



CHAPTER 508 HOME HEALTH

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DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

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BACKGROUND

A West Virginia Medicaid enrolled home health agency provides medically necessary and appropriate services such as skilled nursing (SN), home health aide (HHA), physical therapy (PT), speech therapy (ST), occupational therapy (OT), certain medically necessary supplies, other therapeutic services, and nutritional services to members that require nursing facility level of care on a part-time or intermittent basis.

POLICY

508.1 PROVIDER ENROLLMENT

In order to participate in the WV Medicaid Program and receive payment from the Bureau for Medical Services (BMS), home health agencies must meet the following conditions in addition to requirements set forth in [Chapter 300, Provider Participation Requirements](#):

- Must have certification for participation in Title XVIII, Medicare, by the appropriate certifying agency in the State where the agency is located. (In West Virginia, the [Office of Health Facility Licensure and Certification \(OHFLAC\)](#) in the Department of Health and Human Resources is the certifying agency.)
- Must be approved for Medicare participation before requesting an application from Medicaid for enrollment as a provider. The home health agency must send a copy of approval as a Medicare provider along with the rate of reimbursement set by Medicare for each service which has been approved by Medicare. A change in the Medicare rate and/or services provided must be submitted on the Medicare letterhead to the Medicaid agency.

Providers must ensure that all required documentation is maintained at the agency on behalf of the State of West Virginia and accessible for state and federal audits.

508.2 HOME HEALTH STAFF FINGERPRINT-BASED BACKGROUND CHECK REQUIREMENTS, RESTRICTIONS AND MEDICAID EXCLUSION LIST

At a minimum, a state level fingerprint-based background check, must be conducted by the West Virginia State Police initially and again every three years for all home health provider staff providing direct care services to members including direct-care personnel. If a prospective or current employee has lived out of state within the last five years, an FBI fingerprint-based criminal history check must also be conducted and repeated every 3 years.

Prior to providing home health services, required fingerprint-based checks must be initiated. Home health providers may do a preliminary named-based check utilizing on-line internet companies and use these results until the fingerprint results are received. An individual who is providing direct care services by a home health provider cannot be considered to provide services if ever convicted of:

- Abduction

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- Any violent felony crime including but not limited to rape, sexual assault, homicide, felonious physical assault or felonious battery
- Child/adult abuse or neglect
- Crimes which involve the exploitation, including financial exploitation, of a child or an incapacitated adult
- Any type of felony battery
- Felony arson
- Felony or misdemeanor crime against a child or incapacitated adult which causes harm
- Felony drug related offenses within the last 10 years
- Felony Driving Under the Influence (DUI) within the last 10 years
- Hate crimes
- Kidnapping
- Murder/ homicide
- Neglect or abuse by a caregiver
- Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexually explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, legal representative or custodian, depicting a child engaged in sexually explicit conduct
- Purchase or sale of a child
- Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure
- Healthcare fraud
- Felony forgery

Fingerprint-based background check results, other than those listed above, which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the licensed home health provider before placing an individual in a position to provide services to the member.

If aware of a recent conviction or change in status of an agency staff member providing home health services, the home health provider must take appropriate action, including notification to the BMS Home Health Program Manager within 48 hour period of discovery.

The Federal Office of Inspector General (OIG) Exclusion List must be checked for every agency employee who provides Medicaid services prior to employment and monthly thereafter. Persons on the OIG Exclusion List cannot provide Medicaid services. This list can be obtained at <http://exclusions.oig.hhs.gov>.

A copy of the OIG Exclusion List check for each individual must be printed out and kept in a file for review by the BMS if requested.

All payments for services provided by excluded providers or employees will be recovered by BMS.

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508.3 MEMBER CERTIFICATION AND ELIGIBILITY

Coverage for medically necessary and appropriate home health agency services is available on behalf of all West Virginia eligible Medicaid members subject to the conditions and limitations that apply to these services. For more information regarding these requirements refer to [42 CFR §424.22](#).

508.3.1 Face-to-Face Certification Requirements

The physician responsible for performing the initial certification must document that a face-to-face encounter with the eligible member prior to ordering the provision of home health services has occurred no more than ninety (90) days prior to the home health start of care date or within thirty (30) days of the start of the home health care. The date of the encounter must be included in the certification documentation. For medical review purposes, documentation is required in the certifying physician's medical records and/or the acute/post-acute care facility's medical records (if the patient was directly admitted to home health) to be used as the basis for certification of patient eligibility.

