HSCSN

HSCSN Internal Policy

POLICY NAME: Home Care Services

POLICY ID: UM_22

DEPARTMENT: Utilization Management

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I. PURPOSE

This policy supports governance of HSCSN's delivery of quality services to its enrollees while ensuring compliance with regulations and implementation of industry-specific standards.

II. POLICY STATEMENT

Summary

Home care is caregiving and other support provided to a person with special needs to enable them to stay in their home and community (rather than a facility). Individuals may need home care due to illness, injury, recent surgery, a chronic health condition or disability. Home care includes both informal supports provided by family and friends as well as paid home care services. Health Services for Children with Special Needs, Inc. (HSCSN) is committed to supporting HSCSN enrollees who require home care.

HSCSN offers several different benefits defined under the federal Medicaid program, the District of Columbia State Medicaid Plan and the CASSIP Contract that fall under the general category of Home Care Services. Home care services available to HSCSN enrollees include Home Health Services, Personal Care Aide (PCA) Services, Private-Duty Nursing (PDN), Respite Services, Home Hospice Care, and Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS).

Home Health Services are defined for Medicaid in 42 C.F.R. § 440.70 and by Title 29 (Public Welfare) Chapter 99 (Home Health Services) of the District of Columbia Municipal Regulations (DCMR). Home Health Services include skilled nursing services, home health aide services, physical therapy, occupational therapy, and speech pathology and audiology services as well as medical supplies, equipment and appliances suitable for use in any setting in which normal life activities take place.

An enrollee can receive home health services in any setting in which normal life activities take place, other than a hospital or nursing facility. Home health services can be provided in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) if the services are not required to be provided by the facility. Home health services cannot be limited to services furnished to enrollees who are home

bound. HSCSN does not cover home care services provided in a school setting as they are specifically carved out of the HSCSN contract.

Home health services are distinct from Long-Term care Services and Supports (LTSS), such as personal care aide services. As set forth in DCMR § 9901.1 and 9902.1, skilled nursing and home health aide services offered under the State Plan home health benefit are offered on a "part-time or intermittent basis," in accordance with the federal requirements of 42 CFR § 440.70.

Private-duty nursing (PDN) is defined for Medicaid in 42 C.F.R. § 440.80 and by Title 29 (Public Welfare) Chapter 9, Section 947 of DCMR, Private Duty Nursing Services. PDN services are nursing services for technology-dependent enrollees. These enrollees require more individualized and continuous care than is available from a visiting nurse under the Skilled Nursing Home Health Services benefit available under the State Plan.

Personal care services (also called personal care aide services) are defined for Medicaid in 42 C.F.R. § 440.167 and by Title 29 (Public Welfare) Chapter 50 of DCMR, Medicaid Reimbursement for Person Care Aide Services. The goals of Personal Care Aide (PCA) services are to provide cueing or necessary hands-on assistance to enrollees who are unable to perform one or more activities of daily living and to encourage home-based care as a preferred and cost-effective alternative to institutional care.

Home Health Services, Private-Duty Nursing, and Personal Care Aide Services are all Home Care Services that must be provided by a Home Care Agency that is licensed in the jurisdiction in which the services are rendered and meets the requirements of the DC Medicaid program.

Home Health Services, Private-Duty Nursing, and Personal Care Aide Services require prior authorization from HSCSN and are initially requested using the HSCSN Home Care Services Order Form or a physician order with the same information. With the initial request for Home Care Services, HSCSN asks that the Requesting Provider submits medical records, including a note from a visit with the enrollee within 90 days of the order. The order for Home Care Services should indicate the type of services being requested and the reasons for the service(s). The Home Care Agency is responsible for doing a nursing assessment (as described below), developing and implementing a Home Health Plan of Care (plan of care). For Home Health Services and PDN, the prescribing provider is responsible for reviewing and signing the plan of care at least every 60 days. For PCA, the plan of care can be reviewed and signed yearly.

Home Health Services covered by this Policy include:

- Skilled Nursing Services (as described in Section 9901 of Title 29 DCMR Chapter 99 Home Health Services)
- Home Health Aide Services (as described in Section 9902 of Title 29 DCMR Chapter 99 Home Health Services)
- Physical Therapy Services (as described in Section 9903 of Title 29 DCMR Chapter 99 Home Health Services)
- Occupational Therapy Services (as described in Section 9904 of Title 29 DCMR Chapter 99 Home Health Services)
- Speech Pathology and Audiology Services (as described in Section 9905 of Title 29 DCMR Chapter 99 Home Health Services)

- Private Duty Nursing Services (as described in Section 947 of Title 29 DCMR Chapter 9.

Medicaid reimbursable Home Health Services include Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) which are addressed by HSCSN UM Policy UM_17.

Home Care Services more broadly include Private Duty Nursing (PDN), Personal Care Aide (PCA) services, Respite Services, and home Hospice Care services.

- Private-Duty Nursing Services are addressed in this policy.
- Personal Care Aide Services are addressed by the HSCSN LTSS Policy (UM_20)
- Respite Services are addressed by the Respite Services policy (UM_13).
- Home hospice care is considered separately from Home Health Services and addressed by Section 940 of Chapter 9 of Title 29 DCMR.

