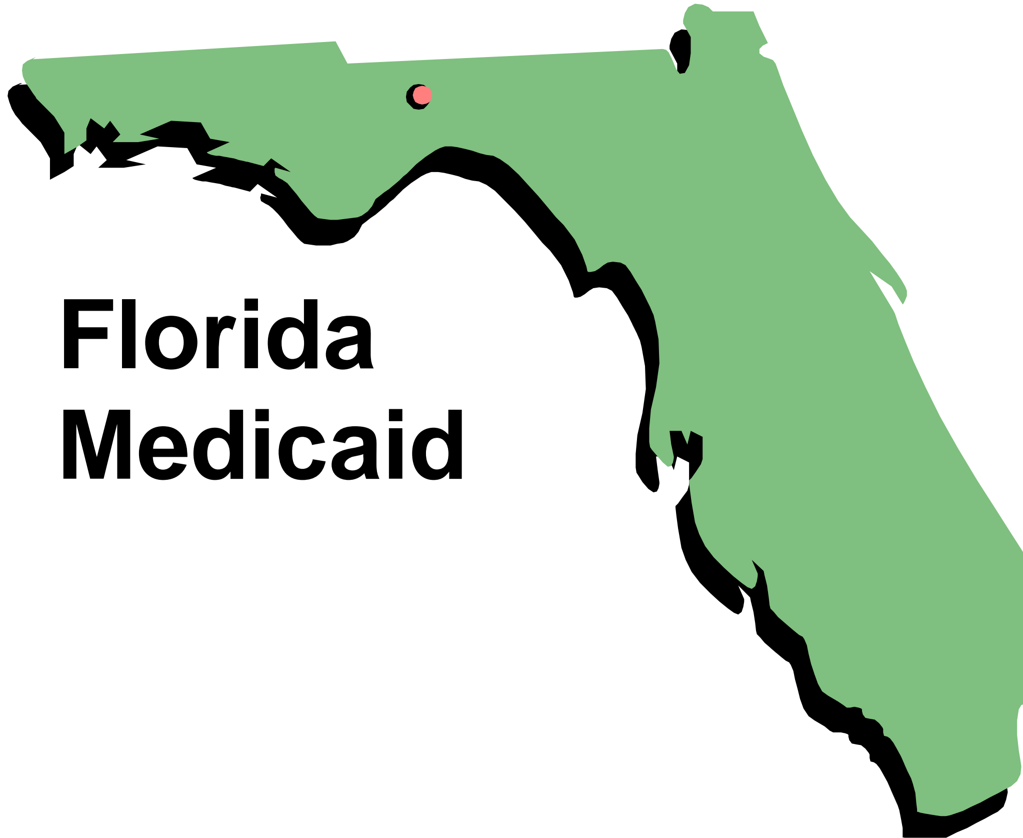

HOME HEALTH SERVICES COVERAGE AND LIMITATIONS HANDBOOK

Agency for Health Care Administration

UPDATE LOG
HOME HEALTH SERVICES
COVERAGE AND LIMITATIONS HANDBOOK

How to Use the Update Log

Introduction

The current Medicaid provider handbooks are posted on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. Changes to a handbook are issued as handbook updates. An update can be a change, addition, or correction to policy. An update may be issued as either replacement pages in an existing handbook or a completely revised handbook.

It is very important that the provider read the updated material and if he maintains a paper copy, file it in the handbook. It is the provider's responsibility to follow correct policy to obtain Medicaid reimbursement.

Explanation of the Update Log

Providers can use the update log to determine if they have received all the updates to the handbook.

Update describes the change that was made.

Effective Date is the date that the update is effective.

Instructions

When a handbook is updated, the provider will be notified by a notice. The notification instructs the provider to obtain the updated handbook from the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Providers who are unable to obtain an updated handbook from the Web site may request a paper copy from the Medicaid fiscal agent's Provider Support Contact Center at 800-289-7799.

UPDATE	EFFECTIVE DATE
Revised Handbook	March 2000
Revised Handbook	October 2003
Revised Handbook	July 2007
Revised Handbook	July 2008
Revised Handbook	December 2011

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HOME HEALTH SERVICES
COVERAGE AND LIMITATIONS HANDBOOK

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INTRODUCTION TO THE HANDBOOK

Overview

Introduction

This chapter introduces the format used for the Florida Medicaid handbooks and tells the reader how to use the handbooks.

Background

There are three types of Florida Medicaid handbooks:

- *Provider General Handbook* describes the Florida Medicaid Program.
- *Coverage and Limitations Handbooks* explain covered services, their limits, who is eligible to receive them, and the fee schedules.
- *Reimbursement Handbooks* describe how to complete and file claims for reimbursement from Medicaid.

Exception: For Prescribed Drugs, the coverage and limitations handbook and the reimbursement handbook are combined into one.

Legal Authority

The following federal and state laws govern Florida Medicaid:

- Title XIX of the Social Security Act.
- Title 42 of the Code of Federal Regulations.
- Chapter 409, Florida Statutes.
- Chapter 59G, Florida Administrative Code.

In This Chapter

This chapter contains:

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Handbook Use and Format

Purpose	The purpose of the Medicaid handbooks is to provide the Medicaid provider with the policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients. The handbooks provide descriptions and instructions on how and when to complete forms, letters or other documentation.
Provider	The term "provider" is used to describe any entity, facility, person or group who is enrolled in the Medicaid program and provides services to Medicaid recipients and bills Medicaid for services.
Recipient	The term "recipient" is used to describe an individual who is eligible for Medicaid.
General Handbook	General information for providers regarding the Florida Medicaid Program, recipient eligibility, provider enrollment, fraud and abuse policy, and important resources are included in the Florida Medicaid Provider General Handbook. This general handbook is distributed to all enrolled Medicaid providers and is updated as needed.
Coverage and Limitations Handbook	Each coverage and limitations handbook is named for the service it describes. A provider who provides more than one type of service will have more than one coverage and limitations handbook.
Reimbursement Handbook	Each reimbursement handbook is named for the claim form that it describes.
Chapter Numbers	The chapter number appears as the first digit before the page number at the bottom of each page.
Page Numbers	Pages are numbered consecutively throughout the handbook. Page numbers follow the chapter number at the bottom of each page.
White Space	The "white space" found throughout a handbook enhances readability and allows space for writing notes.

Characteristics of the Handbook

Format	The format styles used in the handbooks represent a short and regular way of displaying difficult, technical material.
Information Block	Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of the subject. Blocks are separated by horizontal lines. Each block is identified or named with a label.
Label	Labels or names are located in the left margin of each information block. They identify the content of the block in order to help scanning and locating information quickly.
Note	Note is used most frequently to refer the user to important material located elsewhere in the handbook. Note also refers the user to other documents or policies contained in other handbooks.
Topic Roster	Each chapter contains a list of topics on the first page, which serves as a table of contents for the chapter, listing the subjects and the page number where the subject can be found.

Handbook Updates

Update Log	The first page of each handbook will contain the update log. Every update will contain a new updated log page with the most recent update information added to the log. The provider can use the update log to determine if all updates to the current handbook have been received. Each update will be designated by an “Update” and the “Effective Date.”
How Changes Are Updated	The Medicaid handbooks will be updated as needed. Changes may be: 1. Replacement handbook—Major changes will result in the entire handbook being replaced with a new effective date throughout and it will be a clean copy. 2. Revised handbook – Changes will be highlighted in yellow and will be incorporated within the appropriate chapter. These revisions will have an effective date that corresponds to the effective date of the revised handbook.

Handbook Updates, continued

Effective Date of New Material	The month and year that the new material is effective will appear at the bottom of each page. The provider can check this date to ensure that the material being used is the most current and up to date.
Identifying New Information	New material will be identified by yellow highlighting. The following information blocks give examples of how new labels, new information blocks, and new or changed material within an information block will be indicated.
New Label and New Information Block	A new label and a new information block will be identified with yellow highlight to the entire section.
New Material in an Existing Information Block or Paragraph	New or changed material within an existing information block or paragraph will be identified by yellow highlighting to the sentence and/or paragraph affected by the change.

CHAPTER 1
HOME HEALTH SERVICES
PROVIDER QUALIFICATIONS AND REQUIREMENTS

Overview

Introduction

This chapter describes the Medicaid Home Health Services Program, defines the specific authority regulating home health services, defines provider qualifications, and specifies the purpose of the program and who may provide home health services.

Legal Authority

Home health services are governed by Title 42, Code of Federal Regulations (C.F.R.), Part 440.70.

The Florida Medicaid Home Health Services Program is authorized by Chapter 409, Florida Statutes (F.S.) and Chapter 59G, Florida Administrative Code (F.A.C.).

In This Chapter

This chapter contains:

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Purpose and Definitions

Medicaid Provider Handbooks

This handbook is intended for use by home health services providers that furnish services to Medicaid recipients. It must be used in conjunction with the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which contains specific procedures for submitting claims for payment, and the Florida Medicaid Provider General Handbook, which contains general information about the Medicaid program.

Note: The Florida Medicaid provider handbooks are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. The Florida Medicaid Provider General Handbook is incorporated by reference in 59G-5.020, F.A.C.; and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, is incorporated by reference in 59G-4.001, F.A.C.

Purpose of the Home Health Program

The purpose of the home health program is to provide medically-necessary care to an eligible Medicaid recipient whose medical condition, illness or injury requires the care to be delivered in the recipient's place of residence.

Note: See the Glossary in the Florida Medicaid Provider General Handbook for the definition of medically necessary.

Home Health Services Definition

Home health services are medically necessary services, which can be effectively and efficiently provided in the place of residence of a recipient. Services include home health visits (nurse and home health aide), private duty nursing and personal care services for children, therapy services, medical supplies, and durable medical equipment.

Home Health Visit Definition

A home health visit is a face-to-face contact between a registered nurse, licensed practical nurse, or home health aide and a recipient at his place of residence.

A home health visit is not limited to a specific length of time, but is defined as an entry into the recipient's place of residence, for the length of time needed, to provide the medically-necessary nursing or home health aide service(s).

Medicaid reimbursement for a home health visit does not include travel time to or from the recipient's place of residence. Such expenses are administrative and not reimbursable by Medicaid.

Purpose and Definitions, continued

Place of Residence Definition

Place of residence is the location where a Medicaid recipient lives and may include:

- Recipient's private home;
- Assisted Living Facility (ALF);
- Developmental disabilities group home;
- Foster or medical foster care home; or
- Any home where unrelated individuals reside together in a group.

Note: See the topics on the specific services in Chapter 2 for information on place of residence exclusions for a specific service, i.e., Private Duty Nursing.

Attending Physician Definition

The attending physician is the doctor in charge of the recipient's medical condition that causes the recipient to need home health services.

Babysitting

The act of providing custodial care, daycare, afterschool care, supervision, or similar childcare unrelated to the services that are documented to be medically necessary for the recipient.

Independent Personal Care Provider

An independent personal care provider renders personal care services directly to recipients and does not employ others for the provision of personal care services.

Independent Personal Care Group Provider

An independent personal care group provider is an unlicensed group (agency) enrolled to provide personal care services that has one or more staff employed to perform the services. All employees of the unlicensed group provider must meet the qualifications and requirements specified for the provision of personal care services and be enrolled in the Medicaid program as an individual personal care provider.

Purpose and Definitions, continued

Instrumental Activities of Daily Living	Instrumental activities of daily living (IADLs) are tasks which enable a recipient to function independently in the community.
Geographic Service Area	Geographic service area is an area, as specified by county(ies) on the license, in which the home health agency may send its personnel to provide home health services to recipients in their places of residence. A geographic service area cannot encompass more than one AHCA-designated geographic area of the state.
Parent Office	A parent office is a home health agency responsible for the services furnished to recipients and for implementation of the plan of care. Additionally, it is responsible for the development and administrative control of subunits and branch offices. A parent office must meet the Medicare Conditions of Participation.
Branch Office	A branch office is a separately licensed location or site from which a parent home health agency provides services within a portion of its total geographic service area. A branch office is located sufficiently close to share administration, supervision and services with the parent office. It is not required to independently meet the Medicare Conditions of Participation. Offices of a corporate home health agency located in different geographic service areas are required to enroll in Medicaid as parent offices.
Subunit	A subunit is a separately licensed, semi-autonomous organization that serves recipients in a portion of the geographic service area different from that of the parent office. A subunit must independently meet the Medicare Conditions of Participation because it is too far from the parent office to share administration, supervision, and services on a daily basis. A subunit may meet specified standards of the Medicare Conditions of Participation through its parent office.
Quality Improvement Organization (QIO)	The vendor contracted with the Agency for Health Care Administration to monitor the appropriateness, effectiveness, and quality of care provided to Medicaid recipients. The vendor performs prior authorizations of services based on medical necessity determinations.
Intermittent Visits	Services that are provided at intervals up to four times per day.

Purpose and Definitions, continued

Caregiver

An individual such as a parent, foster parent, head of household or family member who attends to the needs of a child or dependent adult. This individual generally provides care without compensation.

Provider

An individual, such as a nurse, aide, or health professional who assists in the identification, prevention, or treatment of an illness or disability. This individual is usually an employee of an agency and provides care for compensation.

Provider Qualifications

Home Health Agency Provider Qualifications

To enroll as a Medicaid provider, a home health agency must be licensed in accordance with Chapter 400, Part III, F.S. and Chapter 59A-8, F.A.C., or applicable laws of the state in which the services are furnished.

The home health agency must:

- Meet the Medicare Conditions of Participation as determined through a survey conducted by the Agency for Health Care Administration (AHCA), Division of Health Quality Assurance (HQA); or
- Be accredited and deemed by the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) or the Community Health Accreditation Program (CHAP) or the Accreditation Commission for Health Care (ACHC) as meeting the Medicare Conditions of Participation.

Home health agencies receiving accreditation and deemed status by JCAHO or CHAP or ACHC are responsible for providing accreditation documentation to HQA.

Independent personal care providers are exempt from this requirement for the provision of personal care services.

Provider Qualifications, continued

Independent Personal Care Provider Qualifications

Medicaid reimburses independent personal care providers under their Medicaid home health provider number, for the provision of personal care services.

To enroll in the Medicaid program, independent personal care providers must:

- Be at least 18 years of age;
- Be trained in the areas of cardiopulmonary resuscitation (CPR), HIV/AIDS, and infection control;
- Have at least one year of experience working in a medical, psychiatric, nursing or child care setting or working with recipients who have a developmental disability. College, vocational or technical training in medical, psychiatric, nursing, child care, or developmental disabilities equal to 30 semester hours, 45 quarter hours, or 720 classroom hours may be substituted for the required experience.

Independent personal care providers are responsible for meeting the experience and training requirements and must maintain on file documented proof of annual or required updated training. The documentation must verify the provider's and its employees' participation in the required training session, the date and location of the training, the name and signature of the trainer, and the name and signature of person(s) in attendance.

Independent personal care group providers must meet the home health licensure exemption requirements defined in 400.464, Florida Statutes in order to be reimbursed for personal care services provided to Medicaid recipients.

Provider Qualifications, continued

Therapy Services

Medicaid reimburses home health agencies, under their Medicaid home health provider number, for the following therapies:

- Occupational therapy;
- Physical therapy; and
- Speech-language pathology services.

To qualify to provide these therapies, the home health agency must list each therapy service on its application for licensure and certification. HQA determines if the agency meets licensure requirements for the provision of the therapy service(s).

Note: See Chapter 2 of this handbook for service coverage and limitations.

Note: See the Florida Medicaid Therapy Services Coverage and Limitations Handbook for additional information. The handbook is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Licensed to Cover County

The parent office must be licensed to cover the county in which the branch office is located in order to receive Medicaid reimbursement for the home health services provided through the branch office.