This face-to-face encounter must be conducted by the physician, an advanced practice registered nurse, or a physician assistant under the supervision of the physician. A face-to-face encounter is required for certification any time a new start of care assessment is completed to initiate care for the home health services.

The non-physician practitioner performing the face-to-face encounter must document the clinical findings of that face-to-face patient encounter and communicate those findings to the certifying physician. The documentation of the face-to-face encounter must be a separate and distinct section of the medical record and must be clearly titled, dated and signed by the certifying physician.

Home health agencies must establish internal processes to comply with the face-to-face encounter requirement mandated by the Patient Protection and Affordable Care Act for purposes of certification of a member's eligibility for Medicaid covered home health services.

If a Home Health Agency claim is denied, the corresponding physician claim for certifying/re-certifying patient eligibility for Medicare-covered home health services is considered non-covered as well because there is no longer a corresponding claim for Medicare-covered home health services.

508.3.2 Member Eligibility

The member must have a need for nursing facility level services including: a need for skilled nursing care on an intermittent basis, or physical therapy, or speech-language pathology services, or have a continued need for occupational therapy.

The member may receive skilled nursing visits if only a registered nurse or licensed practical nurse can provide the service, as certified by a physician, thus allowing the member to be in the community rather than be institutionalized for nursing facility level of services.

There are no age restrictions for members who are eligible to receive home health services.

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508.4 COVERED SERVICES AND GUIDELINES

The West Virginia Medicaid Home Health Program does not follow the Medicare guideline definition for homebound status.

All home health services that exceed 60 visits in a calendar year require prior authorization. Please see [Section 508.10, Prior Authorization](#) for additional information.

A lack of transportation does not justify the need for home health services. Please refer to [Chapter 524, Transportation](#) of the BMS Provider Manual for information on how to obtain this service.

BMS will pay for medically necessary and appropriate home health agency services provided to eligible Medicaid members by a Medicaid enrolled home health agency.

Skilled nursing visits (SNV) must be provided for Medicaid eligible members who have a need for nursing facility level services if only a registered nurse or licensed practical nurse can provide the service. Documentation must clearly indicate the need for the service. Examples of this type of SNV include but are not limited to: IV infusions, central line dressing changes, and sterile dressing changes for wounds with the application of a prescribed medication.

Infants discharged from a neonatal intensive care unit that need nursing facility level services may receive skilled nurse visits for observation and education for the caregivers as appropriate. Documentation must clearly indicate the need for these visits. This documentation must include the mental status of the caregiver.

Home health services may be provided to members who need nursing facility level of care if the normal caregiver is unavailable to provide the care for a short period of time. The home health visits must not duplicate services received from other sources.

A member with a psychiatric disorder who needs nursing facility level services may be eligible for home health services because his/her illness is manifested in part by a refusal to leave his/her place of residence in the community, or cannot leave his/her place of residence unattended due to safety reasons, even if he/she has no physical limitations. The home health services must be provided by a skilled psychiatric nurse. The diagnosis and rationale for nursing facility level services must be made by a psychiatrist. The following conditions may result in the member's inability to leave their place of residence:

- Agoraphobia, paranoia, or panic disorder; or
- Disorders of thought processes wherein the severity of delusions, hallucinations, agitation and/or impairment of thoughts/cognition grossly affect the member's judgment and decision making and therefore the member's safety; or
- Acute depression with severe vegetative symptoms.

The skilled psychiatric nurse must provide all required services for the member with a psychiatric disorder. Many members, who require the services of a skilled psychiatric nurse, also require skilled nursing care related to a physical illness. Therefore, the psychiatric nurse must also have medical and surgical nursing experience to ensure that all the member's home care needs are met. Counseling services may

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be provided by a trained psychiatric nurse. These services should not be duplicative, and concurrent counseling or psychotherapy services by multiple providers are not medically necessary.