HSCSN conducts regular Home Care Rounds to discuss home care services for enrollees. Home Care Rounds may be used to discuss access to services, appropriate services, or possible changes to authorized services. The HSCSN Chief Medical Officer and/or other medical staff, UM home care reviewers and relevant care managers participate in home care rounds. The Primary Care Provider, specialists and/or Home Care Agency involved in the enrollee's care may be invited to participate in a Multidisciplinary Team meeting to discuss services as needed.

Definitions

Adaptive Equipment: Medical devices used to assist the beneficiary in performing activities of daily living.

Certificate of Need (CON) [CASSIP C.3.34]: A document obtained from the D.C. State Health Planning and Development Agency (SHPDA) authorizing an entity to establish a new institutional health care service or to obligate a capital expenditure or take certain other actions as specified in DC Official Code 44-401 et. seq. of the Health Services Planning Program Re-establishment Act of 1996, as amended, and the Certificate of Need (CON) regulations (Title 22B, DC Municipal Regulations, sec.4000, et. seq.). A CON is issued by SHPDA and must be renewed by application to SHPDA.

Child and Adolescent Supplemental Security Income Program (CASSIP) [CASSIP C.3.36]: The Medicaid managed care program specifically designed to provide comprehensive primary, specialty, in-patient, behavioral health, and long-term care to SSI or SSI-eligible children and adolescents.

Covered Services [C.3.56]: The items and services, transportation, care coordination, and case management services described in the CASSIP Contract that, taken together, constitute the services that HSCSN must provide to Enrollees under District and federal law. The term also encompasses any additional items and services described by DHCF and/or Contractor as being available to Enrollees.

Department of Health Care Finance (DHCF) [C.3.67]: The Agency within the District of Columbia Government responsible for administering all Medicaid services under Title XIX (Medicaid) and Title XXI (CHIP) of the Act, for eligible beneficiaries, including the

DC Medicaid Managed Care Program and oversight of its managed care Contractors, as well as the Alliance and including all agents and Contractors of DHCF. For purposes of the CASSIP contract, the Contract Administrator shall be authorized to act on behalf of DHCF unless other individuals are specifically otherwise noted.

Department of Health (DC Health) [C.3.70]: The Agency within the District of Columbia Government responsible for health risks educating the public on the: prevention and control of diseases, injuries, and exposure to environmental hazards in the District of Columbia and identified health risks that require a public response in D.C.

District [C.3.78]: Refers to the Government of the District of Columbia.

Durable Medical Equipment [C.3.81]: Medical equipment that can withstand repeated use, is primarily and customarily used to serve a purpose consistent with the amelioration of physical, mental, or developmental conditions that affect healthy development and functioning, is generally not useful in the absence of a physical, mental, or developmental health condition, and is appropriate for use in a home or community setting.

Enrollee [C.3.93]: An individual who is currently enrolled in CASSIP. Enrollee also refers to the parent, legal guardian, or personal representative of the Enrollee in cases where the Enrollee is a minor or incapacitated as determined by a court.

Home Care Agency or Home Health Services Agency: A home care agency is a business licensed to provide in-home or community-based services such as skilled nursing, private-duty nursing, physical therapy, occupational therapy, speech-language pathology, intravenous therapy, medical social services, home health aide or personal care aide services. A home care agency must be licensed in the jurisdiction where the services are rendered.

Home Health Care [C.3.129]: Health care services that can be provided in the home [or a community setting] for an illness or injury.

Home Health Certification and Plan of Care (also called Home Health Plan of Care or plan of care): The Home Health Certification and Plan of Care is a document completed by a Home Care Agency (usually on a CMS-485 form) that must:

- Be developed in consultation with the enrollee or the enrollee's representative;
- Specify the services to be provided including their frequency and duration, and the expected outcome(s) of the services; and
- Specify how the enrollee's needs, as identified in a nursing assessment, will be met by the services provided;
- Consider the enrollee's preferences regarding the scheduling of services; and
- Be reviewed and signed by the enrollee's physician or advanced practice registered nurse within thirty (30) days of the start of care or re-certification.

Home Health Aide Services: Services on a part-time or intermittent basis that are required by an enrollee due to an illness or injury, and include assistance with activities of daily living, assistance with self-administered medications, or other clinical tasks to assist with the provision of nursing or skilled services such as cleaning around a feeding tube and assistance with oxygen therapy.

Hospice [C3.131]: Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Informal Supports: Unpaid assistance provided to an enrollee by the enrollee's family or another individual who is unrelated to the enrollee.

Medical Record [C.3.173]: Documents, whether created or stored in paper or electronic form, which correspond to and contain information about the medical health care, or allied care, goods, or services furnished in any place of service. The records may be on paper or electronic. Medical records must be dated, signed, or otherwise attested to (as appropriate to the media) and be legible.

Medically Necessary [C.3.174]: Services for individuals that promote normal growth and development and prevent, diagnose, detect, treat, ameliorate the effects or a physical, mental, behavioral, genetic, or congenital condition, injury, or disability and following generally accepted standards of medical practice, including clinically appropriate, in terms of type, frequency, extent, site, and duration and considered effective for the Enrollee's illness, injury, disease, or physical or mental health condition.