Complaint Surveys

Complaints of alleged violations of regulations are investigated by HQA.

Provider Enrollment

General Enrollment Requirement

Home health providers must meet the general Medicaid provider enrollment requirements that are contained in the Florida Medicaid Provider General Handbook. In addition, home health providers must meet the specific enrollment requirements that are listed in this section.

Independent Personal Care Provider Enrollment

Independent personal care providers must meet the general Medicaid provider enrollment requirements that are contained in Chapter 2 of the Florida Medicaid Provider General Handbook. In addition, independent personal care providers must follow the specific enrollment requirements that are listed in this section. Proof of training is required upon enrollment as a personal care provider.

Provider Enrollment, continued

Independent Personal Care Group Provider Enrollment

An unlicensed independent agency or group provider enrolled in the Medicaid program to provide personal care services that employs one or more persons for the actual provision of services must enroll as a personal care provider group. In order to receive payment from Medicaid, each member of the group must enroll in Medicaid as an individual personal care services treating provider within the group for which he performs services. It is the responsibility of the individual treating provider to notify the Medicaid fiscal agent of all group practices with which he is affiliated. Any individual treating provider who is terminating his relationship with a group must notify the Medicaid fiscal agent in writing of this termination in order to update his provider file.

Branch Offices and Subunits

Home health agencies are required to submit a Declaration of Service Address, AHCA Form 2200-0004, for its branch offices and subunits.

Note: The Declaration of Service Address, AHCA Form 2200-0004, can be obtained from the Medicaid fiscal agent by calling 800-289-7799 and selecting Option 4 or the fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Enrollment. The form is incorporated by reference in 59G-5.020, F.A.C.

Closure of a Branch Office or Subunit

A home health agency must report any closure of a practice location and the effective date of the closure to the Medicaid fiscal agent and HQA in writing on office letterhead stationery. The letter must be sent 60 days prior to the closure.

Drop Off Site

Medicaid does not enroll drop-off sites since they are not considered to be places of service.

Surety Bond Requirements

A surety bond is required for home health agencies if there have been (within the past 5 years) or currently are sanctions or terminations (voluntary or involuntary) involved. This requirement is applicable to future terminations or sanctions of a home health agency.

Note: See Chapter 2 in the Florida Medicaid Provider General Handbook for the surety bond requirements and exemptions.

Who May Provide Home Health Services

Qualified Home Health Agency Staff

Home health services are provided by qualified health care professionals.

The home health agency must ensure that all staff (employed or contracted) who provide home health services are qualified and licensed.

Multiple Home Health Services Providers

In situations which require services from more than one home health services provider in order to provide all the care required by a recipient, Medicaid applies the following criteria for reimbursement:

- Medicaid will not reimburse duplicative nursing or home health aide services;
- Each home health services provider is responsible for coordinating its plan of care with other involved home health services providers;
- Each home health services provider is responsible for noting on its plan of care the services being provided by another home health services provider;
- Each home health services provider is accountable for the provided services and billing pursuant to its plan of care; and
- When requesting prior authorization, each home health services provider is responsible for informing the Medicaid Quality Improvement Organization of other home health services providers also providing services to the recipient.

A home health services provider furnishing home health services without documented knowledge of other home health services providers furnishing services to its recipient is at risk for recoupment of reimbursement.

Note: Please refer to Procedure Code Modifiers in Chapter 3 and Appendix A for the valid procedure codes and modifiers.

Nurse Qualifications

Home health nursing services must be provided by a nurse licensed pursuant to Chapter 464, F.S., or applicable laws of the state in which the services are provided.

Who May Provide Home Health Services, continued

Home Health Aide Qualifications

A home health aide must have successfully completed a training program that meets minimum standards for aide training as defined in 42 C.F.R. §484.36(a)(1) and Chapter 400, F.S.

Personal Care Services

Personal care services may be provided by:

- Home health agencies, licensed in accordance with Chapter 400, part III, F.S., or
- Independent personal care providers who meet the experience and training requirements as described in this section and who are enrolled as home health personal care providers with a specialty code of 114.

Skill Level of Staff

The home health services provider must provide staff with the skill level designated or appropriate for each medically necessary covered home health service prescribed in the physician order and approved plan of care. Skill level designation must be reflective of the standards outlined in the Nurse Practice Act. See Florida Statutes Chapter 464. Requests for a skill level higher than the less costly alternative must justify the need.

Staff Substitutions

Whenever staff absences occur, the home health services provider is responsible for providing and assuring that appropriate staff substitutions are made.

Staff discipline must be equivalent to or above the discipline level as specified in the plan of care. Under no circumstances can staff of a lower discipline be substituted for staff of a higher discipline level than ordered. The staff substitution must be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide.

If a nurse is substituted for a home health aide, Medicaid will only reimburse at the home health aide rate. If a Registered Nurse is substituted for a Licensed Practical Nurse, Medicaid will only reimburse at the Licensed Practical Nurse rate.

Multiple Counties

A parent agency may employ staff located in other counties listed on its license to serve the recipients in those counties (a facility cannot be set up in these counties) as long as they meet the qualifications for home health staff. All recipient records and documentation must be housed and maintained at the parent office, including all required home health record documentation, daily progress notes, plans of care, etc. This documentation must be original and must be signed and dated by the individual provider of service on the day the services were rendered. Medicaid does not pay for travel to and from the parent office to transmit this documentation.

Provider Responsibilities

Health Insurance Portability and Accountability Act (HIPAA)

Florida Medicaid has implemented all of the requirements contained in the federal legislation known as the Health Insurance Portability and Accountability Act (HIPAA). As trading partners with Florida Medicaid, all Medicaid providers, including their staff, contracted staff and volunteers, must comply with HIPAA privacy requirements. Providers who meet the definition of a covered entity according to HIPAA must comply with HIPAA Electronic Data Interchange (EDI) requirements. This Coverage and Limitations Handbook contains information regarding changes in procedure codes mandated by HIPAA. The Medicaid Provider Reimbursement Handbooks contain the claims processing requirements for Florida Medicaid, including the changes necessary to comply with HIPAA.

Note: For more information regarding HIPAA privacy in Florida Medicaid see Chapter 2 in the Florida Medicaid Provider General Handbook.

Note: For more information regarding claims processing changes in Florida Medicaid because of HIPAA, see the Florida Medicaid Provider Reimbursement Handbook, CMS-1500.

Note: For more information regarding changes in EDI requirements for Florida Medicaid because of HIPAA, contact the fiscal agent EDI help desk at 866-586-0961 or 800-289-7799, select Option 3.

Record Keeping Requirements

In addition to the specific documentation that is required for the covered services listed in Chapter 2 of this handbook, home health providers must follow the record keeping requirements listed in Chapter 2 of the Florida Medicaid Provider General Handbook.

Chart Forms

The home health services provider must ensure that all staff (employed or contracted) utilize the home health services provider's chart forms for documentation of home health services.

Accountability

The home health services provider is accountable for:

- Services provided by staff (employed or contracted); and
- Billing of the provided services.

CHAPTER 2
HOME HEALTH SERVICES
COVERED SERVICES, LIMITATIONS AND EXCLUSIONS

Overview

Introduction

This chapter describes the services covered under the Florida Medicaid Home Health Services Program. It also describes the requirements to receive services, service limitations, and exclusions.

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Requirements to Receive Services

Introduction

Medicaid reimburses home health services provided to an eligible Medicaid recipient when it is medically necessary to provide those services in his place of residence or other authorized setting.

Medicaid does not reimburse for home health services when the service duplicates another provider's service under the Medicaid program or other state or local program or if a comparable home and community-based service is provided to the recipient at the same time on the same day.
Home health services are not considered emergency services.

Requirements to Receive Services, continued

Medically Necessary

Medicaid reimburses services that do not duplicate another provider's service and are medically necessary for the treatment of a specific documented medical disorder, disease, or impairment.

Chapter 59G-1.010 (166), Florida Administrative Code defines medically necessary as follows:

"Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:
1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT)

EPSDT is a federal requirement that the state Medicaid agency cover diagnostic services, treatment, and other measures described in 42 USC 1396d(a) for Medicaid recipients under 21 years of age if the service is medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination.

The fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior authorization through the Quality Improvement Organization (QIO).

Requirements to Receive Services, continued

Home Health Service Requirements

In order to be reimbursed, home health services must also be:

- Ordered by and remain under the direction of the attending physician (a doctor of podiatric medicine may only authorize plan of care services that are consistent with the functions he is authorized to perform under state law) licensed under Chapter 461, 458 or 459 F.S. or licensed in the state in which the attending physician practices. The ordering physician cannot be employed by or under contract with the home health services provider that is rendering services, unless specifically exempted under s. 409.905 (4)(c)(3), F.S.;
- Consistent with the individualized, written and approved plan of care;
- Provided by qualified staff; and
- Consistent with accepted standards of medical and nursing practice.

Who Can Receive In-Home Services

Medicaid reimburses home health services for Medicaid recipients who are under the care of an attending physician.

The recipient must meet the following requirements:

- Require services that, due to a medical condition, illness or injury, must be delivered at the place of residence rather than an office, clinic or other outpatient facility because:
  - Leaving home is medically contraindicated and would increase the medical risk for exacerbation or deterioration of the condition; and
  - The recipient is unable to leave home without the assistance of another person;
- Require services that are medically necessary and reasonable for the treatment of the documented illness, injury or condition;
- Require services that can be safely, effectively and efficiently provided in the home; and
- Live in a residence other than a hospital, nursing facility or intermediate care facility for the developmentally disabled (ICF/DD). (See exceptions for ICF/DDs in 42 CFR 483, Subpart I.)

Medicaid does not reimburse home health services solely due to age, environment, convenience, or lack of transportation.

Requirements to Receive Services, continued

Physician Treatment Orders

A written physician's order from the treating or attending physician is required to initiate or continue home health services. The treating or attending physician must have provided a physical examination or medical consultation to the recipient within 30 days preceding the request for services and every 180 days thereafter.

At a minimum, the order must describe the:

- Recipient's acute or chronic medical condition or diagnosis that causes a recipient to need home health care;
- Documentation regarding the medical necessity for the service(s) to be provided at home;
- Home health services needed;
- Frequency and duration of the needed services; and
- Minimum skill level (nurse, home health aide) of staff who can provide the services.

Physician orders to initiate or continue home health services must be signed and dated by the attending physician prior to the development of each plan of care and before submitting a request for prior authorization. The ordering physician's National Provider Identifier (NPI), Medicaid Provider Number, or medical license number must be written on the order.

Medicaid will reimburse home health services ordered by an ARNP or physician assistant only if the order has been countersigned by the attending physician.

Dually-eligible Medicare and Medicaid Recipients

Medicaid cannot reimburse a home health agency for services that can be reimbursed by Medicare when a recipient is eligible for both Medicare and Medicaid services.

The home health agency is responsible for retaining documentation in the recipient's record that the service is not Medicare reimbursable.

Note: See Chapter 4 in the Florida Medicaid Provider General Handbook for information on Medicare crossover claims.

Requirements to Receive Services, continued

MediPass Recipients

When a MediPass recipient is referred for home health (RN, LPN, home health aide) services, the home health agency must obtain authorization (MediPass referral number) from the MediPass primary care provider. This does not eliminate the need to receive prior authorization through the Quality Improvement Organization (QIO).

The MediPass authorization number must be entered on the claim when billing the service.

Note: See Chapter 1 in the Florida Medicaid Provider Reimbursement Handbook, CMS 1500, for instructions on entering the MediPass authorization number on the claim.

Children's Medical Services (CMS) Network Recipients

When a CMS Network recipient is referred for home health (RN, LPN, home health aide) services, the home health agency must obtain authorization (CMS referral number) from the CMS Network primary care provider (PCP). This does not eliminate the need to receive prior authorization through the QIO.

The CMS Network PCP authorization number must be entered on the claim when billing the service.

Provider Service Network Recipients

Home health visit services provided to a recipient enrolled in a Provider Service Network (PSN) are authorized and claims are processed through the PSN only. Home health agencies may contact the PSN's Provider Relations Unit for assistance as needed.

Home health claims for a PSN recipient that are submitted directly to the Medicaid fiscal agent will be denied.

Medicaid Health Maintenance Organization (HMO) Recipients

Home health visit services provided to a recipient enrolled in a Medicaid HMO are authorized and reimbursed through the HMO only.

Home health claims for a HMO recipient submitted directly to the Medicaid fiscal agent will be denied.

Plan of Care Requirements

Description

A plan of care (POC) is an individualized written program for a recipient that is developed by health care providers including the attending physician. The POC is designed to meet the medical, health and rehabilitative needs of the recipient. The POC must identify the medical need for home health care, appropriate interventions, and expected health outcomes.

The home health services provider must provide a copy of the initial and subsequent plans of care to the attending physician for the medical record.

Required Plan of Care Document

Licensed home health agencies are required to use the Centers for Medicare and Medicaid Services (CMS) Form-485, (C-3)(02-94) Home Health Certification and Plan of Care, for the plan of care.

Note: See Appendix B for a copy of the CMS-485 and instructions. The form is incorporated by reference in 59G-4.130, F.A.C. It is available by photocopying the form in Appendix B.

Independent personal care providers (including unlicensed agencies enrolled in the home health program to provide personal care services) are required to use the Personal Care Services Plan of Care form.

Note: See Appendix J for a copy of the Personal Care Services Plan of Care form, AHCA-Med Serv Form 5000- 3506, December 2011.

AHCA-Med Serv Form 5000-3506, December 2011 is available by photocopying it from Appendix J. It is incorporated by reference in 59G-4.130, F.A.C.

Plan of Care Components

The POC must include:

- Diagnosis(es), mental status, prognosis, rehabilitation potential, functional limitations, permitted activities, nutritional requirements, medications and treatments.
- Physician orders.
- An explanation of the medical necessity of home health services.
- Nursing services, home health aide services, or therapy to be provided.
- Medical supplies, appliances, or durable medical equipment to be provided.
- Start date, end date, and frequency of in-home services, including the level of staff necessary to perform the services required.
- Safety measures to protect against injury.
- Discharge plan.
- Approval by the attending physician as evidenced by his signature.
- Expected health outcomes.

The physician may approve a POC by faxing a signed copy to the provider; however, the physician must retain the plan with the original signature in the recipient's medical record.

Plan of Care Requirements, continued

Plan of Care Certification Period

The "FROM" and "TO" dates identify the period covered by the POC.

- The FROM date is the first day of the POC.
- The TO date is the last day of the POC.
- The TO date can include up to, but never exceed, 60 days. Personal care services may be approved for up to 180 days if provided by an independent personal care services provider.
- On subsequent recertifications, the next sequential FROM date will be the day after the TO date on the previous POC.

Example of Valid Dates for Plan of Care Certification Period

A physician's order specifies skilled nursing care twice per day from July 1, 2007 to August 29, 2007. The initial POC covers the period July 1, 2007 ("From" date) through August 29, 2007 ("To" date).

- The POC begins on July 1, 2007 and is effective through August 29, 2007;
- A new POC is necessary to continue skilled nursing care on August 30, 2007; and
- August 30, 2007 is day one and the "From" date on the subsequent POC.

General Plan of Care Review Requirements

All plans of care must contain current information concerning the recipient. Photocopies of previous plans of care are not acceptable and will result in denials of prior authorization requests.

Subsequent plans of care must include an assessment of all changes in the recipient's medical conditions including activities of daily living (ADL) since the previous certification period. All applicable POC components must be included in each subsequent POC.

Note: See Prior Authorization in this chapter for the submission requirements for the prior authorization processes.

Note: See Medical Record Requirements under Required Documentation in this chapter for additional information.