Skilled nursing, physical therapy, occupational therapy, and speech-language pathology home health services must be reasonable and necessary for the diagnosis and treatment of the illness or injury within the context of the member's unique medical condition. To determine if the services are reasonable and necessary, the following items will be considered by the UMC:

- The diagnosis is never to be the sole factor in determining medical necessity.
- The determination of medical necessity of the services must be based upon the member's unique condition, whether it is acute, chronic, terminal, or expected to continue over a long period of time, and in some cases if the condition is stable.
- The services are intermittent.
- Documentation must be reasonable, support the establishment of medical necessity, and should clearly define the member's unique circumstance that justifies provision of these services.
- Documentation must be clear, specific, and measurable.
- All professional licensed service orders and notes must be signed and dated.

Any therapy services offered by the Home Health Agency directly or under arrangement are given by a qualified therapist or by a qualified therapy assistant under the supervision of a qualified therapist and in accordance with the plan of care. The qualified therapist assists the physician in evaluating level of function, helps develop the POC (revising it as necessary), prepares clinical and progress notes, advises and consults with the family and other agency personnel, and participates in in-service programs (In accordance with [42 CFR §484.32](#)).

It is the responsibility of the provider to maintain the plan of care (POC) form, (CMS-485 & CMS-486) or the agency's POC form of their choosing, and OASIS assessments on file. Home health agencies must have all required POC data elements in a readily identifiable location within the medical record. Home health visits are subject to post-payment audit.

508.4.1 Skilled Nursing Visit

Revenue Code: 0551

Service Unit: Visit

Service Limit: 60 visits per calendar year in any combination with PT, OT, ST, and HHA services

Definition: Skilled nursing components are the assessment, judgment, intervention, and evaluation of interventions by a licensed registered nurse (RN) or a licensed practical nurse (LPN) under the supervision of the RN, and in accordance with the plan of care (POC).

Skilled nursing visits are covered when provided by a RN or LPN, here in after referred to as a skilled nurse. An RN must complete the initial assessment visit and shall appropriately supervise the LPN within the scope of the West Virginia Board of Nursing rules and regulations.

The initial assessment visit by an RN must be held either within 48 hours of referral or within 48 hours of the member's discharge from a nursing facility, or on the physician-ordered start of care date.

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A RN must complete the comprehensive assessment that also incorporates the use of the current version of Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary of the US Department of Health and Human Services (In accordance with [42 CFR §484.55](#)).

The comprehensive assessment must be completed in a timely manner, consistent with the member's immediate needs, but not later than 5 days after the start of care (In accordance with [42 CFR §484.55](#)).

Services must be medically necessary and reasonable for the diagnosis and treatment of the member's illness or injury. The services include:

- a) Observation, assessment, and evaluation of the member's condition when only the specialized skill and training of a RN or LPN can determine the member's medical status or changes in the member's medical status
- b) Management and evaluation of the member's POC to ensure that the care is achieving its purpose including possible modifications of treatment and/or initiation of additional medical procedures as identified by the RN.
- c) Teaching and training activities by a skilled nurse are covered when it is necessary to teach a member, family member or caregiver how to manage the treatment regimen and the skill being taught is reasonable and necessary to the treatment of the illness, injury or functional loss. There is no requirement that the member, family member or other caregiver be taught to provide a service if the member, family member or caregiver cannot or chooses not to provide the care.

When documentation indicates a reasonable potential for a complication or further acute episode, RN visits for observation and assessment will be covered for a maximum of three weeks from the start of care. Visits may be covered longer if there remains a reasonable potential for such a complication or acute episode. Documentation in the medical record must clearly indicate a change in the health status (e.g. atypical fluctuation of vital signs) for observation and assessment to continue as a skilled service.

In all cases, documentation of the member's mental status must clearly indicate why the member cannot be educated to provide the skilled care. Additionally, if there are others in the household who might be able to provide care, documentation must indicate why these individuals cannot provide the care or are unwilling to do so.

508.4.2 Home Health Aide Services

Revenue Code: 0571

Service Unit: Visit

Service Limit: 60 visits per calendar year in any combination with SN, PT, OT, and ST services

Definition: A person specially trained to assist sick, disabled, infirm, or frail persons at their place of residence in the community when no family member is fully able to assume this responsibility.