Long-Term Care Services and Supports (LTSS): Long-term care services and supports are a set of services available to enrollees in need of support due to chronic physical, cognitive, developmental, or behavioral health conditions, or other functional impairments that limit their ability to care for themselves. LTSS services can be provided in the home, community-based settings, or by long-term care facilities. At present, HSCSN considers Personal Care Aide (PCA) Services to be an LTSS service and requests for PCA trigger an LTSS assessment. Other covered services that may be considered broadly as LTSS include Private-Duty Nursing (PDN), Home Modifications, Respite Care, Skilled Nursing Facility (SNF), and Intermediate Care Facility (ICF) services.

Personal Care Aide (PCA) [C.3.198]: An individual who provides services through a Provider agency [Home Care Agency] to assist the patient in activities of daily living (i.e., bathing, dressing, toileting, ambulation, or eating). [In the District of Columbia, home care agencies may offer home health or personal care aide services and employ or contract with qualified home health or personal care aides to perform those services. A home health aide or personal care aide is qualified by completing seventy-five (75) hours of classroom and supervised practice training, with at least sixteen (16) hours devoted to supervised practical training, and by passing a competency evaluation.]

Personal Care Aide (PCA) services: PCA services are health-related services that are provided to individuals who are unable to perform one or more activities of daily living (ADL) such as bathing, dressing, grooming, toileting, ambulation, or feeding oneself, as a result of a medical condition or physical or cognitive impairment, causing substantial disability. In order to be eligible for PCA services, the enrollee needs to have a disability and require significant assistance in order to perform activities of daily living (ADLs) compared to other individuals of the same age.

Private-Duty Nursing (PDN): Private-Duty Nursing services are nursing services for technology-dependent enrollees who require long-term and more individualized and continuous care than is available from a visiting nurse under the Skilled Nursing Home

Health Services benefit [DCMR 29-947]. PDN is for technology-dependent enrollees who require continuous monitoring and/or frequent skilled nursing interventions on at least a daily basis, necessitating shifts of nursing care.

Prior Authorization or Pre-authorization (Authorization) [C.3.214]: The process used to determine whether to approve a treatment request involving services covered under the Contract.

Provider [C.3.215]: Under 42 C.F.R. § 400.203, any individual or entity that is engaged in the delivery of health care services or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services.

Rehabilitation Services and Devices [C.3.222]: Health care services that help a person keep, get back, or improve skills and functioning for daily living that has been lost or impaired because a person was sick, hurt, or disabled.

Requesting Provider: The Requesting Provider is either a treating physician or advanced practice registered nurse (APRN or nurse practitioner) who is appropriately licensed, and has had a prior professional relationship with the enrollee that included an examination(s) done in a hospital, primary care or other physician's office, nursing facility, or in the enrollee's home prior to the order for home care services.

Respite [C.3.226]: A CASSIP covered benefit designed to offer a short-term, intermittent period of relief for a parent, other non-paid caregivers, or person(s) who normally provide the primary care for and lives with a CASSIP Enrollee that has or is suspected of having needs that require constant monitoring, assistance with activities of daily living, and/or intense in-person supports.

Service Authorization Request [C3.240]: A request by a Provider or Enrollee for treatment involving one (1) or more Covered items and Services under the Contract.

Skilled Nursing Services: Medicaid reimburseable Skilled Nursing services are part-time or intermittent skilled nursing care services that are needed by an enrollee due to an illness or injury and are furnished by a licensed nurse (LPN or RN) in accordance with the enrollee's home health plan of care and through a licensed home care agency [DCMR 29-9901].

Utilization Management [C.3.270]: An objective and systematic process for planning, organizing, directing, and coordinating health care resources to provide Medically Necessary, timely, and quality health care services in the most cost-effective manner.

Utilization Review Criteria [C.3.271]: Detailed standards, guidelines, decision algorithms, models, or informational tools that describe the clinical factors to be considered relevant to making determinations of medical necessity including, but not limited to, level of care, place of service, the scope of service, and duration of service.

III. PROCEDURE

1) General Requirements for Home Health Services under DC Medicaid and HSCSN

A. In order to qualify for Medicaid reimbursement, Home Health Services must be:
    1. Ordered by a physician;

2. Provided at the enrollee's residence or in a setting in which normal life activities take place with exceptions of an ICF/IID as described in C below and school settings. HSCSN does not cover home care services provided in a school setting as they are specifically carved out of the CASSIP contract.
3. Delivered in accordance with a plan of care developed by a Registered Nurse (R.N.) under a process that meets the requirements Subsection 9900.11 of Chapter 99 of Title 29 DCMR.