Plan of Care Requirements, continued

Additional Plan of Care Review Requirements for Licensed Home Health Agencies

For licensed home health agencies, the attending physician must review the POC at least every 60 days. The attending physician is required to indicate his approval by signing each POC. The attending physician must countersign an ARNP or physician assistant signature on a POC.

The POC must be reviewed and signed by the attending physician before submitting the prior authorization request. Payments of home health claims submitted without proper authorization or prior to the physician signing the POC are subject to recoupment.

Each POC must include as a separate document the physician order for home health services. A new physician's order must be obtained before the creation of each POC.

Additional Plan of Care Review Requirements for Independent Personal Care Providers

For personal care services, the physician must review the POC at least every 180 days. The attending physician is required to indicate approval by signing each POC.

The POC must be reviewed and signed by the attending physician before submitting the prior authorization request. Payments of home health claims submitted without proper authorization or prior to the physician signing the POC are subject to recoupment. A new physician's order must be obtained before the creation of each POC.

Recipient's Copy of the Plan of Care

The home health services provider must provide a copy of the initial and subsequent plans of care to the recipient or legal guardian if requested.

Patient Condition Summaries

Home health agencies must provide the attending physician a summary of the recipient's condition at least every 60 days. This summary must include all necessary information to support the justification for:

- Continuation of the home health services; or
- Termination of the home health services.

Plan of Care Requirements, continued

Compliance Review

The Agency for Health Care Administration (AHCA) or its designee will periodically conduct on-site or desk reviews of home health services providers for the purpose of determining compliance with Medicaid requirements.

During such reviews, AHCA or its designee will request from the provider copies of certain records.

At the time of the request, all records must be provided to the AHCA or its designee regardless of the media format on which the original records are retained by the provider. All medical records must be reproduced onto paper copies, at the provider's expense.

Services

Medicaid does not reimburse open-ended orders. (Examples: Skilled nursing visits 1 x month and PRN x 2 months for Foley catheter change, or private duty nursing up to 24 hours a day up to 7 days a week.)

Medicaid may reimburse orders that reflect a limited range of visits or minimum and maximum number of hours to be provided. In order to be reimbursed the order must include the following:

- Description of the recipient's medical signs and symptoms that require services;
- Specific limit on the number of those visits to be made under that order; and
- Minimum and maximum number of hours per day.

(Examples: Skilled nursing visits 1 x month for 2 months for Foley catheter change and PRN x 2 visits for Foley catheter obstruction or 4 hours a day, 2 days a week.)

If more services are needed, an additional physician order must be obtained and an addendum reflecting the service(s) must be added to the current POC.

Covered, Limited and Excluded Services

Covered Services For Adults

Medicaid reimburses the following services provided to eligible recipients age 21 years or older:

- Licensed nurse and home health aide visits;
- Limited durable medical equipment and supplies; and
- Limited therapy evaluations.

Covered Services For Children

Medicaid reimburses for the following services provided to eligible recipients under age 21 years:

- Licensed nurse and home health aide visits;
- Private duty nursing;
- Personal care;
- Occupational, physical and speech-language pathology evaluations and treatments; and
- Durable medical equipment and supplies.

Covered, Limited and Excluded Services, continued

Exclusions

Listed below are examples of services that are not reimbursable under the Medicaid home health services program:

- Audiology services;
- Housekeeping, homemaker, and chore services, including shopping;
- Meals-on-wheels;
- Mental health and psychiatric services (these services are covered under the Medicaid Community Behavioral Health Program);
- Normal newborn and postpartum services, except in the event of complications;
- Respite care;
- Services which can be effectively and efficiently obtained outside the recipient's place of residence without any medical contraindications;
- Baby-sittin;
- Services to a recipient residing in a community residential facility when those services duplicate services the facility or institution is required to provide;
- Social services;
- Transportation services (except when necessary to protect the health and safety of the recipient and no other transportation service is available).
- Escort services;
- Care, grooming, or feeding of pets and animals;
- Yard work, gardening, or home maintenance work;
- Day care or after school care;
- Assistance with homework;
- Companion sitting or leisure activities;
- Home health visits, private duty nursing, or personal care services furnished by parents, grandparents, stepparents, spouses, siblings, sons, daughters, relatives, household members, or any person with custodial or legal responsibility for a Medicaid recipient. Exceptions to this exclusion are for:
  1. Parents or legal guardians authorized by the Agency for Health Care Administration to provide private duty nursing services to their children. See Private Duty Nursing Services in this chapter and Appendix C for a copy of the authorization form.
  2. Children enrolled in the Developmental Disabilities Home and Community Based Services Medicaid waivers under the 1915j State plan amendment authorizing self-directed care, may receive personal care services provided by the relatives listed above who are also enrolled as state plan providers.
- Respiratory therapy. (See the Florida Medicaid Therapy Services Coverage and Limitations Handbook for respiratory therapy provider enrollment requirements.)

Covered, Limited and Excluded Services, continued

Exclusions, continued

- Nursing assessments related to the plan of care;
- Attending physicians for certifying the home health plan of care. (See the Florida Medicaid Physician Services Coverage and Limitations Handbook for information on reimbursement of evaluation and management services.); and
- Services to a recipient enrolled in hospice when the services are related to the treatment of the terminal illness or associated condition.

Note: The Florida Medicaid provider handbooks are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Out-of-State Services

Medicaid reimburses out-of-state home health services that are prior authorized.

Whenever a Florida Medicaid recipient receives an out-of-state prior authorized Medicaid service, that recipient may be eligible to receive medically-necessary home health services out-of-state.

The following requirements must be met in order for a recipient to qualify for out-of-state home health services:

- The recipient must meet all in-state home health program requirements;
- Out-of-state home health services must be prior authorized by the Florida Medicaid Transplant Coordinator or Medicaid out-of-state services coordinator;
- The home health agency must be a Medicaid or Medicare provider in the relevant state; and
- The home health agency must enroll as a Florida Medicaid provider.

Out-of-state home health services must be coordinated through the authorized hospital, which must provide an anticipated plan of outpatient care that is signed and dated by the recipient's attending physician.

Covered, Limited and Excluded Services, continued

Infusion Therapy Services

An infusion therapy service includes set-up, infusion, and take down time. It also includes recipient assessment time at the beginning and end of the procedure.

For adults, each single episode of infusion therapy service is reimbursed as a skilled nursing visit regardless of the length of time required for the infusion service.

For children (birth through 20 years of age), an infusion therapy service is reimbursed as:

- A skilled nursing visit if the length of time required for the service is less than two hours; or
- A private duty nursing service if the length of time required for the service is two hours or more.

Drugs for infusion therapy services and formulae or solutions for nutrition-infusion services are reimbursed through the Medicaid Durable Medical Equipment and Medical Supply Services Program and the Medicaid Prescribed Drug Program.

Assisted Living Facility (ALF) Services

Medicaid does not reimburse services that duplicate those an ALF provides to a resident in its contract and service plan with the resident.

Home health agencies are responsible to determine that the provided home health service is not included in the ALF resident contract and service plan.

Medicaid does not reimburse home health visit services provided to recipients living in an ALF when the following apply:

- The nurse or home health aide providing the service is an employee, directly or by contract, of both the home health agency billing for the service and the ALF; and
- The nurse or home health aide performs the home health visit service during a time period when he is also being paid or reimbursed for his services by the ALF.

Licensed Nurse and Home Health Aide Services

Home Health Visit Limitations

Home health visits are limited to a maximum of four intermittent visits per day. The visits may be any combination of licensed nurse and home health aide visits.

The minimum length of time between home health visits provided to a recipient on the same day must be at least one hour.

Prior Authorization of Services

All home health services must be prior authorized by the Medicaid Quality Improvement Organization prior to the delivery of services. Home health services are authorized by the Medicaid Quality Improvement Organization (QIO) if the services are determined to be medically necessary.

Note: See Prior Authorization in this chapter for additional information.

Place of Service Exclusions

Medicaid does not reimburse for home health services provided in the following locations:

- Hospitals;
- Nursing facilities;
- Intermediate care facilities for the developmentally disabled (ICF/DD). (See exceptions for ICF/DDs in 42 CFR 483, Subpart I);
- Day care centers for children or adults; and
- Prescribed pediatric extended care centers (PPEC).

Exceptions to Place of Service Exclusions

Short-term nursing services provided by a RN or LPN are allowed in an ICF/DD when the services are medically necessary to avoid transfer of the recipient to a nursing facility.

Short-term nursing means services provided for a time span limited by the nursing needs surrounding a specific acute medical event. Example: Orthopedic surgical procedure requiring more nursing intervention than is available in the ICF/DD during the initial recuperation period.

Licensed Nurse and Home Health Aide Services, continued

Home Health Nurse Visit Requirements

Home health nurse visit services must be:

- Provided through home health visits;
- Medically necessary;
- Furnished by a registered nurse (RN) or a licensed practical nurse (LPN); and
- Ordered by the attending physician and specified in the physician approved plan of care.

Supervisory Requirement

RNs must supervise home health services provided by a LPN or a home health aide in accordance with the standards defined in 42 CFR 484.36(d)2 and Rule 59A-8.008, F.A.C. If the recipient requires only nursing; or nursing and physical, respiratory, occupational or speech therapy services; or nursing and dietetic and nutrition services, case management shall be provided by a licensed RN directly employed by the agency. If the recipient is receiving only physical, speech, respiratory or occupational therapy services or is receiving only one or more of these therapy services and home health aide services, case management shall be provided by the licensed therapist, who is a direct employee of the home health agency or a contractor.

The supervising RN must:

- Assign tasks to LPNs and home health aides;
- Ensure that a medical record is maintained for each recipient;
- Ensure that nursing progress notes are made in the recipient's medical record for each in-home visit; and
- Ensure that all medical records are available when required for review by Medicaid or agency designee.

Medicaid does not reimburse for required RN supervision duties or visits.

Skilled Nursing Services

The following are examples of nursing services reimbursable by Medicaid:

- Administration of intravenous medication;
- Administration of intramuscular injections, hypodermoclysis, and subcutaneous injections only when not able to be self administered appropriately.
- Insertion, replacement and sterile irrigation of catheters;
- Colostomy and ileostomy care;, excluding care performed by recipients;
- Treatment of decubitus ulcers when:
  - deep or wide without necrotic center;
  - deep or wide with layers of necrotic tissue; or
  - infected and draining;

Licensed Nurse and Home Health Aide Services, continued

Skilled Nursing Services, continued

- Treatment of widespread infected or draining skin disorders;
- Administration of prescribed heat treatment that requires observation by licensed nursing personnel to adequately evaluate the individual's progress;
- Restorative nursing procedures, including related teaching and adaptive aspects of nursing, which are a part of active treatment and require the presence of licensed nurses at the time of performance;
- Nasopharyngeal, tracheotomy aspiration, ventilator care;
- Levin tube and gastrostomy feedings, excluding feedings performed by the recipient, family or caregiver; and
- Complex wound care requiring packing, irrigation, and application of an agent prescribed by the physician.

Medicaid does not reimburse skilled nursing services solely for the purposes of monitoring medication compliance or assisting with self-administered medication.

Home Health Aide Service Requirements

Home health aide services may be reimbursed only when they are:

- Ordered by the attending physician;
- Documented as medically necessary;
- Provided by an appropriately trained aide;
- Consistent with the physician approved plan of care; and
- Delegated in writing and provided under the supervision of a registered nurse.

Home Health Aide Services

Home health aide services help maintain a recipient's health or facilitate treatment of the recipient's illness or injury. The following are examples of home health aide services reimbursed by Medicaid:

- Assisting with the change of a colostomy bag;
- Assisting with transfer ;
- Reinforcing a dressing;
- Assisting the individual with prescribed range of motion exercises that have been taught by the RN;
- Measuring and preparing prescribed special diets;
- Providing oral hygiene;
- Bathing and skin care; and
- Assisting with self-administered medication.

Home health aides must not perform any services that require the direct care skills of a licensed nurse.

Licensed Nurse and Home Health Aide Services, continued

Types of Home Health Aide Visits

Medicaid reimburses two types of home health aide visits:

- Medicaid reimburses a home health aide visit that is associated with a skilled nursing service. The physician's order and plan of care must identify the recipient's need for both home health aide services and skilled nursing services in the home. The skilled nursing service must be provided in addition to the supervisory nursing service. This type of home health aide visit may be reimbursable by Medicare; and if so, the service must be billed to Medicare first for a dually-eligible Medicare and Medicaid recipient.
- Medicaid reimburses a home health aide visit that is unassociated with a skilled nursing service. The physician's order and plan of care must identify the recipient's need for home health aide services only. This type of home health aide visit is not reimbursable by Medicare. Providers should bill this service for a dually-eligible Medicare and Medicaid recipient directly to Medicaid, unless the recipient has other third party insurance.

Both types of visits must meet all the home health aide requirements including being provided under the supervision of a registered nurse.

Different procedure codes are used for these two types of visits, and a modifier must be added to the procedure code when billing for a dually-eligible Medicare and Medicaid recipient.

Note: See Chapter 3, for information on modifiers and Appendix A for information on procedure codes and modifiers.

Private Duty Nursing Services (For recipients under age 21 years old)

Private Duty Nursing Definition

Private duty nursing services are medically-necessary skilled nursing services that may be provided to recipients under age 21 years old in their home or other authorized settings to support the care required by their complex medical condition.

Who Can Receive Private Duty Nursing

Medicaid reimburses private duty nursing services for recipients under the age of 21 who:

- Have complex medical problems;
- Require more extensive and continual care than can be provided through a home health nurse visit; and
- Are unable to attend a Pediatric Prescribed Extended Care (PPEC) Center as outlined in the PPEC Services section in this chapter.

Note: See the Glossary in the Florida Medicaid Provider General Handbook for the definition of medically complex.

Private Duty Nursing Services, continued

Private Duty Nursing Requirements

Private duty nursing services must be:

- Ordered by the attending physician;
- Documented as medically necessary;
- Provided by a registered nurse or a licensed practical nurse;
- Consistent with the physician approved plan of care; and
- Prior authorized before services are provided.

Parental Responsibility

Private duty nursing services are authorized to supplement care provided by parents and caregivers. Parents and caregivers must participate in providing care to the fullest extent possible. Training must be offered to parents and caregivers by the home health services provider to enable them to provide care that they can safely render without jeopardizing the health or safety of the recipient. The home health services provider must document the methods used to train a parent or caregiver in the medical record.

Medicaid may reimburse private duty nursing services rendered to a recipient whose parent or caregiver is **not** available or able to care for him. Supporting documentation must accompany the prior authorization request in order to substantiate a parent or caregiver's inability to participate in the care of the recipient (i.e., work or school schedules and medical documentation*). If a parent or caregiver is unable to provide a work schedule, a statement attesting to the work schedule must be presented to the QIO when requesting authorization.

Medicaid does not reimburse private duty nursing services provided primarily for the convenience of the child, the parents, or the caregiver.

Medicaid does not reimburse private duty nursing for respite care. Examples are parent or caregiver recreation, socialization, and volunteer activities, or periodic relief to attend to personal matters unrelated to the medically necessary care of the recipient.

Note: See Appendix F, G, H, and I for copies of the Parent or Legal guardian medical limitations, work, and school schedule forms, AHCA-Med Serv Forms 5000: 3501, October 2010; 3503, December 2011; 3504, December 2011; and 3505, December 2011. The forms are available by photocopying them from Appendix F, G, H, and I. They are incorporated by reference in 59G-4.130, F.A.C.

Private Duty Nursing Services, continued

Private Duty Nursing Provided by a Parent or Legal Guardian

Medicaid will reimburse a home health agency for the provision of private duty nursing services to an eligible child by a parent or legal guardian who has a valid license as a RN or LPN in the State of Florida and is employed by a Medicaid enrolled home health agency.