The Home Health Agency must use employees who meet the personnel qualifications specified in accordance with [42 CFR §484.4, Home Health Aide](#) and [42 CFR §484.36, Conditions of Participation: Home Health Aide Services](#).

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Home health aide services are ordered by the member's attending physician and delivered according to a plan of care (POC) that is established by the RN, PT, OT, or ST, and authorized by the attending physician.

The home health aide service is provided under the professional supervision of an RN or licensed therapist (PT/OT/ST) in accordance with the federal conditions of participation ([42 CFR §484.36](#)).

Home health aide services help maintain a member's health and facilitate treatment of the member's illness or injury. Typical tasks include:

- a) Assisting a member with activities of daily living (ADLs) such as bathing, caring for hair and teeth, eating, exercising, transferring, and elimination;
- b) Assisting a member in taking self-administered medications that do not require the skills of a licensed nurse to be provided safely and effectively;
- c) Assisting with home maintenance that is incidental to a member's medical care needs, (e.g. light cleaning, preparing meals, taking out trash, and shopping for groceries); and,
- d) Performing simple delegated tasks such as taking a member's temperature, pulse, respiration, and blood pressure; weighing the member; changing dressings that do not require the skills of a licensed nurse; and reporting changes in the member's condition and needs to an appropriate health care professional,

Home health aide training must follow standards listed in [42 CFR §484.36](#) with classroom and supervised practical training totaling at least 75 hours, with at least 16 hours devoted to supervised practical training. Then, the individual being trained must complete at least 16 hours of classroom training before beginning the supervised practical training.

508.4.3 Speech-Language Pathology Therapy Services

Revenue Code: 0441

Service Unit: Visit

Service Limit: 60 visits per calendar year in any combination with SN, PT, OT, and HHA services

Definition: Speech Therapy services are furnished only by or under supervision of a WV licensed speech pathologist or audiologist to treat speech and language disorders that result in communication disabilities. The services are also provided to treat swallowing disorders (dysphagia), regardless of the presence of a communication disability (In accordance with [42 CFR §484.32](#)).

Also see [Chapter 530, Speech and Audiology Services](#)

508.4.4 Physical Therapy

Revenue Code: 0421

Service Unit: Visit

Service Limit: 60 visits per calendar year in any combination with SN, OT, ST, and HHA services

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Definition: Physical Therapy services are covered when provided by a WV licensed physical therapist (PT) or a licensed physical therapy assistant (PTA) under the direction of a licensed PT. These services help relieve pain; restore maximum body function; and prevent disability following disease, injury, or loss to a part of the body.

Services furnished by a qualified physical therapy assistant may be furnished under the supervision of a qualified physical therapist. A physical therapy assistant performs services planned, delegated, and supervised by the therapist, assists in preparing clinical notes and progress reports, and participates in education of the member and family, and in-service programs (In accordance with [42 CFR §484.32\(a\)](#)).

Also see [Chapter 515, Occupational and Physical Therapy Services](#)

508.4.5 Occupational Therapy

Revenue Code: 0431

Service Unit: Visit

Service Limit: 60 visits per calendar year in any combination with SN, PT, ST, and HHA services

Definition: Occupational Therapy services are covered when provided by a WV licensed occupational therapist (OT) or by a licensed occupational therapy assistant under the direction and supervision of a licensed OT. Services help improve and restore functions impaired by illness or injury. When a member's functions are permanently lost or reduced, occupational therapy helps improve the member's ability to perform the tasks needed for independent living.

Services furnished by a qualified occupational therapy assistant may be furnished under the supervision of a qualified occupational therapist. A qualified occupational therapy assistant performs services planned, delegated, and supervised by the therapist, assists in preparing clinical notes and progress reports, and participates in education the member and family, and in in-service programs (In accordance with [42 CFR §484.32\(a\)](#)).

Also see [Chapter 515, Occupational and Physical Therapy Services](#)

508.5 BILLING PROCEDURE

All claims must be billed using the UB04 or the equivalent electronic format to the BMS Fiscal Agent. Only revenue codes are required to be submitted on claim form. The BMS Fiscal Agent contact information can be found on the [Home Health Services website](#).