B. Except as described in (C) below, and in accordance with 42 CFR § 440.70(c)(1), Home Health Services shall not be delivered in a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF/IID), or any setting in which payment is or could be made under Medicaid for enrollee services that include room and board.
C. Home Health services may be provided in an ICF/IID if the home health service is not provided as part of the facility's services as required under 42 CFR § 483.460.
D. An enrollee shall be eligible for Home Health Services if the following conditions are met:
    1. HSCSN receives an order for Home Health Services from the enrollee's physician establishing that the services are medically necessary in accordance with the requirements set forth in this policy; and
    2. HSCSN provides prior authorization in accordance with this policy.
E. In order for the services contained in the physician's order to be reimburseable by HSCSN, the order (or Plan of Care) must be signed and dated by a physician knowledgeable about the enrollee's needs and conditions and must state the amount, frequency, scope and duration of the service. The physician's signature on the order constitutes certification by the physician that the services ordered reflect the health status and needs of the enrollee, and that the enrollee is eligible for the service.
F. For all Home Health services, in order to be reimbursed the ordering physician shall:
    1. Document that a face-to-face encounter, related to the primary reason the enrollee requires Home Health Services, occurred between the enrollee and the health practitioner, within ninety (90) days of the start of services; and
    2. Indicate the name of the practitioner who conducted the face-to-face encounter and the date of the encounter on the order.
    3. The enrollee's physician shall approve the initial plan of care by signing it within thirty (30) calendar days of the development of the plan of care, and noting his or her license number and National Provider Identification number on the plan of care.
    4. The plan of care for services shall be reviewed, updated and signed by the physician at least every sixty (60) calendar days.
    5. All home health services described in the plan of care require prior authorization and approval by HSCSN in order to be reimbursed.
G. Home Health Services must be rendered through a Home Care Agency that meets the requirements of DC Medicaid and licensed in the jurisdiction in which services are rendered. Home Care Agencies providing services to enrollees under the age of 18 years in the District of Columbia must have a Pediatric Certificate of Need. The individual rendering services must also be licensed or certified as per the jurisdiction in which services are rendered.

2) Requirements for Specific Home Health Services (as defined by Title 29 DCMR Chapter 990)

A. **Skilled Nursing Services**

1. Skilled Nursing services are part-time or intermittent skilled nursing care services that are needed by an enrollee due to an illness or injury, and are furnished by licensed nurses in accordance with the enrollee's plan of care.
2. Skilled Nursing services consist of the following duties:
    a. Conducting initial assessments either prior to service provision or at the onset of care and reassessments at least every sixty (60) calendar days thereafter to develop and update a plan of care;
    b. Coordinating the enrollee's care and referrals among all Home Care Agency providers;
    c. Implementing preventive and rehabilitative nursing procedures;
    d. Administering medications and treatments as prescribed by a licensed practitioner as outlined under the plan of care;
    e. Recording progress notes at each visit and summary notes at least once every sixty (60) calendar days;
    f. Making necessary updates to the plan of care, and reporting any changes in the enrollee's condition to his or her physician;
    g. Instructing the enrollee on treatment regimens identified under the plan of care;
    h. Updating the physician on changes in the enrollee's condition and obtaining orders to implement those changes; and
    i. For R.N.s who supervise nursing services delivered by a skilled nurse (R.N. or L.P.N.) and services delivered by Home Health Aides and Personal Care Aides, duties shall include, at minimum, the following:
        1. Supervising the enrollee's skilled nurse and aide on-site, at least once every sixty (60) calendar days;
        2. Ensuring that new or revised physician orders have been obtained initially from the treating physician and then at least every sixty (60) calendar days thereafter, to promote continuity of care;
        3. Reviewing the enrollee's plan of care, including ensuring integration of other services into the plan of care;
        4. Monitoring the enrollee's general health outcomes, including taking vital signs, conducting a comprehensive physical examination, and determining mental status;
        5. Determining if the enrollee has any unmet medical needs;
        6. Ensuring that all home health services are provided safely and in accordance with the plan of care;
        7. Ensuring that the enrollee has received education on any needed services;
        8. Ensuring the safe discharge or transfer of the enrollee;
        9. Ensuring that the physician receives progress notes when the enrollee's health condition changes, or when there are deviations from the plan of care;
        10. Ensuring that a summary report of the visit is sent to the physician every sixty (60) calendar days; and
        11. Reporting any instances of abuse, neglect, exploitation or fraud to HSCSN, DHCF and other appropriate District government agencies, including the Department of Health, to promote a safe and therapeutic environment in accordance with 17 DCMR § 5414.

3. For Medicaid reimbursable services, the initial assessment to develop the plan of care and reassessments to update the plan of care shall only be conducted by an R.N. The R.N. conducting an initial assessment or periodic reassessment in accordance with 29 DCMR § 99 shall certify in writing that the statements made in the assessment are true and accurate.
4. Consistent with the Department of Health regulations at 22-B DCMR § 3917, Medicaid reimbursable Skilled Nursing services provided by an L.P.N. shall be supervised by an R.N.
5. When an L.P.N. provides Skilled Nursing services, the duties of the L.P.N. shall not include supervisory duties.
6. When an R.N. is supervising a skilled nurse (L.P.N. or R.N.) providing Medicaid reimbursable services, the R.N. shall monitor and supervise the services provided by the L.P.N., R.N., Home Health Aide, or Personal Care Aide, including conducting a site visit at least once every sixty (60) calendar days, or more frequently, if specified in the enrollee's plan of care.
7. The skilled nurse shall record progress notes during each visit which shall comply with the standards of nursing care established under 17 DCMR § 5414 and 5514, and which shall include the following information:
    a. Notations regarding any unusual health or behavioral events or changes in status;
    b. Notations regarding any matter requiring follow-up on the part of the service provider, HSCSN or DHCF; and
    c. A concise written statement of the enrollee's progress or lack of progress, medical conditions, functional losses, and treatment goals as outlined in the plan of care that demonstrates that the enrollee's services continue to be reasonable and necessary.
8. The skilled nurse shall prepare summary notes every sixty calendar (60) days summarizing the progress notes recorded at each visit and bringing attention to any matter requiring follow-up on the part of the Home Care Agency or HSCSN.
9. Skilled Nursing services shall be reimbursed by HSCSN for up to six (6) hours a day with prior authorization. Enrollees may also qualify for additional hours if they meet the requirements below. The need for continuing Skilled Nursing services shall be reassessed and certified by the physician at least every sixty (60) calendar days.
10. HSCSN may authorize additional hours of Skilled Nursing services above the six (6) hour per day limit for an enrollee if DHCF determines that:
    a. Additional hours are medically necessary as reflected on the physician's order;
    b. The enrollee's needs can be safely met in the home; and the enrollee's services are being delivered in a cost-effective manner appropriate to the enrollee's level of care.
11. Authorization of Skilled Nursing services is done according to procedures described in HSCSN policy UM_09, Authorization of Health Services.
12. Medical Necessity of Skilled Nursing services is evaluated using InterQual criteria. For requests for more than 4 hours per day, the request is sent for second-level review to an HSCSN medical director.
13. For initiation of Skilled Nursing services, an enrollee or his/her physician shall obtain prior authorization for the initiation of Skilled Nursing services by submitting a physician's order and relevant medical records to support the enrollee's need for Skilled Nursing services.