The home health agency is required to submit an Authorization for Private Duty Nursing Provider by a Parent or Legal Guardian, AHCA-Med Serv Form 046, July 2008, for approval when private duty nursing services are provided by a parent or legal guardian. Payments of home health claims for private duty nursing services provided by a parent or legal guardian without prior approval by Medicaid are subject to recoupment.

When private duty nursing services are provided by a parent or legal guardian employed by a home health agency, the home health agency's initial assessment and all subsequent POC recertification assessments must be completed by an RN that is not a household member.

Medicaid will only reimburse a home health agency up to 40 hours per week of private duty nursing services provided by a parent or legal guardian. Parents and legal guardians must participate in providing care to the fullest extent possible and are expected to continue to provide non-reimbursed care as the primary caregiver.

Medicaid will not approve additional private duty nursing hours for the child so that the child's parent or legal guardian who is providing private duty nursing for the child can also work outside the home or for respite. The parent or legal guardian is not eligible to participate in this program if he is unable to provide the required skilled nursing care because of a medical condition or disability.

Medicaid may authorize additional hours for the parent or legal guardian to sleep if the child's medical condition requires an awake caregiver to provide continuous or frequent intervention or medically-necessary observation during the night. See Appendix D, Guideline for Evaluating Family Support and Care Supplements, December 2011.

Any other authorized private duty nursing hours must be provided by a non-relative RN or LPN employed by the home health agency.

Note: See Appendix C for a copy of the Authorization for Private Duty Nursing Provider by a Parent or Legal Guardian, AHCA-Med Serv Form 046, July 2008. The form is available by photocopying it from Appendix C. It is incorporated by reference in 59G-4.130, F.A.C.

Private Duty Nursing Services, continued

PPEC Services

A recipient who is medically able to attend a prescribed pediatric extended care (PPEC) center and whose needs can be met by the PPEC shall be provided with PPEC services instead of private duty nursing services. PPEC services must be approved by Medicaid or the Medicaid QIO.

Medicaid may reimburse private duty nursing services for a period of 30 calendar days in order for PPEC services to become established.

If additional time is needed, the provider, recipient, or physician can request a reconsideration. Information or documentation must be submitted to justify the additional time.

The QIO will evaluate whether the child's needs can be met by a PPEC center in consultation with the child's physician and parent or legal guardian. After the review for PPEC services, private duty nursing may be provided as a wraparound alternative for an individual needing additional services when PPEC is not available.

Note: The Florida Medicaid Pediatric Prescribed Extended Care Services Coverage and Limitations Handbook is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. The handbook is incorporated by reference in 59G-4.260, F.A.C.

Limitations

Private duty nursing services are limited to a minimum of two continuous hours per day.

Private duty nursing service of less than two hours per day is considered a visit and must be billed as a home health nurse visit.

Note: Please see Licensed Nurse and Home Health Aide Services in this chapter for information on home health visits.

Private Duty Nursing Services, continued

Flex Hours or Banking of Hours

Medicaid does not allow "banking of hours" or "flex hours". Only the number of hours that are medically necessary may be approved. Home health service providers must request only the number hours that are expected to be used and must indicate the times of day and days per week that the hours are needed. If a recipient requires additional hours due to unforeseen circumstances or change in medical or social circumstances, the home health service providers should submit a modification request to the QIO for the additional hours needed.

Prior Authorization Process

Private duty nursing services will be prior authorized by the Medicaid QIO if the services are determined to be medically necessary. The request for the authorization must be submitted prior to the delivery of services.

Initial requests for private duty nursing will be authorized for up to 60 days to allow for reassessment of the recipient's condition.

Private duty nursing services will be decreased over time as parents and caregivers are taught skills to care for their child and are capable of safely providing that care or as the child's condition improves.

Note: See Prior Authorization in this chapter for additional information.

Medical Foster Care

Medical foster care providers are responsible for the overall care of the children assigned to them. The use of private duty nursing services in the medical foster care home is intended to meet medical needs of the child that cannot be met by the medical foster care provider.

See the section on Alternative Caregivers in Chapter 2 of the Florida Medicaid Medical Foster Care Services Coverage and Limitations Handbook for more information and the circumstances in which private duty nursing may be reimbursed for children in medical foster care.

Note: The Florida Medicaid Medical Foster Care Services Coverage and Limitations Handbook is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Private Duty Nursing Services, continued

Place of Service Requirement

Private duty nursing services must be provided according to an individualized plan of care in the eligible Medicaid recipient's place of residence or, under authorized situations, outside the place of residence.

Place of Service Exclusions

Medicaid does not reimburse for private duty nursing services provided in the following locations:

- Hospital;
- Nursing facility;
- Intermediate care facility for the developmentally disabled (ICF/DD);
- Physician's office;
- Clinic; or
- PPEC.

Services Outside Place of Residence

Medicaid only reimburses for private duty nursing services outside the place of residence if:

- The services are unavailable through other public or private resources, including schools (documentation will be required); and
- The services are medically necessary while the child is outside the home.

School Services

Private duty nursing may be considered for the medically-complex child at school if:

- The Agency for Health Care Administration (AHCA) or the child's primary care physician considers going to school a viable option given the child's medical status; and
- The school system is not currently providing the intensity of nursing care required by the child, and private duty nursing services would enable the child to attend school (documentation will be required).

Private Duty Nursing Services, continued

Training Exclusions

Medicaid will not reimburse for professional development training for home health private duty nursing staff or other home health personnel.

Services Overlap Days

When services begin one day and end the next day, billing should reflect the total number of care hours provided on each day.
Example:

- Services begin at 11 p.m. on January 31 and continue to 7 a.m. on February 1.
- Services begin again at 11 p.m. on February 1 and continue to 7 a.m. on February 2.

Billing would be as follows:

- January 31 = 1 hour (11 p.m. to midnight);
- February 1 = 8 hours (midnight to 7 a.m. and 11 p.m. to midnight);
- February 2 = 7 hours (midnight to 7 a.m.).

Personal Care Services (For recipients under age 21 years old)

Personal Care Services Definition

Personal care services provide medically necessary assistance with activities of daily living (ADL) and age appropriate instrumental activities of daily living (IADL) that enable the recipient to accomplish tasks that they would normally be able to do for themselves if they did not have a medical condition or disability.

In accordance with federal law, AHCA will pay for such other necessary health care, diagnostic services, treatment and other measures described in Section 1905(a) (42 USC 1396d(a)) of the Social Security Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.

Who Can Receive Personal Care Services

Medicaid reimburses personal care services for recipients under the age of 21 who:

- Have a medical condition or disability that substantially limits their ability to perform their ADLs or IADLs; and
- Require more individual and continuous care than can be provided through a home health aide visit.

Personal Care Services, continued

Personal Care Services Requirements

Personal care services must be:

- Documented as medically necessary;
- Prescribed by the attending physician if provided through a home health agency;
- Supervised by a registered nurse if provided through a home health agency;
- Supervised by the parent or legal guardian if provided by a non-home health agency;
- Supervised by the recipient if the services are provided by a non-home health agency and the recipient is a legal adult between the ages of 18 and 21 years of age with no legal guardian;
- Provided by a home health aide or independent personal care provider;
- Consistent with the physician, support coordinator, or case manager approved plan of care; and
- Authorized prior to providing services.

Parental Responsibility

Personal care services are authorized to supplement care provided by parents, and caregivers. Parents and caregivers must participate in providing care to the fullest extent possible. Training must be offered by the home health service provider to parents and caregivers to enable them to provide care they can safely render without jeopardizing the health or safety of the recipient. The home health services provider must document the methods used to train a parent or caregiver in the medical record.

Medicaid can reimburse personal care services rendered to a recipient whose parent or caregiver is not able to care for him. Supporting documentation must accompany the prior authorization request in order to substantiate a parent or caregiver's inability to participate in the care of the recipient*.

Note: See Appendix F, G, H, and I for copies of the Parent or Legal guardian medical limitations, work, and school schedule forms, AHCA-Med Serv Forms 5000: 3501, October 2010; 3503, December 2011; 3504, December 2011; and 3505, December 2011. The forms are available by photocopying them from Appendix F, G, H, and I. They are incorporated by reference in 59G-4.130, F.A.C.

Personal Care Services, continued

Prior Authorization

Personal Care services will be prior authorized by the Medicaid QIO if the services are determined to be medically necessary. The request for the authorization must be submitted prior to the delivery of services.

Initial requests for personal care services will be authorized for up to 60 days to allow for reassessment of the recipient's condition.

Personal care services will be decreased over time as parents and caregivers are taught skills to care for their child and become capable of safely providing the care or if the child's condition improves.

Note: See Prior Authorization in this chapter for additional information on prior authorization.

Flex Hours or Banking of Hours

Medicaid does not allow "banking of hours" or "flex hours". Only the number of hours that are determined medically necessary by the QIO may be approved. Home health service providers must request only the number hours that are expected to be used and must indicate the times of day and days per week that the hours are needed. If a recipient requires additional hours due to unforeseen circumstances or change in medical or social circumstances, the home health service provider should submit a modification request to the QIO for the additional hours needed.

Place of Service Requirement

Personal care services must be provided according to an individualized plan of care in the eligible Medicaid recipient's place of residence or, under authorized situations, outside the place of residence.

Place of Service Exclusions

Medicaid does not reimburse for personal care services provided in the following locations:

- Hospitals;
- Nursing facilities;
- Intermediate care facilities for the developmentally disabled (ICF/DD);
- Physician's offices;
- Clinics; and
- Prescribed pediatric extended care centers.

Services Outside Place of Residence

Medicaid reimburses for personal care services outside the place of residence only if:

- The services are unavailable through other public or private resources, including schools (documentation will be required); and
- The services are medically necessary while the child is outside the home.

Personal Care Services, continued

Reimbursable Personal Care Services

Medicaid reimburses for the following personal care services when they are medically necessary.

ADLS include:
- Eating (oral feedings and fluid intake);
- Bathing;
- Dressing;
- Toileting;
- Transferring; and
- Maintaining continence (examples include taking care of a catheter or colostomy bag or changing a disposable incontinence product when the recipient is unable to control his bowel or bladder functions).

IADLs (when necessary for the recipient to function independently) include:
- Personal hygiene;
- Light housework;
- Laundry;
- Meal preparation;
- Transportation;
- Grocery shopping;
- Using the telephone to take care of essential tasks (examples include paying bills and setting up medical appointments);
- Medication management; and
- Money management.

Medically necessary personal care services may be authorized when a recipient has a documented cognitive impairment which prevents him from knowing when or how to carry out the personal care task. Assistance may be in the form of hands on assistance (actually performing the task for the person) or cuing, along with supervision to ensure the recipient performs the personal care task properly. Additional supporting documentation may be required to substantiate the functional limitations associated with the cognitive impairment.

Note: See Prior Authorization in this chapter for additional information.

Durable Medical Equipment and Therapy Services

Medical Supplies and Equipment

Medicaid reimburses home health agencies, under their Medicaid home health provider number, for medical supplies and durable medical equipment (DME) furnished by qualified providers in accordance with the physician approved plan of care.

Home health agencies that provide DME must comply with the policies and procedures contained in this handbook and in the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook.

Medicaid reimburses home health agencies for DME services provided only at the recipient's place of residence.

Note: See the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook for additional information on program coverage and limitations and corresponding procedure codes. The handbook is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. It is incorporated by reference in 59G-4.070, F.A.C.

Note: See Chapter 1 in the Florida Medicaid Provider General Handbook for information on billing the recipient for supplies and equipment not covered by Medicaid.

Occupational, Physical and Speech Therapy Services

Medicaid reimburses home health agencies, under their Medicaid home health provider number, for occupational, physical and speech therapy services furnished by qualified therapy providers in accordance with a physician approved plan of care. Medicaid reimburses home health agencies only for therapies prescribed by a physician.

Home health agencies that provide these therapy services must comply with the policies and procedures contained in this handbook and in the Florida Medicaid Therapy Services Coverage and Limitations Handbook.

Medicaid reimburses home health agencies for these therapy services provided only at the recipient's place of residence.

Medicaid reimburses for medically necessary therapy services that are provided to Medicaid recipients under the age of 21.

Note: See the Florida Medicaid Therapy Services Coverage and Limitations Handbook for additional information on program coverage and limitations and corresponding procedure codes. The handbook is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. It is incorporated by reference in 59G-4.320, F.A.C.

Required Documentation

Nursing Interventions and Outcomes

Each clinical record must contain documentation of appropriate nursing interventions and expected health outcomes.

Required Reports and Records

The home health services providers must maintain reports and medical records that accurately document the services provided to the recipient.

The medical record must indicate that services were provided in accordance with physician orders and the approved and current plan of care. All care provided to the recipient must be documented in the medical record and signed and dated by the individual who furnishes the care. These records will be used to evaluate any changes made to the plan of care.

Medical Record Release

Upon request by AHCA or its designee, the home health services provider must furnish all medical and Medicaid related records requested and determined to be relevant to the services or goods billed to the Medicaid program.

Required Documentation, continued

Medical Record Requirements

The home health agency must maintain the following documentation in the recipient's current medical record:

- Nursing notes of the initial assessment visit and subsequent visits by RNs;
- Most current plan of care;
- Most current physician's orders (signature and date are required);
- Progress notes;
- Tasks and duties assigned to LPNs and home health aides;
- Dates and signatures of individuals who render care;
- Legal documents;
- Consent forms; and
- Recipient and caregiver verification of services received.

The independent personal care provider must maintain a copy of the plan of care in the recipient's current medical record. Written documentation must be maintained in the recipient's medical record to support the provision of personal care services for which Medicaid reimbursement is requested. Service documentation must contain the following:

- Recipient's name;
- Recipient's Medicaid ID number;
- Date the service was rendered;
- Start and end times;
- Identification of the setting in which the service was rendered;
- Identification of the service rendered, including the specific activities or tasks performed;
- Identification of the supplies or equipment used;
- Updates regarding the recipient's progress, if any, towards meeting the goals of the plan of care;
- Provider's name and provider Medicaid ID number;
- Name of the person rendering the service along with his signature; and
- Recipient and caregiver verification of services received.

Note: See Chapter 2 in the Florida Medicaid Provider General Handbook for additional record keeping requirements.

Prior Authorization for Home Health Services

Introduction

Prior authorization is the approval process required prior to providing certain services to recipients. Medicaid will not reimburse for these services without prior authorization when it is required. Home health service providers are required to adhere to the requirements outlined in this section in order to receive reimbursement for services. Failure to comply with the prior authorization requirements may result in suspending a provider's access to obtain new prior authorizations for Medicaid services until deficiencies are addressed.

Services Requiring Prior Authorization

The following home health services require prior authorization for reimbursement:

- Home health visits (skilled nursing and home health aide services);
- Private duty nursing; and
- Personal care.

General Requirements

The following general requirements apply to prior authorization for home health services for children and adults.

- The request must be submitted to the Medicaid QIO via its web-based Internet system;
- All required documentation to support the request must be submitted directly to the QIO at the time of the request;
- For initial service requests, it is recommended that the home health services provider submit the request to the QIO at least ten business days prior to the start of care;
- For subsequent authorization requests (continued stay requests), the home health services provider must submit the request to the QIO at least ten business days prior to the new certification period.; and
- The earliest effective date of the authorization is the date the request is received by the Medicaid QIO.

Prior Authorization for Home Health Services, continued

Requesting Prior Authorization

All requests for prior authorization must be submitted to the Medicaid QIO via its web-based Internet system.