508.6 REIMBURSEMENT METHODOLOGY

Medicaid reimbursement of Medicare certified home health services shall be based on 90% of the Medicare established low-utilization payment adjustment (LUPA) per visit rate by discipline or the provider's charge, whichever is less. The calculated LUPA rates will include an applicable Core-Base Statistical Area (CBSA) wage index adjustment for the county in which the provider has its initially assigned physical location. If services are rendered to members outside that initially assigned county, payments will be limited to the provider's LUPA rates with no payment recognition for any difference between county wage indexes. The LUPA rate will be adjusted in accordance with Medicare's

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scheduled adjustments. LUPA per visit payment amounts are considered payment-in-full. All private and governmental providers are reimbursed according to the same published fee schedule in accordance with the [WV State Plan, Attachment 4.19 page 5, Home Health Services, 7a,b,and c.](#)

508.7 MEDICAL SUPPLIES

For information or questions regarding home health covered medical supplies, refer to [Chapter 506 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies \(DMEPOS\)](#).

Certain medical supplies are covered for home health when they are:

- a) Ordered by a physician,
- b) Documented in the member's plan of care,
- c) Medically necessary as part of the member's home health care,
- d) Reasonable for use in the home, and
- e) Listed on the comprehensive Covered Medical Supplies List found in [Chapter 506, Durable Medical Equipment, Prosthetics, Orthotics, and Supplies \(DMEPOS\)](#) of the BMS Provider Manual. Those supplies covered by Home Health are identified in [Appendix 506A \(Covered DME Supplies\)](#) in the column labeled Home Health.

Medical supplies are separated into three categories:

- Routine (non-billable): Supplies that are customarily used in small quantities during the usual course of most home visits. They are usually included in the staff's supplies and are not designated for a specific member. These supplies, such as alcohol swabs or gloves, are included in the cost per visit of home health care services.
- Non-Routine (billable): Supplies that are needed to treat a member's specific illness or injury in accordance with the physician's plan of care. The item must be directly identifiable to the member, the cost of the item can be identified and accumulated in a separate cost center, and the item is furnished at the direction of the member's physician and is specifically identified in the plan of care, i.e., the item is needed to treat a member's specific illness. The home health agency must also follow a consistent charging practice for Medicaid and non-Medicaid members receiving the item.
- Non-Covered: Supplies that are not covered under the Medicare home health benefit. Home health agencies cannot bill for these supplies and the cost of the supplies cannot be included as a part of the services provided. Comfort and convenience items are non-covered as well as program exclusions such as over the counter medications; prescription drugs and biologicals (e.g. blood components).

Home health agencies must use reasonable quantities of the least costly product which will adequately meet the needs of the member. Limited amounts of medical supplies may be left with the member between visits where repeated applications are required and rendered by the member or other caregivers.

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508.8 SERVICE LIMITATIONS

Service limitations governing the provision of all WV Medicaid services will apply pursuant to [Chapter 100, General Administration and Information](#), of the BMS Provider Manual. In addition, the following limitations also apply to the requirements for payment of home health agency services described in this chapter.

- Home health agency services are covered when provided by Medicare certified/Medicaid enrolled home health agencies. Only Medicare approved services are reimbursable.
- Services and supplies must be provided pursuant to a physician's written order which details the member-specific plan of care.
- Home health aide services will not be covered unless the member requires skilled nursing services, physical therapy services, speech-language pathology services, or has a continued need for occupational therapy services. Newborn home health care will not be covered unless there is a diagnosis and/or condition that require intermittent skilled nursing services.

508.9 SERVICE EXCLUSIONS

Home health agency services are covered when provided by Medicare certified/Medicaid enrolled home health agencies only for those services for which they have been approved with the following exception: WV Medicaid does not follow the Medicare criteria for "homebound" status. Medicare requires a member to be homebound and Medicaid does not.