14. Skilled Nursing services may be provided without prior authorization for up to four (4) hours a day for a period not to exceed seven (7) calendar days only when the enrollee's need for Skilled Nursing services is immediate, such as an emergency situation or to ensure the safe and orderly discharge of the enrollee from a hospital or other facility to the enrollee's home. In those cases, post-service authorization needs to be requested.
15. A Home Care agency shall obtain prior authorization for continuing Skilled Nursing services every sixty (60) calendar days by submitting an updated Plan of Care and any supporting documentation to HSCSN to support the enrollee's need for ongoing Skilled Nursing services which align with the enrollee's assessed needs, as outlined in the updated plan of care.
16. Enrollees who receive shifts of Skilled Nursing services may not concurrently receive Private Duty Nursing services.
17. For enrollees who are technology-dependent and receiving long-term nursing services, private-duty nursing may be more appropriate.

B. **Home Health Aide Services**

1. Medicaid reimbursable Home Health Aide services are services that are required by an enrollee due to an illness or injury, and include assistance with activities of daily living, assistance with self-administered medications, or other clinical tasks to assist with the provision of nursing or skilled services such as cleaning around a feeding tube and assistance with oxygen therapy, on a part-time or intermittent basis.
2. Home Health Aide services consist of the following duties:
    a. Performing personal care including assistance with activities of daily living such as bathing, personal hygiene, toileting, transferring from the wheelchair, and instrumental activities such as meal preparation, laundry, grocery shopping, and telephone use;
    b. Changing urinary drainage bags;
    c. Assisting the enrollee with transfer, ambulation, and exercise as prescribed;
    d. Assisting the enrollee with self-administration of medication;
    e. Measuring and recording temperature, pulse, respiration, and blood pressure;
    f. Measuring and recording height and weight;
    g. Observing, recording, and reporting the enrollee's physical condition, behavior, or appearance;
    h. Preparing meals in accordance with dietary guidelines;
    i. Assisting with skills necessary for food consumption;
    j. Implementing universal precautions to ensure infection control;
    k. Performing tasks related to keeping the enrollee's living area in a condition that promotes the beneficiary's health and comfort;
    l. Changing simple dressings that do not require the skills of a licensed nurse;
    m. Assisting the enrollee with activities that are directly supportive of skilled therapy services;
    n. Assisting with routine care of prosthetic and orthotic devices;
    o. Emptying and changing colostomy bags and performing care of the stoma;
    p. Cleaning around a gastrostomy tube site;
    q. Administering an enema; and
    r. Assisting with oxygen therapy.

3. Home Health Aide services shall be reimbursed by HSCSN for up to eight (8) hours per day with prior authorization. The need for continuing Home Health Aide services shall be reassessed and certified by the physician at least every sixty (60) days.
4. HSCSN may authorize additional hours of Home Health Aide services above the eight (8) hour per day limit for an enrollee if HSCSN determines that:
    a. Additional hours are medically necessary as reflected on the physician's order;
    b. The enrollee's needs can be safely met in the home; and
    c. The enrollee's services are being delivered in a cost-effective manner appropriate to the enrollee's level of care.
5. An enrollee and his/her physician shall obtain prior authorization for the initiation of Home Health Aide services by submitting a physician's order which aligns with the enrollee's assessed needs. To support medical necessity the Requesting Provider submits medical records, including a note from a visit with the enrollee within 90 days of the order. The order for home health aide services should indicate the reasons for the service(s).
6. Authorization of Home Health Aide services is done according to procedures described in HSCSN policy UM_09, Authorization of Health Services.
7. Medical Necessity of Home Health Aide services is evaluated using InterQual criteria and if meets criteria, then the request can be approved for up to 60 days. For requests for more than 8 hours per day, the request is sent for second-level review to an HSCSN medical director.
8. The Home Care agency shall obtain prior authorization for continuing Medicaid reimbursable Home Health Aide services at least every sixty (60) calendar days by submitting an updated physician's order and any supporting documentation to HSCSN to support the enrollee's need for ongoing Home Health Aide services which aligns with the enrollee's assessed needs, as outlined in the updated plan of care.
9. The UMR will apply InterQual criteria for re-authorization requests for Home Health Aide services. All re-authorization requests are sent to an HSCSN medical director for second-level review.
10. If an enrollee is receiving Adult Day Health Program (ADHP) services under Chapter 97 of Title 29 DCMR on the same day that Home Health Aide services are delivered, the combination of Medicaid reimbursable ADHP and Home Health Aide services shall not exceed a total of twelve (12) hours per day.
11. An enrollee shall not receive Personal Care Aide (PCA) services under Chapter 42 or Chapter 50 of Title 29 DCMR and Home Health Aide services concurrently. Claims for PCA services submitted by a provider for any hour in which the enrollee was receiving Medicaid reimbursable Home Health Aide services shall be denied.
12. An enrollee in need of long-term assistance with activities of daily living may be more appropriate for Personal Care Aide services under Long-Term Supports & Services.