At a minimum, each prior authorization request must include all of the following:

- Recipient's name, address, date of birth, and Medicaid ID number;
- Home health agency or independent personal care provider's Medicaid provider number, name and address;
- Procedure code(s), with modifier(s) if applicable, matching the services reflected in the plan of care;
- Units of service requested;
- Summary of the recipient's current health status, including diagnosis(es);
- Planned dates and times of service;
- Ordering provider's Medicaid provider number, National Provider Identifier, or Florida Medical License number, name, and address;
- The nursing assessment (for services provided by a licensed home health agency);
- A copy of the active plan of care signed by the attending physician;
- Patient condition summaries that substantiate medical necessity and the need for requested services, such as a hospital discharge summary (if services are being requested as a result of a hospitalization), physician or nurse progress notes, or history and physical;
- A copy of the documentation that demonstrates that the recipient has been examined or received medical consultation by the ordering or attending physician at least 30 days before initiating services and every 180 days thereafter. Note: See Appendix E for a copy of the Physician Visit Documentation Form, AHCA-Med Serv Form 5000-3502, October 2010. The form is available by photocopying it from Appendix E. It is incorporated by reference in 59G-4.130, F.A.C;
- A copy of the current physician's order. Note: See Appendix K for a copy of the Medicaid Physician's Written Prescription For Home Health Services Form. AHCA-Med Serv Form 5000-3525, December 2011. The form is available by photocopying it from Appendix K. It is incorporated by reference in 59G-4.130, F.A.C.
- For private duty nursing and personal care services, the following supportive documentation must be furnished regarding the caregiver's availability and ability to provide care, as applicable:
- Medical information validating limitations in providing care. Note: See Appendix F for a copy of the Parent or Legal Guardian Medical Limitations Form, AHCA-Med Serv Form 5000- 3501, October 2010. The form is available by photocopying it from Appendix F. It is incorporated by reference in 59G-4.130, F.A.C.;
- Work schedules. Note: See Appendix G and H for a copy of the Parent or Legal Guardian Work Schedule Forms, AHCA-Med Serv Forms 5000: 3503, December 2011 and 3504, December 2011. These forms are available by photocopying them from Appendix G and H. They are incorporated by reference in 59G-4.130, F.A.C.; and
- School schedules. Note: See Appendix I for a copy of the Parent or Legal Guardian School Schedule Form, AHCA-Med Serv Form 5000- 3505, December 2011.The form is available by photocopying it from Appendix I. It is incorporated by reference in 59G-4.130, F.A.C.

Prior Authorization for Home Health Services, continued

Requesting Prior Authorization

- The QIO may request a copy of the assessment developed by the Florida Department of Health, Children's Medical Services (CMS) when private duty nursing services are requested for children who are enrolled in the CMS Network.

Review Criteria

The QIO may use a national standardized set of criteria, or other set of criteria*, approved by the AHCA, as a guide to establish medical necessity for prior authorization of home health services at the first review nurse level.
If services cannot be approved by the first level nurse reviewer, the QIO's physician peer reviewer will determine medical necessity using his clinical judgment, acceptable standards of care, state and federal laws, and AHCA's medical necessity definition.

The QIO will utilize guidelines, approved by the AHCA (see Appendix D), for determining the level of parental responsibility in providing care for the recipient.

Note: See Appendix D for a copy of the Guidelines for Evaluating Family Support and Care Supplements, December 2011. The guideline is available by photocopying it from Appendix D. It is incorporated by reference in 59G-4.130, F.A.C.

Note: See Appendix L for a copy of the Review Criteria for Private Duty Nursing Services, December 2011. The criteria are available by photocopying them from Appendix L. They are incorporated by reference in 59G-4.130, F.A.C.

Note: See Appendix M for a copy of the Review Criteria for Personal Care Services, December 2011. The criteria are available by photocopying them from Appendix M. They are incorporated by reference in 59G-4.130, F.A.C.

Approval Process

The Medicaid QIO will review each prior authorization request and approve, deny or request additional information to support the request.

Prior authorization requests for home health services that appear to deviate from treatment norms, established standards of care, or utilization norms may be subject to a more intensified review by the QIO prior to rendering a determination. This may include a telephonic or face-to-face contact with the Medicaid recipient in his place of residence, interviews with the ordering physician, and a review of the recipient's medical record.

The Medicaid QIO will post the status of the request on its Internet system. Providers must check the Internet system for the status of submitted prior authorization requests.

Approved Request

When the request is approved, the approval will contain a prior authorization number for billing and reference.

An approved request is not a guarantee that Medicaid will reimburse the service. The provider and recipient must be eligible on the date of service, and the service must not have exceeded any applicable service limits.

Prior Authorization for Home Health Services, continued

Content and Limitations on Approved Requests

The approval of services is accessed via the Internet system and specifies:

- Procedure code;
- Units of service authorized;
- Dates of service;
- The discipline authorized to provide the service; and
- The number of days for which the authorization is valid.

Changes to Approved Requests (Modifications)

For any requested change, the provider must submit via the Internet, additional new information, not previously submitted, documenting the need for the additiona visits or hours.

When requesting additional visits or hours within a certification period, the provider should indicate that the request:

- Is for additional visits or hours or a change to an already requested certification period;
- For licensed home health agencies, includes the attending physician approved POC, new orders, and a reason for the adjustment; and
- For independent personal care service providers, includes the attending physician approved POC, and a reason for the adjustment.

Medicaid Quality Improvement Organization Decision Process

If a physician denial or modified approval is proposed, the Medicaid peer review organization informs the provider via the Internet. (In a modified approval, a portion of the requested visits or hours may be denied due to lack of medical necessity.)

The Medicaid QIO will post the notice of denial or modified approval on its Internet system.

If the physician determines that services are not medically necessary, the recipient and provider will be notified in writing that the services will be denied or reduced. The notification letter will include information regarding the recipient's appeal rights.

Reconsideration Review

If a denial determination is rendered, the provider, recipient, or physician may request reconsideration. If reconsideration is requested, additional information must be submitted to the QIO to facilitate the approval process.

A reconsideration review of the denial decision must be requested via the Medicaid QIO Internet system within five business days of the date of the final denial or modified approval determination.

Prior Authorization for Home Health Services, continued

Prior Authorization Number

When the request is approved, the approval will contain a prior authorization number for billing and reference. Only one prior authorization number will be issued per certification period
For Medicaid to reimburse the service:

The prior authorization number must be entered in field 23 on the claim form;
- The certification period, corresponding to the prior authorization number entered in field 23, must match the dates of service shown on the claim; and
- The Medicaid provider number and Medicaid recipient identification number on the claim form and the plan of care must match.

The Medicaid provider must not submit a claim prior to providing the services.

Termination of Services

A modification request must be submitted to the Medicaid QIO when a home health services provider terminates services. The modification request must include, at a minimum, the last date that services were provided to the recipient and the number of units used on the prior authorization number up until the point of discharge. The provider that terminates services does not bill for the date of discharge. Failure to comply with this discharge procedure requirement may result in suspending a provider's access to obtaining new prior authorizations for Medicaid services until deficiencies are addressed.

Submission of a Claim for Payment

Providers must submit a claim for payment for a prior authorized procedure after the service has been approved and provided.

In order to receive reimbursement for the service, the provider must enter the prior authorization number on the claim.

Note: For additional information on completing the claim see Chapter 1 in the Florida Medicaid Provider Reimbursement Handbook, CMS 1500.

Prior Authorization for Home Health Services, continued

Medically-Needy Eligibility

A Medically-Needy recipient is an individual who would qualify for Medicaid except that the individual's income or resources exceed Medicaid's income or resource limits.

On a month-by-month basis, the individual's medical expenses are subtracted from his income. If the remainder falls below Medicaid's income limits, the individual may qualify for Medicaid for the month or for part of the month, depending on the date the medical expenses were incurred.

Note: See Chapter 3 in the Florida Medicaid Provider General Handbook for additional information on Medically-Needy eligibility. See Chapter 2 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for billing information on Medically-Needy recipients.

Medically-Needy Prior Authorization

The Medicaid QIO cannot obtain a prior authorization number from the Medicaid fiscal agent for a Medically-Needy individual who is in a period of ineligibility. If the individual becomes eligible for the dates that the services were rendered, the provider must notify the QIO via the Internet that the recipient is a Medically-Needy individual and state the recipient's dates of eligibility for each month prior authorization is being requested.

CHAPTER 3
HOME HEALTH SERVICES
PROCEDURE CODES AND FEES

Overview

Introduction

This chapter provides and describes the procedure codes, fees and copayment requirements for recipients receiving home health services.

In This Chapter

This chapter contains:

TOPIC	PAGE
Reimbursement Information	3-1
Procedure Code Modifiers	3-5

Reimbursement Information

Who Can Be Reimbursed

Medicaid will only reimburse a home health agency for home health visit and private duty nursing services. Medicaid will reimburse a home health agency or an independent personal care services provider for personal care services. The nurse, home health aide, or independent personal care provider must be awake and actively providing care to the recipient during the hours billed to the Medicaid program.

Procedure Codes

The new procedure codes listed in this handbook are Level II Healthcare Common Procedure Coding System (HCPCS) codes. The codes are part of the national standard code set described in the HCPCS Level II Expert code book. Please refer to the HCPCS Level II Expert code book for complete descriptions of the standard codes. The HCPCS Level II Expert code book is copyright by Ingenix, Inc. All rights reserved. Level II codes are usually used to describe medical services and supplies. These codes begin with a single letter (A through V) followed by four numeric digits.

Diagnosis Code

When submitting claims for payment, providers must select the diagnosis codes that most accurately reflect the Medicaid recipient's medical need for nursing or home health aide services. To be reimbursable, a diagnosis code specific to the fourth or fifth digit as identified in the latest ICD-9-CM codes is required on each claim line.

The use of general or generic diagnosis codes such as "general debility" as the only primary diagnosis code is inappropriate and will result in further review by the Medicaid Quality Improvement Organization (QIO).

Reimbursement Information, continued

Reimbursement for Home Health Services

Medicaid reimbursement for home health services is the lesser of:

- The amount billed;
- The maximum fee listed on the Home Health Services Fee Schedule; or
- The provider's usual and customary charge.

Copayment

Medicaid recipients, unless exempt, are responsible to pay a copayment of $2.00 per home health provider, per day.

Note: See Chapter 1 in the Florida Medicaid Provider General Handbook for additional information about copayment requirements and categories of recipients who are exempt from copayment. The handbook is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Handbooks. It is incorporated by reference in 59G-5.020, F.A.C.

Visit Reimbursement

Medicaid reimburses per home health visit. The staffing resources needed to provide a service are included in the visit reimbursement.

Medicaid does not reimburse per individual staff person(s) providing a home health visit.

All claims for home health visits furnished by licensed home health agencies enrolled in Miami-Dade county must be generated through the Telephonic Home Health Services Delivery Monitoring and Verification Program in order to be reimbursed through the Medicaid program.

Home Health Visits for Multiple Recipients at One Location

Home health visit services provided to two or more recipients with individual residences at a single location are reimbursed as one visit for each individual receiving a home health service at that location (for example, visits at an assisted living facility). The provider should bill using the TT modifier on all cases, but should reduce their billing for each as indicated in policy for subsequent cases within the same residence.

Home health visit services provided to two or more recipients sharing a residence at a single location (for example, visits at a group home) are reimbursed as follows:

- For the first recipient, Medicaid reimburses the service at the established Medicaid visit rate;
- For the second recipient, Medicaid reimburses the service at 50 percent of the established Medicaid visit rate; and
- For any additional recipients, Medicaid reimburses the services at 50 percent of the established Medicaid visit rate.

Note: Please call your area Medicaid office for billing instructions. The area offices' telephone numbers are listed in Appendix A of the Florida Medicaid Provider General Handbook and on the AHCA Web site at www.ahca.myflorida.com.

Reimbursement Information, continued

Private Duty Nursing and Personal Care Services for Multiple Recipients at One Location

Private duty nursing (PDN) and personal care (PC) furnished by one nurse, home health aide or independent personal care provider to two or more recipients at a single place of residence is reimbursed as follows:

- For the first recipient, Medicaid reimburses the services at the established Medicaid rate;
- For the second recipient, Medicaid reimburses the services at 50 percent of the established Medicaid rate; and
- For additional recipients, Medicaid reimburses services at 25 percent of the established Medicaid rate.

A modifier must be added to the home health PDN or PC visit procedure code to identify a home health PDN or PC service provided to more than one recipient in the same setting. The provider should bill using the TT modifier on all cases, but should reduce their billing for each child as indicated in policy for subsequent cases within the same residence.

Note: Please refer to Procedure Code Modifiers in this chapter and Appendix A for the valid procedure codes and modifiers.

Multiple Home Health Service Providers

In situations that require services from more than one home health agency in order to provide all the care required by a recipient, each home health agency is responsible for coordinating its plan of care with the other involved home health agencies. In addition, each home health agency is responsible for informing the Medicaid QIO of the other home health agencies that are also providing services to the recipient. A home health agency providing home health services without documented knowledge of other home health agencies providing services to its recipient is at risk for recoupment of reimbursement.

For billing purposes, the home health agency must add a UF modifier to the home health service procedure code to identify that services are being coordinated with another home health agency. A home health services provider furnishing home health services to a recipient that another provider is providing services to that does not adhere to the modified billing procedure is at risk for recoupment of reimbursement.

Note: Please refer to Procedure Code Modifiers in this chapter and Appendix A for the valid procedure codes and modifiers.

Reimbursement Information, continued

Dually-Eligible Recipients

A dually-eligible recipient is one who is enrolled in both Medicare and Medicaid.

A modifier must be added to the home health visit procedure code to identify a home health visit service provided to a dually-eligible recipient. If a claim is submitted for a dually-eligible recipient and the modifier is not added to the procedure code, the claim will deny.

Prior authorization requests submitted to the Medicaid QIO must include the modifier if the recipient is dually eligible.

The home health services provider is responsible for retaining documentation in the recipient's record that the service is not Medicare reimbursable. (Medicaid is a secondary payer to Medicare.) A copy of the Medicare denial may be requested by the QIO prior to rendering a determination on requests for services for dually eligible recipients.

Note: Please refer to Procedure Code Modifiers in this chapter and Appendix A for the valid procedure codes and modifiers.

Home Health Aide Visit Associated with Skilled Nursing Services

A home health aide visit associated with a skilled nursing service may be reimbursable by Medicare; and if so, the service must be billed to Medicare first for a dually-eligible Medicare and Medicaid recipient.

A modifier must be added to the home health aide visit procedure code to identify that the home health aide visit service is associated with a skilled nursing service.

Note: Please refer to Procedure Code Modifiers in this chapter and Appendix A for the valid procedure codes and modifiers.

Reimbursement Information, continued

Procedure Codes and Fees

Each procedure code found in Appendix A, Home Health Services Fee Schedule, corresponds to a service described in Chapter 2 of this handbook.

The fee schedule gives:

- The codes associated with the type of service;
- The modifier if the procedure code requires one;
- A brief description of the service; and
- The maximum fee that Medicaid will reimburse for the procedure.

Procedure Code Modifiers

Definition of Modifier

For certain types of services, a two-digit modifier must be entered on the CMS-1500 claim form. Modifiers more fully describe the procedure performed so that accurate payment may be determined.

The modifier is entered in the field next to the procedure code field in item 24D, under Modifier.

Home health services providers must use the modifiers with the procedure codes listed on Appendix A, Home Health Services Fee Schedule, when billing for the specific services in the procedure code descriptions. The modifiers listed in Appendix A can only be used with the procedure codes listed. Use of modifiers with any other procedure codes will cause the claim to deny or pay incorrectly.

Note: See Chapter 1 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for additional information on entering modifiers on the claim form.

