therapy,
 - 2. Occupational therapy, and/or
 - 3. Speech-language pathology and audiology services.

Source: 42 C.F.R. § 440.70, 484; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 07/01/2021; Revised eff. 09/01/2018.

Rule 1.5: Reimbursement

- A. In order to receive reimbursement from the Division of Medicaid for the face-to-face encounter, the encounter must be conducted by an enrolled Medicaid provider.
- B. The Division of Medicaid reimburses for home health services based on reasonable cost determined in accordance with the State Plan and Medicare principles of reimbursement, except when Medicare guidelines are contradictory to directives of the State Plan or the Division of Medicaid. In such a situation, the State Plan or the Division of Medicaid will prevail.

1. Medicaid cost reporting schedules must be included with the Medicare cost report to compute Medicaid reimbursement.
 2. A schedule must be completed to reflect the lower of reasonable costs or customary charge provisions as they apply to Medicaid.
 3. In addition to the lower of costs or charge limitations, reimbursement for home health services is limited to and cannot exceed the prevailing costs of providing nursing facility services.
- C. The Division of Medicaid reimburses for the initial assessment visit for skilled nursing services and aide services as listed below:
1. If a beneficiary is assessed for services without a skilled nursing service performed during the initial assessment visit and is not admitted to the home health program, the initial assessment visit cannot be billed and must be claimed as an administrative cost.
 2. If a beneficiary is assessed for services and a skilled nursing service is performed during the initial assessment visit and is admitted to the home health program for continuation of skilled nursing and/or aide visits, the initial assessment visit can be billed and is not considered an administrative cost.
 3. If a beneficiary is assessed for services with a skilled nursing service performed during the initial assessment visit only and is not admitted to the home health program, the home health agency must elect either to:
 - a) Claim the initial assessment visit as an administrative cost, or
 - b) Admit and discharge the beneficiary on the same day from the home health program and bill for the one (1) initial assessment visit and is not considered an administrative cost.
 4. If a beneficiary is assessed for only home health aide services and a skilled nursing service is not performed during the initial assessment visit and the beneficiary is not admitted to the home health program, the initial assessment visit cannot be billed and is considered as an administrative cost.
 5. If a beneficiary is assessed for only home health aide services and a skilled nursing service is performed during the initial assessment visit and the beneficiary is admitted to the home health program, the home health agency must elect either to:
 - a) Claim the initial assessment visit as an administrative cost, or
 - b) Bill the initial assessment visit as a skilled nursing service.
- D. Supervisory visits are administrative costs and are not directly reimbursable.

E. The Division of Medicaid reimburses a medical supply add-on calculated as described in the State Plan.

Source: 42 C.F.R. § 440.70; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with SPA 23-0003 (eff. 02/01/2023) eff. 05/01/2023; Revised eff. 07/01/2021; Revised eff. 09/01/2018.

Rule 1.6: Documentation

A. The Division of Medicaid requires the home health agency to maintain auditable records that substantiate the services provided and include, at a minimum, the following in each beneficiary's record verifying services provided by the home health agency are medically necessary [Refer to Maintenance of Records Part 200, Rule 1.3.]:

1. Physician or non-physician practitioner (NPP) referral,
2. Appropriate information identifying the beneficiary,
3. Name of the physician or NPP,
4. Documentation of the face-to-face encounter with the ordering physician or allowed non-physician practitioner (NPP) including:
 - a) Documentation that the required face-to-face encounter related to the primary reason the beneficiary needs the services occurred ninety (90) days before or thirty (30) days after the start of home health services,
 - b) Identification of the physician or allowed NPP who conducted the encounter, and
 - c) The date of the face-to-face encounter,
5. If the face-to-face encounter was performed by an allowed NPP, the clinical findings of the face-to-face encounter must be incorporated into a written or electronic document in the beneficiary's medical record.
6. Documentation that the services cannot be provided in any other setting other than the beneficiary's residence.
7. The initial order and all recertifications signed by the physician or NPP which must include:
 - a) Justification home health services are medically necessary and reasonable for treatment of the beneficiary's illness, injury, or condition,

- b) The type of services required, and
 - c) The estimated duration home health services will be needed,
8. The beneficiary's plan of care,
 9. Documentation that the beneficiary's plan of care is reviewed and recertified by a physician or NPP every sixty (60) days,
 10. Signed copy of orders, new orders or changes in orders for medications, medical supplies, treatments, dietary, and activities,
 11. Case conference report(s) covering all disciplines,
 12. Lab results and other diagnostic test results,
 13. Discharge summary to include transfers and hospital stays,
 14. Documentation of all verbal communications between the home health agency and the physician and/or allowed NPP, and
 15. Documentation that a supervisory visit was made by a registered nurse (RN) at least every sixty (60) days for home health aide services.
- B. Home health agencies must provide and the physician must maintain copies of the documentation in Miss. Admin. Code Part 215, Rule 1.6.A. in each beneficiary's record verifying services provided by the home health agency are medically necessary. [Refer to Maintenance of Records Part 200, Rule 1.3.]

Source: 42 C.F.R. §§ 440.70, 484.48; Miss. Code Ann. §§ 43-13-117, 43-13-118, 43-13-121, 43-13-129.

History: Revised eff. 07/01/2021; Revised eff. 09/01/2018.

Rule 1.7: Early, Periodic Screening, Diagnosis and Treatment (EPSDT)

- A. The Division of Medicaid covers all medically necessary services for beneficiaries who qualify for the federally mandated Early, Periodic Screening, Diagnosis and Treatment (EPSDT) program without regard to service limitations and with prior authorization.
- B. Physical therapy, speech-language pathology and audiology services are reimbursed on a fee-for-service basis at an all-inclusive, per visit rate plus a medical supply add-on calculated as described in the State Plan.

Source: 42 C.F.R. § 440.70; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 09/01/2018.