C. **Physical Therapy Services**

1. Medicaid reimbursable Physical Therapy services are skilled services designed to treat an enrollee's identified physical dysfunction or reduce the degree of pain associated with movement, injury or long-term disability. Physical Therapy services should also maximize independence and prevent further disability, maintain health, and promote mobility.

2. Medicaid reimbursable Physical Therapy services shall be provided in accordance with the enrollee's plan of care.
3. In accordance with the District's Medicaid State Plan, Physical Therapy is provided as part of a plan of care in a hospital, skilled care facility, intermediate care facility or through a Home Care Agency.
4. Medicaid-reimbursable Physical Therapy services shall be provided by a physical therapist with at least two (2) years of experience and licensed in accordance with the District of Columbia Health Occupations Revision Act of 1985, as amended, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 *et seq*.) and implementing rules, or licensed in the jurisdiction in which the services are rendered.
5. Medicaid-reimbursable Physical Therapy services shall consist of the following duties:
    a. Conducting an initial evaluation and assessment that summarizes the physician's order and documents the enrollee's strength, range of motion, balance, coordination, muscle performance, respiration, and motor functions;
    b. Developing and describing therapy plans which explain therapeutic strategies, rationale, treatment approaches and activities to support treatment goals;
    c. Maintaining ongoing involvement and consulting with other service providers and caregivers;
    d. Consulting and instructing the enrollee, family, or other caregivers on the therapy plan;
    e. Recording daily progress notes and summary notes at least quarterly, or more frequently as needed;
    f. Assessing the enrollee's need for the use of adaptive equipment;
    g. Routinely assessing (at least annually and more frequently as needed) the appropriateness, quality, and functioning of adaptive equipment to ensure it addresses the enrollee's needs;
    h. Accurately completing documentation required to obtain or repair adaptive equipment in accordance with established insurance, Medicare and Medicaid guidelines; and
    i. Conducting periodic examinations and modifying treatments for the enrollee receiving services and ensuring that Physical Therapy recommendations are incorporated into the plan of care.
6. Authorization of Physical Therapy services is done according to procedures described in HSCSN policy UM_09, Authorization of Health Services.
7. Medical Necessity of Physical Therapy services is evaluated using InterQual criteria and if meets criteria, then the request can be approved for up to 2 visits per week for 60 days. For requests for more than 2 visits per week, the request is sent for second-level to an HSCSN medical director.

D. **Occupational Therapy Services**

1. Medicaid reimbursable Occupational Therapy services are skilled services designed to maximize independence, gain skills, prevent further disability, and develop, restore, or maintain an enrollee's daily living and work skills.
2. Occupational Therapy services shall be provided in accordance with the enrollee's plan of care.
3. Occupational Therapy is provided as part of a plan of care in a hospital, skilled care facility, intermediate care facility or through a Home Care Agency.
4. Occupational Therapy services shall consist of the following duties:

a. Conducting an initial evaluation and assessment that:
    1. Summarizes the physician's order;
    2. Documents the enrollee's strength, range of motion, balance, coordination, muscle performance, respiration, and motor functions; and
    3. Reflects the enrollee's living and vocational goals;
b. Developing and describing therapy plans which explain therapeutic strategies, rationale, treatment approaches and activities to support treatment goals;
c. Consulting and instructing the beneficiary, family, or other caregivers on the therapy plan;
d. Recording daily progress notes and summary notes at least quarterly, or more frequently as needed;
e. Assessing the enrollee's need for the use of adaptive equipment;
f. Routinely assessing (at least annually and more frequently as needed) the appropriateness, quality, and functioning of adaptive equipment to ensure it addresses the enrollee's needs;
g. Completing documentation required to obtain or repair adaptive equipment in accordance with established insurance, Medicare and Medicaid guidelines;
h. Conducting and documenting quarterly assessments to verify the condition of the adaptive equipment; and
i. Conducting periodic examinations to modify treatments for the enrollee, when necessary, and ensure that Occupational Therapy recommendations are incorporated into the plan of care.

5. Authorization of Occupational Therapy services is done according to procedures described in HSCSN policy UM_09, Authorization of Health Services.
6. Medical Necessity of Occupational Therapy services is evaluated using InterQual criteria and if meets criteria, then the request can be approved for up to 2 visits per week for 60 days. For requests for more than 2 visits per week, the request is sent for second-level review to an HSCSN medical director.