In addition to the exclusions listed in to [Chapter 100, General Administration and Information](#), of the BMS Provider Manual, the BMS will not pay for the following services as a home health benefit:

- Services not directly related to the member's diagnosis, symptoms, or medical history
- Duplicative services provided to members receiving benefits through the Home and Community-Based Aged/Disabled Waiver (ADW) Program
- Duplicative services provided to members receiving benefits through the Home and Community-Based Intellectual and/or Developmental Disabilities Waiver (IDDW) Program
- Duplicative services provided to members receiving benefits through the Home and Community-Based Personal Care Services (PCS) Program
- Duplicative services provided to the members receiving benefits through the Home and Community-Based Traumatic Brain Injury Waiver (TBIW) Program
- Duplicative services provided to members receiving benefits of the Hospice program
- Services provided to members receiving duplicative services from a behavioral health or community provider
- Custodial care
- Telephone consultations
- Missed appointments, including but not limited to, canceled appointments and appointments not kept
- Time spent in preparation of reports
- Experimental services or drugs

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508.10 PRIOR AUTHORIZATION

The initial 60 visits do not require prior authorization; however the home health provider must register the member's initial 60 visits with the BMS UMC. The member must meet the medical necessity requirements; including documentation of admitting diagnoses and verification of medical necessity. The total 60 visits may include any combination of the following home health services: skilled nurse visits (SNV), physical therapy (PT), occupational therapy (OT), speech-language pathology (ST), and home health aide (HHA). All visits provided will be subject to disallowance upon review if medical necessity requirements are not met.

Home health agencies must obtain additional authorization from the BMS Utilization Management Contractor (UMC) for home health services that exceed the initial 60 visits. There are no age restrictions for members who are eligible to receive home health services.

Prior authorizations must be:

1. Obtained by the supervising physician or non-physician practitioner;
2. Individualized to meet the member's specific needs; and
3. Authorized by the BMS Utilization Management Contractor (UMC).

Prior Authorization must be requested within ten (10) business days of the requested service start date for the authorization. Services may be initiated prior to receipt of the initial authorization based on member need. Appropriate documentation of diagnosis is required for the initial registration (first 60 visits) in the calendar year. Subsequent authorization junctures in the calendar year (if 60 visits are exceeded) require additional documentation of medical necessity to exceed initial limits.

508.11 CARE PLAN OVERSIGHT (CPO)

Care plan oversight (CPO) consists of physician supervision of members receiving home health or hospice care when the member requires complex or multidisciplinary care modalities with ongoing physician involvement.

The BMS provides payment for one (1) CPO service per member per calendar month.

CPO services are also not payable to physicians having a 5% or greater ownership interest in or a relationship with a home health agency or hospice provider that is directly providing services to Medicaid members.

The physician who bills for CPO services must be the same physician who signed the home health or hospice plan of care.

508.12 COORDINATION OF CARE AND PAYMENT LIMITS

Home health agency providers must determine whether Medicaid eligible members referred for home health agency services are authorized to receive similar services under other Medicaid programs or benefits. Home health agency providers must coordinate the provision of home health agency

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services with other Medicaid service providers in order to avoid duplication of similar services and subsequent disallowance of payments.

Requirements for coordination of care and payment limits for specific services are described in this section for the following benefits:

- Hospice
- Home and Community-Based Intellectual and/or Developmental Disabilities Waiver (IDDW) Program
- Home and Community-Based Aged and Disabled Waiver (ADW) Program
- Home and Community-Based Traumatic Brain Injury Waiver (TBIW) Program
- Personal Care Services (PCS) Program
- Children with Special Health Care Needs (CSHCN)

508.13 HOSPICE

Members who have elected to receive services through a hospice agency are not eligible to receive services through a home health agency. Medical care and case management of members receiving hospice services are the responsibility of the hospice agency. Home health agency services provided to hospice members must be coordinated by the hospice agency. Documentation of the referral from the hospice physician must be maintained in the member's records of both the hospice agency and the home health agency. Please refer to [Chapter 509, Hospice Services](#) for additional information.

508.14 INTELLECTUAL AND/OR DEVELOPMENTAL DISABILITIES WAIVER (IDDW)

Members who have been determined eligible for and are enrolled in the Home and Community-Based Intellectual and/or Developmental Disabilities Waiver (IDDW) Program may receive services from a home health agency that do not duplicate IDDW services. An agreement between the IDDW coordination agency and the home health agency must be on record. The need for home health agency services must be documented in the member's Individual Program Plan (IPP). Documentation of the referral from the members attending physician must be maintained in the member's records of both the IDDW Program coordination agency and the home health agency. Refer to [Chapter 513, Intellectual and/or Developmental Disabilities Waiver Services](#) for additional information.