APPENDIX A

HOME HEALTH SERVICES FEE SCHEDULE

APPENDIX A
HOME HEALTH SERVICES FEE SCHEDULE
HOME HEALTH VISITS

CODE	MOD 1	MOD 2	MOD 3	DESCRIPTION OF SERVICE	MAXIMUM FEE
T1030				Registered Nurse (RN) Visit	$31.04/per visit
T1030	TT			Registered Nurse (RN) Visit provided to more than one recipient in the same setting	$31.04/per visit - 1st recipient $15.52/per visit for each additional recipient
T1030	GY			Registered Nurse (RN) Visit to Dually-Eligible Recipient	$31.04/per visit
T1030	GY	TT		Registered Nurse (RN) Visit to Dually-Eligible Recipient provided to more than one recipient in the same setting.	$31.04/per visit – 1st recipient $15.52/per visit for each additional recipient
T1031				Licensed Practical Nurse (LPN) Visit	$26.19/per visit
T1031	TT			Licensed Practical Nurse (LPN) Visit provided to more than one recipient in the same setting.	$26.19/per visit – 1st recipient $13.10/per visit for each additional recipient
T1031	GY			Licensed Practical Nurse (LPN) Visit to Dually-Eligible Recipient	$26.19/per visit
T1031	GY	TT		Licensed Practical Nurse (LPN) Visit to Dually-Eligible Recipient provided to more than one recipient in the same setting.	$26.19/per visit – 1st recipient $13.10/per visit for each additional recipient
T1021	TD			Home Health Aide (HHA) Visit—associated with skilled nursing services	$17.46/per visit
T1021	TD	TT		Home Health Aide (HHA) Visit—associated with skilled nursing services provided to more than one recipient in the same setting.	$17.46/per visit – 1st recipient $8.73/per visit for each additional recipient
T1021	TD	GY		Home Health Aide (HHA) Visit—associated with skilled nursing services to Dually-Eligible Recipient	$17.46/per visit
T1021	TD	GY	TT	Home Health Aide (HHA) Visit—associated with skilled nursing services to Dually-Eligible Recipient provided to more than one recipient in the same setting.	$17.46/per visit – 1st recipient $8.73/per visit for each additional recipient
T1021				Home Health Aide (HHA) Visit—unassociated with skilled nursing services	$17.46/per visit
T1021	TT			Home Health Aide (HHA) Visit—unassociated with skilled nursing services provided to more than one recipient in the same setting.	$17.46/per visit – 1st recipient $8.73/per visit for each additional recipient
T1021	GY			Home Health Aide (HHA) Visit—unassociated with skilled nursing services to a Dually-Eligible Recipient	$17.46/per visit

Appendix A, Home Health Services Fee Schedule, continued

CODE	MOD 1	MOD 2	MOD 3	DESCRIPTION OF SERVICE	MAXIMUM FEE
T1021	GY	TT		Home Health Aide (HHA) Visit—unassociated with skilled nursing services to a Dually-Eligible Recipient provided to more than one recipient in the same setting.	$17.46/per visit – 1st recipient $8.73/per visit for each additional recipient

PRIVATE DUTY NURSING

CODE	MOD 1	MOD 2	DESCRIPTION OF SERVICE	MAXIMUM FEE
S9123			Private duty nursing rendered by a RN (2 to 24 hours per day)*	$29.10/hr
S9123	TT		Private duty nursing rendered by a RN (2 to 24 hours per day)* provided to more than one recipient in the same setting.**	$29.10/hr – 1st recipient $14.55/hr – 2nd recipient $7.28/hr – each additional recipient
S9123	UF		Private duty nursing rendered by a RN (2 to 24 hours per day)* provided by more than one provider in the same setting***	$29.10/hr
S9124			Private duty nursing rendered by a LPN (2 to 24 hours per day)*	$23.28/hr
S9124	TT		Private duty nursing rendered by a LPN (2 to 24 hours per day)* provided to more than one recipient in the same setting.	$23.28/hr - 1st recipient $11.64/hr. - 2nd recipient $5.82/hr. - each additional recipient
S9124	UF		Private duty nursing rendered by a LPN (2 to 24 hours per day)* provided by more than one provider in the same setting	$23.28/hr

*Any portion of the hour that exceeds 30 minutes may be rounded up to the next hour, but the total may not exceed the daily authorized number of hours.** The provider should bill using the TT modifier on all cases, but should reduce their billing for each as indicated in policy for subsequent cases within the same residence. ***The home health agency must add a UF modifier to the home health service procedure code to identify that services are being coordinated with another home health agency.

Appendix A, Home Health Services Fee Schedule, continued

PERSONAL CARE SERVICES

CODE	MODIFIER	DESCRIPTION OF SERVICE	MAXIMUM FEE
S9122		Personal care rendered by a home health service provider (1 to 24 hours per day)*	$15.00/hr
S9122	TT	Personal care rendered by a home health service provider (1 to 24 hours per day)* provided to more than one recipient in the same setting.	$15.00/hr . - 1st recipient $7.50/hr. - 2nd recipient $3.75/hr. - each additional recipient
S9122	UF	Personal care rendered by a home health service provider (1 to 24 hours per day)* provided by more than one provider in the same setting	$15.00/hr

*Any portion of the hour that exceeds 30 minutes may be rounded up to the next hour, but the total may not exceed the daily authorized number of hours.

APPENDIX B

CMS FORM 485 – PLAN OF CARE AND INSTRUCTIONS

APPENDIX B

MEDICAID INSTRUCTIONS FOR CMS FORM 485 – PLAN OF CARE

ITEM 1 – PATIENT'S HIC NUMBER

For Medicaid agencies, enter the patient's Medicaid number.

ITEM 2 – START OF CARE DATE (SOC)

This is the date service originally began. This date will remain the same on subsequent plans of care as long as the reason(s) for providing home health care remains the same.

ITEM 3 – CERTIFICATION PERIOD

This identifies the period covered by the plan of care. Enter the six-digit month, day and year, i.e., MMDDYY

FROM DATE

- The first day this POC covers includes this day.
- On the initial certification, the "FROM" date will be the same as start of care date.

TO DATE

- This is the end of the certification. The "TO" date is the last day of the plan of care.
- The "TO" date can include up to, but never exceed, 60 calendar days.
- On subsequent recertifications the next sequential "FROM" date will be the day after the "TO" date on the previous plan of care.

ITEM 4 – MEDICAL RECORD NUMBER

No entry needed.

ITEM 5 – PROVIDER NUMBER

Enter the provider number assigned by Medicaid. This number is comprised of nine digits.

ITEM 6 – PATIENT'S NAME AND ADDRESS

Enter the recipient's last name, first name, and middle initial as shown on the recipient's Medicaid eligibility file. List the address where care is being rendered.

ITEM 7 – PROVIDER'S NAME AND ADDRESS

Enter your agency's name and address.

ITEM 8 – DATE OF BIRTH

Enter the recipient's date of birth in six-digit format, i.e., MMDDYY.

***Medicaid Instructions for CMS Form 485 – Plan of Care**, continued*

ITEM 9 – SEX

Check the appropriate box.

M – Male F – Female

ITEM 10 – MEDICATIONS

Enter all medications including over-the-counter drugs.

Enter dosage, frequency and route of administration.

Enter an "N" after the medication(s) that are "new" orders for the current certification period.

Enter a "C" after the medication(s) that are "change" orders either in dose, frequency or route of administration for the current certification period.

(New or changed medications indicate and support changes or exacerbations in the recipient's condition that may warrant additional or continuing home health services.)

Note: N = new medication within last 30 days.
C = changed medication (dosage, frequency, or route of administration) within last 60 days.

ITEM 11 – PRINCIPAL DIAGNOSIS

Enter a valid ICD-9 code which best describes the principal reason for home health services. The code is the full ICD-9-CM diagnosis code including all digits.

If more than one diagnosis is treated concurrently, enter the diagnosis that represents the most acute condition and requires the most intensive services.

The principal diagnosis may change on subsequent forms only if the patient develops an acute condition or an exacerbation of a secondary diagnosis requiring intensive services different than those on the established plan.

Enter the date of onset or exacerbation in six-digit format (MMDDYY).

Indicate if the diagnosis is a new onset ("O") or an exacerbation ("E") of a pre-existing or chronic condition by placing an "O" or an "E" after the diagnosis date.

If the diagnosis is neither new nor an exacerbation or flare-up of a condition, enter the original date of onset of the condition.

Diagnosis date does not refer to dates of the certification period on the plan of care.

ITEM 12 – SURGICAL PROCEDURE, DATE and ICD-9-CM Code

Enter a valid ICD-9-CM surgical code and date of the surgical procedure. At a minimum, the month and year should be present for date of surgery.

This entry is only necessary if relevant to services being rendered or if the surgical procedure was within the last six months.

Medicaid Instructions for CMS Form 485 – Plan of Care, continued

ITEM 13 – OTHER PERTINENT DIAGNOSES

Enter all pertinent diagnoses relevant to the care rendered. Place in order of seriousness to justify the discipline and services being rendered.

Other pertinent diagnoses are all conditions that coexisted at the time the plan of care was established or developed subsequently.

Enter the date of onset, if it is a new diagnosis, or the most recent exacerbation of a previous diagnosis. Enter the date in MMDDYY format.

ITEM 14 – DME AND SUPPLIES

List supplies and equipment needed for care.

ITEM 15 – SAFETY MEASURES

Enter the physician's instructions for safety measures or those identified by the home health agency.

ITEM 16 – NUTRITIONAL REQUIREMENTS

Enter the physician's orders for the diet including:

- Therapeutic diets;
- Specific dietary requirements; and
- Fluid restrictions or requirements.

Total parenteral nutrition (TPN) can be listed under this item or under medications.

ITEM 17 – ALLERGIES

Enter medicine allergies or other allergies or "NKA."

ITEM 18A – FUNCTIONAL LIMITATIONS

Check current limitations as assessed by the physician or home health agency. If "other" is checked, provide detail below other or in an addendum to the POC.

ITEM 18B – ACTIVITIES PERMITTED

Check all activities allowed by physician. If "Other" is checked, a narrative explanation is required.

ITEM 19 – MENTAL STATUS

Check the most appropriate blocks that describe the patient's mental status. If "Other" is checked, specify here.

ITEM 20 – PROGNOSIS

Check the box that specifies the most appropriate prognosis for the patient.

Medicaid Instructions for CMS Form 485 – Plan of Care*,* continued

ITEM 21 – ORDERS FOR DISCIPLINE AND TREATMENTS

List the frequency and duration of visits for each discipline.

List all the services and treatments to be provided by each discipline.

Frequency denotes the number of visits per discipline to be rendered, stated in days, weeks, or months.

Duration identifies the length of time the services are to be rendered and may be expressed in days, weeks or months.

Note: If this field incorporates the physician treatment order (initial or continuation), it must include the requirements for physician treatment orders listed in Chapter 2 of the Home Health Services Coverage and Limitations Handbook.

ITEM 22 – GOALS/REHABILITATION POTENTIAL/DISCHARGE PLANS

Enter the physician's description of achievable goals and the patient's ability to meet these goals.

Address discharge plans, including plans for care after discharge.

Rehabilitation potential should include the expected health outcomes and the patient's ability to achieve goals and estimate of time needed to achieve them. This information should be pertinent to nature of the patient's condition and ability to respond and include more than words "Fair" or "Poor".

ITEM 23 – NURSE'S SIGNATURE AND DATE OF VERBAL START OF CARE

This field identifies the person who spoke with the attending physician and received verbal authorization to either begin or continue services. Enter the date the verbal order was received. This date may precede the SOC date in Field 2 and may precede the "From" date in Field 3

ITEM 24 – PHYSICIAN'S NAME AND ADDRESS

Enter the name and address of the attending physician that established the plan of care.

ITEM 25 – DATE HHA RECEIVED SIGNED POC

Enter the date the agency received the signed, but *not dated,* POC. Enter "N/A" if Item 27 is completed.

It is recommended that agencies date stamp every plan of care upon return from the physician.

ITEM 26 – PHYSICIAN CERTIFICATION STATEMENT

No entry needed.

***Medicaid Instructions for CMS Form 485 – Plan of Care**, continued*

ITEM 27 – ATTENDING PHYSICIAN'S SIGNATURE AND DATE SIGNED

The form must be signed prior to submission of prior authorization request. If a rubber stamp signature is used, it must be initialed by the physician.

Faxed signatures are acceptable; however, the physician must retain the plan with his original signature in the recipient's medical record. The home health agency is responsible for obtaining original signatures if an issue surfaces that would require verification of an original signature.

The plan of care may be signed by another physician who is authorized by the attending physician to care for his or her patients in his or her absence, i.e., partnership agreement.

Do not pre-date or write the date in this field. If the physician does not date his/her signature, leave it blank and document in Item 25.

ITEM 28 – ANTI-FRAUD STATEMENT

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB No. 0938-0357

HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No.	2. Start Of Care Date	3. Certification Period From: To:	4. Medical Record No.	5. Provider No.

6. Patient's Name and Address

7. Provider's Name, Address and Telephone Number

8. Date of Birth

9. Sex ☐ M ☐ F

10. Medications: Dose/Frequency/Route (N)ew (C)hanged

11. ICD-9-CM	Principal Diagnosis	Date
12. ICD-9-CM	Surgical Procedure	Date
13. ICD-9-CM	Other Pertinent Diagnoses	Date

14. DME and Supplies

15. Safety Measures:

16. Nutritional Req.

17. Allergies:

18.A. Functional Limitations

1 ☐ Amputation
2 ☐ Bowel/Bladder (Incontinence)
3 ☐ Contracture
4 ☐ Hearing
5 ☐ Paralysis
6 ☐ Endurance
7 ☐ Ambulation
8 ☐ Speech
9 ☐ Legally Blind
A ☐ Dyspnea With Minimal Exertion
B ☐ Other (Specify)

18.B. Activities Permitted

1 ☐ Complete Bedrest
2 ☐ Bedrest BRP
3 ☐ Up As Tolerated
4 ☐ Transfer Bed/Chair
5 ☐ Exercises Prescribed
6 ☐ Partial Weight Bearing
7 ☐ Independent At Home
8 ☐ Crutches
9 ☐ Cane
A ☐ Wheelchair
B ☐ Walker
C ☐ No Restrictions
D ☐ Other (Specify)

19. Mental Status: 1 ☐ Oriented 2 ☐ Comatose 3 ☐ Forgetful 4 ☐ Depressed 5 ☐ Disoriented 6 ☐ Lethargic 7 ☐ Agitated 8 ☐ Other

20. Prognosis: 1 ☐ Poor 2 ☐ Guarded 3 ☐ Fair 4 ☐ Good 5 ☐ Excellent

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)

22. Goals/Rehabilitation Potential/Discharge Plans

23. Nurse's Signature and Date of Verbal SOC Where Applicable:

25. Date HHA Received Signed POT

24. Physician's Name and Address

26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.

27. Attending Physician's Signature and Date Signed

28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

Form CMS-485 (C-3) (02-94) (Formerly HCFA-485) (Print Aligned)

APPENDIX C

AUTHORIZATION FOR PRIVATE DUTY NURSING PROVIDED BY A PARENT OR LEGAL GUARDIAN

AUTHORIZATION FOR PRIVATE DUTY NURSING PROVIDED BY A PARENT OR LEGAL GUARDIAN

Home Health Agency Name ___________________________________ Date of Request ___________

Medicaid Provider Number ______________ Phone Number (   )___________ County ___________

____
Street Address | City | State | Zip Code

This is to certify that

Child's Name____ Date of Birth ___________

Child's Medicaid Number_________________

____
Street Address | City | State | Zip Code

has been evaluated and approved to receive private duty nursing services in the child's place of residence as outlined in the Florida Medicaid Home Health Services Coverage and Limitations Handbook. The private duty nursing services will be provided by a parent or legal guardian who meets the following criteria:

1. Has a valid license as a Registered Nurse (RN) or Licensed Practical Nurse (LPN) in the State of Florida; and
2. Employed by a Medicaid enrolled home health agency

Parent or Legal Guardian Name ____

Florida License Number (RN or LPN) _________________ Expiration Date ___________________

Phone Number (   ) _______________

I certify that an initial assessment and all subsequent plan of care assessments for this child will be completed by a Registered Nurse that is not a household member while the parent or legal guardian is authorized to provide private duty nursing services. I understand that Medicaid will only reimburse a home health agency up to 40 hours per week of private duty nursing services provided by a parent or legal guardian. A non-relative RN or LPN employed by the home health agency must provide all other authorized private duty nursing hours above the 40 hour a week limit.