E. **Speech Pathology & Audiology Services**

1. Medicaid reimbursable Speech Pathology and Audiology services are skilled therapeutic interventions to address communicative and speech disorders to maximize a enrollee's expressive and receptive communication skills and are intended to treat the enrollee's medical or non-medical communicative disorder.
2. Speech Pathology and Audiology services shall be provided in accordance with the enrollee's plan of care.
3. In accordance with the District of Columbia Medicaid State Plan, Speech Pathology and Audiology services shall be limited to enrollees eligible through the Early Periodic Screening Diagnostic Treatment (EPSDT) benefit.
4. In accordance with the District of Columbia Medicaid State Plan, Speech Pathology and Audiology services shall only be provided by a facility licensed to provide medical rehabilitation services or a Home Care Agency.
5. Speech Pathology and Audiology services shall consist of the following duties:
    a. Conducting a comprehensive assessment, which shall include the following:

1. A background review and current functional review of communication capabilities in different environments, including employment, residence, and other settings in which normal life activities take place;
2. An evaluation of the enrollee's potential for using augmentative or alternative speech devices, methods, or strategies;
3. An evaluation of the enrollee's potential for using sign language or other expressive communication methods; and
4. A needs assessment for the use of adaptive eating equipment.

b. Developing and implementing the treatment plan that describes treatment strategies including, direct therapy, training caregivers, monitoring requirements, monitoring instructions, and anticipated outcomes;
c. Assisting enrollees with voice disorders to develop proper control of vocal and respiratory systems for correct voice production, if applicable;
d. Conducting aural rehabilitation by teaching sign language and/or lip reading to people who have hearing loss, if applicable;
e. Recording daily progress notes and summary notes at least quarterly, or more frequently as needed;
f. Conducting periodic examinations, modifying treatments for the beneficiary receiving services and ensuring that the recommendations are incorporated into the Plan of Care; when necessary; and
g. Conducting discharge planning.

6. Authorization of Speech Pathology & Audiology services is done according to procedures described in HSCSN policy UM_09, Authorization of Health Services.
7. Medical Necessity of Speech Pathology & Audiology services is evaluated using InterQual criteria and if meets criteria, then the request can be approved for up to 2 visits per week for 60 days. For requests for more than 2 visits per week, the request is sent for second-level review to an HSCSN medical director.

3) Private-Duty Nursing (PDN) Services

A. Private Duty Nursing Services are services for technology-dependent enrollees. These enrollees require more individualized and continuous care than is available from a visiting nurse under the Skilled Nursing benefit.
B. Eligibility
    1. PDN services must be ordered by a physician and provided in the enrollee's residence and community in accordance with a Plan of Care developed by a Registered Nurse.
    2. For PDN services to be reimbursed:
        a. There must be an order for Private Duty Nursing services from the enrollee's physician certifying that the services are medically necessary in accordance with HSCSN medical necessity criteria.
        b. There must be a Plan of Care developed by an RN and signed by the prescriber within 30 days of the start date of the Plan or Care.
        c. A prior authorization from HSCSN must have been obtained.
    3. Authorization of PDN services is done according to procedures described in HSCSN policy UM_09, Authorization of Health Services.

4. For the initial authorization of PDN, the prescribing physician must submit
    a. Documentation that a face-to-face encounter with the prescribing physician, related to the primary reason the enrollee requires PDN services, occurred within ninety (90) days of the order.
    b. An inpatient attending may conduct the face-to-face visit for those enrollees receiving PDN immediately after acute or post-acute stay in a facility.
    c. An HSCSN order form (or an order with the same information) as well as medical records including a note from a visit within 90 days of the order.
5. PDN services are considered medically necessary only if an enrollee is technology-dependent. An enrollee is only considered technology-dependent if the enrollee meets the following criteria:
    a. The enrollee is dependent on a ventilator or other positive pressure ventilation.
    b. The enrollee has a tracheostomy, or
    c. The enrollee requires enteral tube feeding or
    d. The enrollee requires parenteral nutrition or other IV infusion at home, or
    e. The enrollee has other technology that is life-sustaining and requires a skilled caregiver to use it, and
    f. Constant supervision and monitoring by a skilled caregiver is required by both the enrollee and the technology.
6. Medical necessity is determined by HSCSN using InterQual Criteria for PDN and second-level review by an HSCSN medical director based on the HSCSN definition of medical necessity
7. Authorized hours of PDN per day are based on the recommendation using InterQual criteria plus:
    a. An additional eight (8) hours to relieve family caregivers when an awake and alert caregiver is medically necessary at all times.
    b. Additional hours for enrollees who need skilled intervention and/or monitoring while the primary caregiver works or attends school. Private duty nursing hours provided will be up to the number of hours that the primary caregiver is at work/school plus one hour travel time. Written documentation of the work/school hours (including times) must be submitted with the PDN request. If additional travel time is needed beyond one hour, documentation must be provided to justify the increase.
    c. No more than 20 hours per day (140 hours per week) will be authorized except under extraordinary circumstances and with second-level review by an HSCSN medical director.
8. Each enrollee who receives PDN must have a primary caregiver who:
    a. Lives with the enrollee and is willing to be trained in all aspects of the enrollee's care.
    b. Accepts responsibility for the enrollee's health, safety and welfare.
    c. Has the ability and availability to be trained to care for the enrollee and assume a portion of the care (minimum of 4 hours per day).
    d. Is willing to provide direct care to the enrollee during planned and unplanned times when a nurse is not available.

9. Requests for re-authorization of PDN are submitted by the home care agency rendering services and must be submitted prior to the start of the next authorization (certification) period.
    a. Documents to be submitted with re-authorization requests:
        1. Updated Home Health Plan of Care
        2. Last two nursing supervisory notes
        3. Two weeks of nursing progress notes
        4. Start and End Dates for services
        5. Procedure codes requested and units

C. Requirements
1. The Home Care Agency must be enrolled with DC Medicaid and meet the requirements as outlined in section 947.15 of Title 29 DCMR Chapter 9.
2. PDN services are provided by an R.N. or licensed practical nurse (L.P.N.) licensed in accordance with the DC Health Occupations Revision Act.
3. The Home Care Agency is responsible for the following:
    a. Conducting an initial assessment and periodic re-assessments at least every sixty (60) calendar days to develop and update a plan of care.
    b. Coordinating the enrollee's care and referrals among all Home Care Agencies involved.
    c. Implementing preventive and rehabilitative nursing procedures.
    d. Administering medications and treatments as prescribed by a licensed physician, pursuant to the DC Health Occupations Revision Act.
    e. Recording daily progress notes and summary notes at least once every sixty (60) calendar days.
    f. Making necessary updates to the plan of care, and reporting any changes in the enrollee's condition to his or her prescribing physician.
    g. Instructing the enrollee or caregivers on treatment regimens included in the plan of care.
    h. Obtaining physician orders to implement any changes in the plan of care.
4. HSCSN will not reimburse a home care agency for concurrent (at the same time) delivery of PDN and PCA unless it is demonstrated that the concurrent services are medically necessary to maintain the enrollee's health and safety as determined by HSCSN and prior authorization is given. When a second caregiver is needed intermittently for care with the nurse, it is expected that family caregivers will meet the need for a second caregiver.
5. HSCSN will not reimburse a home care agency for concurrent delivery of PDN and skilled nursing services.

4) Requirements of Supervisory Nurses

A. For R.N.s who supervise services delivered by a home care agency including Skilled Nursing, Home Health Aide services, Private Duty Nursing or Personal Care Aide services, duties include, at the minimum, the following:
1. Supervising the enrollee's skilled nursing and aide on site, at least once every sixty (60) calendar days.
2. Ensuring that new or revised physician orders have been obtained form the treating physician initially, as needed, and every sixty (60) calendar days thereafter, to promote continuity of care.
3. Reviewing the enrollee's plan of care.

4. Monitoring the enrollee's general health outcomes, including taking vital signs, conducting a physical examination, and determining mental status.
5. Determining if the enrollee has any unmet needs.
6. Ensuring that all home health services are provided safely and in accordance with the plan of care.
7. Ensuring that the enrollee has received education on any needed services.
8. Ensuring the safe discharge or transfer of the enrollee.
9. Ensuring that the physician receives progress notes when enrollee's health condition changes, or when there are deviations from the plan of care.
10. Ensuring that a summary report of the visit has been sent to the physician every sixty (60) calendar days.
11. Reporting any instance of abuse, neglect, exploitation or fraud to HSCSN and other appropriate DC government agencies, to promote a safe and therapeutic environment in accordance with 17 DCMR § 5414.

5) Other Requirements for Home Care Services

A. Services not covered include:
   1. Services that are not medically necessary.
   2. Services that duplicate or supplant what the enrollee's caregivers can provide.
   3. Services that are provided for enrollee or caregiver convenience.
   4. Services that are provided without RN supervision.
   5. Home care services while the enrollee is in school.
   6. Observation "in case something happens" or "stand-by" care in the event the participant might need nursing such as in with seizures, asthma exacerbations, or aspiration.
   7. Custodial services
   8. Companion care
   9. Homemaker services

B. Possible reasons for HSCSN to terminate home care services (end authorization):
   1. The enrollee is no longer eligible for HSCSN or Medicaid.
   2. The Enrollee/caregiver requests termination of services.
   3. The place of service is considered unsafe for the provision of home care services.

C. The enrollee or other persons in the household subject the provider to physical or verbal abuse, sexual harassment, and/or exposure the use of illegal substances, illegal situations or threats of physical harm.
   1. The enrollee refuses services based solely or partly on the race, religion, gender, marital status, color, age, disability or national origin of the home care staff.
   2. The home care agency is no longer able to provide services as authorized (i.e. no qualified staff available).

IV. ACCOUNTABLE EXECUTIVE(S) AND REVIEWER(S)

A. Accountable Executive(s): Levey, Eric

B. Committee(s) Responsible for Review: Benefits and Utilization Management Committee

V. APPROVAL

Approved by:

Levey, Eric — Date

VI. REFERENCES

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References:
NCQA Standards: N/A
CN Documents/Policies: N/A
CASSIP Contract Sections: C.3
Federal Regulations: 42 C.F.R. § 440.70; 42 CFR § 440.80; 42 C.F.R. § 440.167; 42 CFR § 483.460
District Regulations: Title 29 (Public Welfare) Chapter 99 (Home Health Services) of DCMR;17 DCMR § 5414; Title 29 DCMR Chapter 990
Transmittals: N/A
Internal Policies: UM_13, UM_17, UM_20
Internal Documents: N/A
Committees: Benefits and Utilization Management Committee