____ _________________________
Home Health Agency Authorized Representative | Date

____ _________________________
Parent or Legal Guardian | Date

____ _________________________
Approval by Medicaid Representative | Date

Submit the form for approval to:
Bureau of Medicaid Services, MS #20
Long Term Care and Behavioral Health Care Section
2727 Mahan Drive
Tallahassee, FL 32308

This form must be filed in the child's medical record

AHCA-Med Serv Form 046

APPENDIX D

GUIDELINES FOR EVALUATING FAMILY SUPPORT AND CARE SUPPLEMENTS

GUIDELINES FOR EVALUATING FAMILY SUPPORT AND CARE SUPPLEMENTS

Private duty nursing reimbursed by the Medicaid program are to supplement the care provided by the parent, legal guardian, or caregiver. Parents, legal guardians, or caregivers must participate in the care of the recipient to the fullest extent possible. Medicaid does not reimburse private duty nursing services provided solely for the convenience of the child, the parent, or the caregiver.

Authorization for services is determined by medical necessity. These guidelines will be used by the QIO when making an assessment of the recipient's family support and care supplements (including the parent, legal guardian, or caregiver's ability to provide care), the recipient and family schedules (work, school, and sleep), and the parent or legal guardian's care for other family dependents.

These guidelines will be used by the first level nurse reviewer to assess the level of parental responsibility, when applicable.

If the requested services cannot be approved by the first level nurse reviewer, the QIO's physician peer reviewer will determine medical necessity using his clinical judgment, acceptable standards of care, state and federal laws, and AHCA's medical necessity definition.

Activity Affecting Parental Availability	Approval Guidelines
Employment (Work Hours)	Based upon the work schedule submitted from the parent, legal guardian, or caregiver's employer. If self employed, the parent, legal guardian, or caregiver must document the work schedule in a statement.
Sleep Hours	The recipient must require continual medical intervention during the times that sleep hours would be approved. The QIO may approve up to 8 hours of care per day based upon the child's level of need for medical intervention.
School	Based upon parent, legal guardian, or caregiver's school schedule. Requires proof of enrollment from the academic or vocational institution with the current class schedule and with the current school term start and end dates.
Caring for Other Dependents	The QIO may approve up to 2 hours per day if there are other minor dependents in the home under the age of 18. The QIO will also take into consideration any special needs that the other children may have and the availability of other caretakers in the home.
Medical Limitations	Based upon documentation from the parent, legal guardian, or caregiver's physician and not from the physician attending or treating the recipient.
Ancillary tasks critical to the health and well-being of the child receiving private duty nursing services. Tasks may include grocery shopping, picking up medications, laundry, and light housekeeping to maintain a safe environment for the child.	Up to 4 hours per week. The QIO will consider the availability of other caregivers in the home who can assist with these tasks.

APPENDIX E

PHYSICIAN VISIT DOCUMENTATION FORM

PHYSICIAN VISIT DOCUMENTATION FORM

This form must be completed by the Physician ordering home health services.

Date: ______________________

Medicaid Recipient's Name:____

Physician's Name:____

Physician's Address:____

____

Physician's Telephone Number:__(_______)___________________________

Diagnosis(es): ____

Date of the recipient's last examination or consultation in your office: ______________

Please describe the patient's ongoing need for home health services:

____

____

____

____

____

____

I hereby certify that I have examined the above named recipient on ____________ and have ordered home health services to treat the recipient's acute or chronic medical condition as described above.

Signature of Physician: ___________________________

National Provider Identifier: ________________

Pursuant to 409.905 (4) (c), Florida Statutes: In order for Medicaid to reimburse for home health services, the physician ordering the services must have examined the recipient within the 30 days preceding the initial request for the services and biannually thereafter.

After completion of this form, please send directly to the recipient's home health agency.

AHCA-Med Serv Form 5000-3502

APPENDIX F

PARENT OR LEGAL GUARDIAN MEDICAL LIMITATIONS FORM

PARENT OR LEGAL GUARDIAN MEDICAL LIMITATIONS

This form must be completed by the Parent or Legal Guardian's Physician.

Date: ____________________________

Patient's Name: ____

Physician's Name: ____

Physician's Address: ____

____

Physician's Telephone Number: (________) ____

Please describe any medical limitation or disability that the above named individual may have that would limit their ability to participate in the care of a patient with complex medical needs (e.g. lifting restrictions, developmental disorder, bed rest for pregnancy, etc.):

____

____

____

____

____

____

____

If limitation/disability is temporary, please document the expected timeframe for resolution.

____

Signature of Physician: ________________________________

National Provider Identifier: ____________________

Signature of Parent/Legal Guardian: ____
(By my signature, I am allowing release of this information to be used for the purpose of determining authorization for my child.)

For use by the Provider:

Recipient's Name: ________________________________ Recipient Medicaid ID: ________________

APPENDIX G

PARENT OR LEGAL GUARDIAN WORK SCHEDULE FORM

PARENT OR LEGAL GUARDIAN WORK SCHEDULE

This form must be completed by a Supervisor at the place of employment.

Parent/Legal Guardian's Name:____

Name of Employer: ____

Address: ____

____

Work Schedule:
(Include work hours for each day)

Monday: ______________________

Tuesday: ______________________

Wednesday: ______________________

Thursday: ______________________

Friday: ______________________

Saturday: ______________________

Sunday: ______________________

If employee works a variable work schedule, please indicate the average number of hours per week, this employee works: ______________________________

Any person who makes, presents or submits a document that is false or fraudulent is subject to a reduction or termination of Medicaid services.

Supervisor Name: ________________________

Title:________________________________

Telephone Number: (______) ______________

Signature:______________________________

Date: ________________________________

For use by the Provider:

Recipient's Name: ________________________________ Recipient Medicaid ID: _________________

AHCA-Med Serv Form 5000-3503

APPENDIX H

PARENT OR LEGAL GUARDIAN STATEMENT OF WORK SCHEDULE FORM

PARENT OR LEGAL GUARDIAN STATEMENT OF WORK SCHEDULE

Recipient's Name:____

Parent/Legal Guardian's Name:____________________________________

Statement of Work Schedule

Name of Employer: ____

Address: ____

____

Work Schedule:
(Include work hours for each day)

Monday: ____________________

Tuesday: ____________________

Wednesday: ____________________

Thursday: ____________________

Friday: ____________________

Saturday: ____________________

Sunday: ____________________

My signature below certifies that I am self-employed and that the schedule above is true and accurate. I understand that any person who makes, presents, or submits documentation that is false or fraudulent is subject to a reduction or termination of Medicaid services.

Parent/Legal Guardian Signature:______________________________

Date:______________________________________

Telephone Number:_(__________)______________________

For use by the Provider:

Recipient's Name: ______________________________ Recipient Medicaid ID: ________________

AHCA-Med Serv Form 5000-3504

APPENDIX I

PARENT OR LEGAL GUARDIAN SCHOOL SCHEDULE FORM

PARENT OR LEGAL GUARDIAN SCHOOL SCHEDULE

This form must be completed by a school Advisor or representative.

Parent/Legal Guardian's Name:____

Name of School: ____

Address: ____

____

Current School Term: ☐ Fall ☐ Spring ☐ Summer Year: ___________

Term start date: _____________ Term end date:_____________

Class Schedule:
(Include class hours for each day)

Monday: ___________________________

Tuesday: ___________________________

Wednesday: ___________________________

Thursday: ___________________________

Friday: ___________________________

Saturday: ___________________________

Sunday: ___________________________

Name of School Representative: ___________________________

Title: ____

Telephone Number: (________) _______________________________

Signature: ____

Date: ____

For use by the Provider:

Recipient's Name: _____________________________ Recipient Medicaid ID: _______________

AHCA-Med Serv Form 5000-3505

APPENDIX J

MEDICAID INSTRUCTIONS FOR PERSONAL CARE SERVICES PLAN OF CARE AND FORM

APPENDIX J
MEDICAID INSTRUCTIONS FOR THE PERSONAL CARE SERVICES PLAN OF CARE

ITEM 1 - ALLERGIES

Enter any known medicine or other allergies that the recipient has. If unknown, enter "NKA"

ITEM 2 – CERTIFICATION PERIOD

This identifies the period covered by the plan of care. Enter the eight-digit month, day and year, (i.e., MMDDYYYY).

FROM DATE

- The first day this POC covers includes this day.
- On the initial certification, the "FROM" date will be the same as start of care date.

TO DATE

- This is the end of the certification. The "TO" date is the last day of the plan of care.
- The "TO" date can include up to, but never exceed, 180 calendar days.
- On subsequent re-certifications the next sequential "FROM" date will be the day after the "TO" date on the previous plan of care.

ITEM 3 – MEDICAID ID NUMBER

Enter the recipient's ten digit Medicaid identification number.

ITEM 4 – MEDIPASS AUTHORIZATION NUMBER

If the recipient is enrolled in the MediPass program, enter the primary care physician's MediPass authorization number. This can be obtained by contacting the recipient's MediPass primary care physician.

ITEM 5 – PATIENT'S NAME

Enter the recipient's last name and first name as shown on the recipient's Medicaid eligibility file.

ITEM 6 – GENDER

Check the appropriate box.

ITEM 7 – DATE OF BIRTH

Enter the recipient's date of birth in the eight-digit format, (i.e., MMDDYYYY).

ITEM 8 – COUNTY OF RESIDENCE

Enter the county in which the recipient resides.

ITEM 9 – PATIENT'S ADDRESS

Enter the recipient's address (street address, city, state, and zip code) where care is being provided.

AHCA-Med Serv Form 5000-3506

Personal Care Services Plan of Care

For Use by Unlicensed Independent Personal Care Providers

Medicaid Instructions for Personal Care Services Plan of Care*,* continued

ITEM 10 – PHONE NUMBER

Enter the recipient's home telephone number.

ITEM 11 – MEDICAID AREA OFFICE

Enter the recipient's local Medicaid area office.

ITEM 12 – PROVIDER NAME

Enter your name.

ITEM 13 – PROVIDER MEDICAID ID NUMBER

Enter your Medicaid provider ID number.

ITEM 14 – PROVIDER ADDRESS

Enter your address.

ITEM 15 – TELEPHONE NUMBER

Enter your telephone number.

ITEM 16 – DIAGNOSIS(ES)

Enter a valid ICD-9 code which best describes the recipient's primary reason for needing personal care services on the first line. The code is the full ICD-9-CM diagnosis code including all digits.

Enter all other pertinent diagnoses relevant to the care rendered. Other pertinent diagnoses are all conditions that coexisted at the time the plan of care was established or developed subsequently.

Enter the date of onset or exacerbation in eight-digit format (MMDDYY) for each diagnosis. The diagnosis date does not refer to dates of the certification period on the plan of care.

The diagnoses should come from the recipient's primary care physician and be documented on the written physician's order.

ITEM 17 – MEDICATIONS

Enter ALL of the recipient's medications including over-the-counter drugs.

Enter dosage (*mg, one, two, etc*), frequency (*how often*) and route of administration (*oral, rectal, etc.*).

ITEM 18 – DURABLE MEDICAL EQUIPMENT AND SUPPLIES

List supplies and equipment needed for care. For example, gloves, wheel chair, commode, incontinence supplies (briefs), walker, cane, etc.

AHCA-Med Serv Form 5000-3506

***Medicaid Instructions for Personal Care Services Plan of Care**, continued*

ITEM 19 – NUTRITIONAL REQUIREMENTS

Enter the physician's orders for the diet including any therapeutic diets or specific dietary requirements and restrictions (i.e., normal, soft, liquid).

ITEM 20 – HOW DOES THE PATIENT EAT

Check the appropriate box.

ITEM 21 – FUNCTIONAL LIMITATIONS

Check current limitations as assessed by the physician. If "Other" is checked, provide detail below other or in an addendum to the POC.

ITEM 22 – SAFETY MEASURES

Enter the physician's instructions for safety measures or those identified by your assessment of the recipient (i.e., keeping path ways clean and free of clutter, assisting with walking, etc.).

ITEM 23 –PERMITTED PHYSICAL ACTIVITIES

Check all activities allowed by the recipient's physician. If "Other" is checked, a detailed explanation is required.

ITEM 24 – MENTAL STATUS

Check the most appropriate box that describes the recipient's mental status. If "Other" is checked, specify.

ITEM 25 – PARENT/GUARDIAN WORK AND SCHOOL SCHEDULE

If applicable, enter the parent or legal guardian's work and school schedule (include the hours and days).

ITEM 26 – PARENT/GUARDIAN PHYSICAL INFORMATION

If applicable, enter any medical or physical limitations that the parent or legal guardian has that would prevent him from participating in the child's care to the fullest extent possible.

ITEM 27 – NUMBER OF OTHER CHILDREN IN THE HOME

Enter the number of children who live in the same place of residence as the residence.

If recipient lives in a group home for children with special needs, enter "N/A".

ITEM 28 – AGE OF OTHER CHILDREN IN THE HOME

Enter the age of the each of the children living in the home (from Item 27).

If recipient lives in a group home for children with special needs, enter "N/A".

AHCA-Med Serv Form 5000-3506

Personal Care Services Plan of Care

For Use by Unlicensed Independent Personal Care Providers

Medicaid Instructions for Personal Care Services Plan of Care, continued

ITEM 29 – SPECIAL NEEDS OF OTHER CHILDREN IN THE HOME

If applicable, enter the special needs of any other children who live in the same home with the recipient.

If recipient lives in a group home for children with special needs, enter that here.

ITEM 30 – SPECIFIC HOURS PER DAY AND DAYS OF WEEK SERVICE WILL BE PROVIDED

Enter the specific hours per day and days per week that you will be providing medically necessary personal care services, as prescribed by the recipient's physician.

ITEM 31 – SERVICES PROVIDED

Check all activities of living/self care tasks that you will be assisting the recipient to accomplish. If "Other" is checked, a detailed explanation is required.

ITEM 32 – EXPECTED HEALTH OUTCOME/ REHABILITATION POTENTIAL

Check the most appropriate box that describes the recipient's expected health outcome and the ability for the recipient to achieve goals (i.e., re-learn or acquire the ability to perform some or all of his self care tasks).

ITEM 33 –DISCHARGE PLAN

Address discharge plans (if applicable).

PHYSICIAN CERTIFICATION

Enter the name of the attending physician that prescribed the services. The plan of care must be signed and dated by the attending physician prior to submission of a prior authorization request.

Faxed signatures are acceptable; however, the physician must retain the plan with his original signature in the recipient's medical record. The provider is responsible for obtaining original signatures if an issue surfaces that would require verification of an original signature.

The plan of care may be signed by another physician who is authorized by the attending physician to care for his patients in his absence,(i.e., partnership agreement).

SIGNATURES

The plan of care must be signed and dated by the recipient's parent or legal guardian. A recipient 18 years of age or older who is capable of signing the plan of care may do so, instead of the parent or legal guardian.

Enter the parent or legal guardian's printed name (if applicable).

The plan of care must also be signed by the provider rendering care.

AHCA-Med Serv Form 5000-3506

PATIENT INFORMATION

1. **ALLERGIES:**

2. **Certification Request:** (check one)
Initial ☐ Re-certification ☐

Certification Period: __/__/____ From __/__/____ To
(Re-certification required every 180 days)

3. Medicaid ID Number (10 digits) _ _ _ _ _ _ _ _ _ _

4. MediPass Authorization # (if applicable): _ _ _ _ _ _ _ _ - _ _

5. Last Name: First Name:

6. Gender: Male ☐ Female ☐

7. Date of Birth: __/__/____

8. County of Residence:

9. Street Address:

City: State: Zip Code:

10. Phone # (___)___ - ____

11. Medicaid Area Office:

PROVIDER INFORMATION

12. Name:

13. Provider Medicaid ID Number: _ _ _ _ _ _ _ - _ _

14. Street Address:

City: State: Zip Code:

15. Phone # (___)___ - ____

PATIENT MEDICAL AND SOCIAL INFORMATION

16. Diagnosis(es):

ICD-9 Code(s) *(Provided by a Physician):*	Written Description:	Date of Diagnosis:
_ _ _ . _ _		__/__/____
_ _ _ . _ _		__/__/____
_ _ _ . _ _		__/__/____

17. Medications (Dose/Route/Frequency):

18. Durable Medical Equipment & Supplies Used by the Recipient:

19. Nutritional Requirements: _____

20. How Does the Patient Eat? (*check one*): Feeds Self ☐ Needs Assistance ☐ G-Tube ☐

21. Functional Limitations (*check all that apply):*

☐ Amputation *(describe):* _____
☐ Limited use of arms, hands, or feet
☐ Hearing impaired
☐ Requires assistance to ambulate
☐ Shortness of breath/breathing difficulty (*explain*): _____
☐ Bowel/bladder incontinence (*frequency*): _____
☐ Paralysis
☐ Tires easily when moving about
☐ Speech difficulty
☐ Legally blind
☐ Other (*explain*): _____

AHCA-Med Serv Form 5000-3506

Personal Care Services Plan of Care

For Use by Unlicensed Independent Personal Care Providers

22. Safety Measures Required:

23. Permitted Physical Activities (*check all that apply):*
- ☐ Bed rest
- ☐ Up as tolerated
- ☐ Exercises prescribed
- ☐ Use of gait ball
- ☐ Assisted transfer from bed to chair
- ☐ Other (*specify*): _____

24. Mental/Neurological Status (*check all that apply):*
- ☐ Alert/oriented
- ☐ Forgetful
- ☐ Combative
- ☐ Agitated
- ☐ Depressed
- ☐ Seizures (how often): _____
- ☐ Disoriented
- ☐ Lethargic
- ☐ Other (*specify*): _____

25. Parent/Guardian Work/School Hours and Days *(if applicable)*:

26. Parent/Guardian physical limitations in caring for child *(if applicable)*:

27. Number of other children in the home:

28. Age of other children in the home:

29. Special needs of other children in the home *(if applicable)*:

SERVICE INFORMATION

30. Specific Hours/Days of Service *(prescribed by the physician)*:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

31. Services Provided (*check all that apply):*
- ☐ Bathing and Grooming
- ☐ Oral Hygiene
- ☐ Oral Feedings and Fluid Intake
- ☐ Toileting and Elimination
- ☐ Range of Motion and Positioning
- ☐ Other _____

32. Expected Health Outcome/Rehabilitation Potential (*check one*): Excellent ☐ Good ☐ Poor ☐ Unchanged ☐

33. Discharge Plan:

PHYSICIAN CERTIFICATION

I certify that personal care services are medically necessary for this individual, as furnished under this plan of care. This individual is under my care and I have examined him within the last 6 months.

Signature of Physician: ______________________________ Date: __/__/____

Physician Name: _____ Date Seen By Physician __/__/____

SIGNATURES

I acknowledge that I have reviewed this plan of care and the information herein is accurate.

Signature of Recipient/Parent/Legal Guardian: Date: __/__/____

Legal Guardian Printed Name *(if applicable)*:

Signature of Personal Care Provider: ______________________________ Date: __/__/____

ATTACH PRESCRIPTION

AHCA-Med Serv Form 5000-3506

APPENDIX K

MEDICAID PHYSICIAN'S WRITTEN PRESCRIPTION FOR HOME HEALTH SERVICES

APPENDIX K

MEDICAID PHYSICIAN'S WRITTEN PRESCRIPTION FOR HOME HEALTH SERVICES

GENERAL INFORMATION

1. **TODAY'S DATE:** _ _ / _ _ / _ _ _ _

2. **Certification Request:** (check one)
   Initial ☐ Re-certification ☐

   (Re-certification required at least every 60 days for home health visits and at least every 180 days for private duty nursing and personal care services.)

3. Date of last physician's office visit: _ _ / _ _ / _ _ _ _

PATIENT INFORMATION

4. Medicaid ID Number (10 digits) _ _ _ _ _ _ _ _ _ _

5. MediPass Authorization # (if applicable): _ _ _ _ _ _ _ - _ _

6. Last Name: ________________ First Name: ___________

7. Gender: Male ☐ Female ☐

8. Date of Birth: _ _ / _ _ / _ _ _ _

9. Phone #(_ _ _) _ _ _ - _ _ _ _

10. Street Address: ____________________________________
    City: __________________________ State: _____ Zip Code: ___________

PATIENT MEDICAL AND SOCIAL INFORMATION

11. Diagnosis(es):

ICD-9 Code(s) *(Provided by a Physician):*	Written Description:	Date of Diagnosis:
_ _ _ . _ _		__/__/____
_ _ _ . _ _		__/__/____
_ _ _ . _ _		__/__/____

12. Home Health Services ordered:

13. Frequency and duration:

14. Reason services must be provided (must be medically necessary):

15. Skill level required (i.e. RN, LPN, or Aide): _____

ORDERING PHYSICIAN INFORMATION

16. Name: _____________________________

17. Phone # (_ _ _) _ _ _ - _ _ _ _

18. Street Address: ___________________________
    City: __________________State:___ Zip Code: ______

19. Provider Medicaid ID Number: _ _ _ _ _ _ _ - _ _
    OR
    Provider NPI Number: _ _ _ _ _ _ _ _ _ _
    OR
    Provider Medical License Number: _ _ _ _ _ _ _

PHYSICIAN'S SIGNATURE: ***I certify that home health services are medically necessary for this individual, as furnished in this written prescription for services. This individual is under my care and I have examined him within 30 days prior to the initiation of services or within the last 6 months for continuation of services.***

Signature:**____*****Date:*** __/__/____

AHCA-Med Serv Form 5000-3525

APPENDIX L

MEDICAID REVIEW CRITERIA FOR PRIVATE DUTY NURSING SERVICES

REVIEW CRITERIA FOR PRIVATE DUTY NURSING SERVICES

Introduction:

- Private duty nursing (PDN) services provide skilled nursing services to a recipient under the age of 21 in their home or other authorized setting to support the care required by the child's medical condition.
- These services require more continuous care than can be provided through a skilled nursing visit.
- Home health agencies requesting PDN services must provide supporting documentation in accordance with the Florida Medicaid Home Health Services Coverage and Limitations Handbook to support the request.
- First level reviewers evaluate all information to ensure that requested services are appropriate for skilled nursing.

Clinical Indicators for Private Duty Nursing (PDN)

The requested services must be medically necessary and all documentation must substantiate the need for skilled nursing services. The following clinical indicators must be present in the request for services before PDN services can be authorized.

1. Clinical Presentation (One or more of the following must be satisfied)
    - Illness/Injury/Exacerbation/Surgery
    - Discharge from Inpatient facility
    - Newborn/infant and poor weight gain
2. Skilled intervention required (One or more of the following must be satisfied)
    - Modification of initial or on-going treatment/medication regimen
    - Lack of adherence
    - Management of plan of care
    - Exacerbation of known illness
3. Recipient's caregiver unable to manage care (One or more of the following indicators must be satisfied):
    - Lack of caregiver availability
    - Knowledge deficit
    - Physical limitation
4. Care required in the home setting or other authorized setting (One or more of the following indicators must be satisfied)
    - Activity restrictions requiring ≥ minimum assistance in transfer/bed mobility/locomotion to leave home/residence
    - Isolation and/or immunocompromised host/communicable disease

Criteria for First Level Reviewers:

All requested services must meet the definition of medical necessity and be age-appropriate. This is especially important in the pediatric population because of changes in growth and development. Requests for PDN services must consider the role any parents or caregivers play in the care of a recipient. Home health agencies must provide documentation that accurately reflects a recipient's specific diagnoses, system and organ function, home environment and necessary skilled nursing interventions. This documentation should include assessments from both the home health agency and the treating/attending physician. First level reviewers focus on how the requested services meet the needs of the recipient while conforming to the policies outlined in the Home Health Coverage and Limitations Handbook. First level reviewers will consider information that includes, but is not limited to the following:

1. Provider assessment[1,2] of:
   - Home environment
   - Care required in the home or other authorized setting
   - Caregiver availability
   - Caregiver skills/deficit

2. Provider documentation of organ system dysfunction including but not limited to
   - Genitourinary system[3]
     - Initiate/continue teaching of self-catheterization and voiding schedule
     - Catheter change/irrigation/reinsertion and recipient/caregiver unable to perform
     - Postvoid residual
     - Suprapubic tube
   - Cardiovascular system
     - Significant arrhythmias
     - Blood pressure monitoring
     - Signs of congestive heart failure

3. Endocrine system
   - Fluid monitoring for diabetes insipidus[4]
   - Care for diabetes mellitus including
     - Insulin injections/pump
     - Blood sugar testing/monitoring
     - Diet/Meal planning
     - Eye/foot/skin care

4. Gastrointestinal system and nutrition[5]
   - Initiate/continue teaching of prescribed bowel regimen
   - Manual disimpaction and caregiver unable to perform
   - Aspiration precautions
   - Feeding tube care (includes pump management)
   - TPN
   - Formula medication administration
   - Site care/dressing

5. Hematologic system
   - Administration of injectable anticoagulants

6. Neurologic system[6]
   - Seizure precautions/interventions
   - Vagal nerve stimulator

7. Musculoskeletal system[7]
   - Cast care
   - Wound care
   - Decubiti/pressure ulcers

8. Respiratory system[8,9]
   - Tracheostomy care
   - Technology dependent child

First level reviewers will approve the frequency and duration of services that are medically necessary. Up to 12 hours may be approved by the first level nurse reviewers. If additional hours are requested, the case will be referred to a physician reviewer for final determination.

Citations

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APPENDIX M

MEDICAID REVIEW CRITERIA FOR PERSONAL CARE SERVICES

REVIEW CRITERIA FOR PERSONAL CARE SERVICES

Introduction:

Personal care services provide medically necessary assistance with activities of daily living (ADL) and age appropriate instrumental activities of daily living (IADL) that enable the recipient to accomplish tasks that they would normally be able to do for themselves if they did not have a medical condition or disability.

Medicaid reimburses personal care services for recipients under the age of 21 who have a medical condition or disability that substantially limits their ability to perform their ADLs or IADLs.

Clinical Indicators for Personal Care Services (PC)

The following indicate the level of functional impairment of a recipient. All functional impairments must be age-appropriate and consistent with the level of functional impairment.

One of the following levels of functional impairment must be satisfied.

1. Minimal functional impairment
   (One of the following indicators must be satisfied)
   - ADL's requiring at least minimum assistance
   - Ambulates with assist of person/device
   - Transfers requiring at least minimum assistance
2. Moderate functional impairment
   (Two of the following indicators must be satisfied)
   - ADL's requiring at least minimum assistance
   - Ambulates with assist of person/device
   - Transfers requiring at least minimum assistance
3. Maximum functional impairment
   (All of the following indicators must be satisfied)
   - ADL's requiring total assistance
   - Non-ambulatory
   - Transfers requiring 1-2 person assist
4. Maximum and persistent functional impairment without available caregiver support
   (All of the following indicators must be satisfied)
   - ADL's requiring total assistance
   - Non-ambulatory
   - Transfers requiring 1-2 person assist
   - Attending/treating physician must certify that all of the above impairments are present.

Criteria for First Level Reviewers:

First level reviewers may approve requests for personal care services when the supporting documentation satisfies the following criteria:

1. Personal care services

- Medicaid reimburses for the following personal care services when they are medically necessary.

- ADLS include:
  - Eating (oral feedings and fluid intake);
  - Bathing;
  - Dressing;
  - Toileting;
  - Transferring; and
  - Maintaining continence (examples include taking care of a catheter or colostomy bag or changing a disposable incontinence product when the recipient is unable to control his bowel or bladder functions).

- IADLs (when necessary for the recipient to function independently) include:
  - Personal hygiene;
  - Light housework;
  - Laundry;
  - Meal preparation;
  - Transportation;
  - Grocery shopping;
  - Using the telephone to take care of essential tasks (examples include paying bills and setting up medical appointments);
  - Medication management; and
  - Money management.

- The recipient must:

  - Require services due to a medical condition or disability which substantially limits his ability to perform the activities of daily living. This occurs when:

    - The recipient cannot independently perform the personal care tasks because of a physical and/or cognitive impairment*;

    - The recipient would normally perform the (age-appropriate) personal care tasks for themselves if they did not have a medical condition or disability; and

    - There is no household parent or legal guardian to meet the need on a regular basis.

  - Require services that are medically necessary and reasonable for the treatment of the documented illness, injury or condition.

  - Recipient's caregiver agrees to participate fully in the authorized plan of care.

<u>*Note:</u> Medically necessary personal care services may be authorized when a recipient has a documented cognitive impairment which prevents him from knowing when or how to carry out the personal care task. Assistance may be in the form of hands on assistance (actually performing the task for the person) or cuing, along with supervision to ensure the recipient performs the personal care task properly. Additional supporting documentation may be required to substantiate the functional limitations associated with the cognitive impairment. In addition, one of the following indicators must be satisfied:

- Incapable of learning despite efforts to train in care task

- Memory deficit(s) prevents managing care task

2. Authorization of Hours

When requests for PCS meet the above criteria, first level reviewers may approve up to 6 hours/day using the following guidelines. *If additional hours are requested, the case will be referred to a physician reviewer for final determination.*

Personal Care Task	General Time Allowances
Bathing	
Full-body Bath: Tub, shower or sponge/bed bath.	Up to 30 minutes. May rotate with partial bath based on recipient's needs.
Partial Bath: A sponge bath includes, at minimum, bathing of the face, hands, and perineum.	15–20 minutes per partial bath.
Dressing	
Laying out clothing, handing and retrieving clothing, putting clothes on and taking them off, including handling fasteners, zippers, and buttons.	15 minutes
Application of prosthetic devices or application of therapeutic stockings.	May add 15 minutes for applying hose and/or prosthesis
Grooming/Skin Care	
Brushing teeth, denture care, shaving, washing and drying face and hands. Applying lotion to non-broken skin.	15–30 minutes
Shampoo and comb hair, basic hair care, basic nail care.	15 minutes
Positioning	
Moving recipient to and from a lying position, turning side to side, and positioning recipient in bed.	10 minutes/every 2 hours when medically indicated
Transfers	
Moving recipient into and out of a bed, chair, or wheelchair. May include the use of assistive devices.	15 minutes/every 2 hours when medically indicated
Toileting & Maintaining Continence	
Includes transfer on or off the toilet, bedside commode, urinal, or bedpan. Includes cleaning the perineum and cleaning after an incontinent episode. Includes taking care of a catheter or colostomy bag or changing a disposable incontinence product.	15–45 minutes
Eating	
Taking in food by any method. Extra time may be allowed for preparing a special diet.	30 minutes per meal
Delegated Medical Monitoring and Activities	
Non-skilled medical tasks that are delegated to the aide by the RN, in accordance with Florida laws and practice acts. The tasks include, but are not limited to, assisting recipient with pre-poured medications, monitoring vital signs, and measurement of intake/output.	15–30 minutes day for all monitoring tasks performed.