508.15 AGED AND DISABLED WAIVER (ADW)

Members who have been determined eligible for and are enrolled in the Home and Community Based Aged and Disabled Waiver (ADW) Program may receive services from a home health agency that do not duplicate ADW services. Home health agency services provided to the ADW member must be coordinated by the ADW case management agency, and in general may only include skilled nursing care or therapy services for post-hospitalization stays or acute episodes of chronic conditions. The need for home health services must be documented in the member's plan of care (POC). Documentation of the referral from the members attending physician must be maintained in the member's records of both the ADW agency and the home health agency. Please refer to [Chapter 501, Aged and Disabled Waiver Services](#) for additional information.

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508.16 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

Members who have been determined eligible for and are enrolled in the Home and Community-Based Traumatic Brain Injury Waiver (TBIW) Program may receive services from a home health agency that do not duplicate TBIW services. Home health agency services provided to the TBIW member must be coordinated by the TBIW case management agency, and in general may only include skilled nursing care or therapy services for post-hospitalization stays or acute episodes of chronic conditions. The need for home health services must be documented in the member's plan of care (POC).

Documentation of the referral from the members attending physician must be maintained in the member's records of both the TBIW agency and the home health agency. Please refer to [Chapter 512, Traumatic Brain Injury Waiver Services](#) for additional information.

508.17 PERSONAL CARE SERVICES (PCS)

Members who are receiving personal care services (PCS) provided through behavioral health or community care programs may also receive home health agency services. These services are limited to services which can only be performed by a skilled nurse and/or a licensed therapist (PT/OT/ST). The home health agency must maintain documentation regarding the need for services as well as the plan of care (POC) for the member. No payment shall be made to home health agencies for home health aide services provided to members who are also receiving personal care services. Please refer to [Chapter 517, Personal Care Services](#) for additional information.

508.18 CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)

Staff of the Children with Special Health Care Needs program shall authorize all care, including home health services, for children receiving specialized medical services under the auspices of the CSHCN program. The CSHCN program evaluates requests for prior authorization of home services based on Medicaid policy requirements for such services, regardless of the child's eligibility for the Medicaid program.

Requests for prior authorization of home health services for CSHCN enrollees should be forwarded to the CSHCN program as follows:

Children with Special Health Care Needs
350 Capitol Street, Room 427
Charleston, West Virginia 25301

508.19 MANAGED CARE ORGANIZATION (MCO)

If the Medicaid member is enrolled in an MCO, coverage and prior authorization requirements of the health plan must be followed. If the member is enrolled in the PAAS Program, authorization or a referral must be given by the member's primary care physician (PCP). Medicaid will not reimburse for services if the MCO denies payment because their requirements were not followed.

508.20 PRIVATE DUTY NURSING (PDN)/EPSDT SERVICES

Please refer to [Chapter 532, Private Duty Nursing Services](#) for additional information.

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508.21 DOCUMENTATION REQUIREMENTS

It is the responsibility of the provider to maintain the plan of care (POC) form, (CMS-485 & CMS-486) or the agency's POC form of their choosing, and OASIS assessments on file. Home health agencies must have all required plan of care data elements in a readily identifiable location within the medical record. Home health visits are subject to post-payment audit.

508.22 HOW TO OBTAIN INFORMATION

For additional information, please refer to the [Home Health webpage](#) on the BMS website.

Program Contact Information:

<http://www.dhhr.wv.gov/bms/Programs/HomeHealth/Pages/Program-Contact-Information.aspx>

GLOSSARY

Definitions in [Chapter 200, Definitions and Acronyms](#) apply to all West Virginia Medicaid services, including those covered by this chapter. Definitions in this glossary are specific to this chapter.

Abuse: The infliction or threat to inflict bodily injury on or the imprisonment of any child or incapacitated adult.

Felony: A serious criminal offense punishable by imprisonment in the penitentiary.

Financial Exploitation: Illegal or improper use of an elder's or incapacitated adult's resources. Obvious examples of financial exploitation include cashing a person's checks without authorization; forging a person's signature; or misusing or stealing a person's money or possessions. Another example is deceiving a person into signing any contract, will, or other document.

Legal Representative: A personal representative with legal standing (as by power of attorney, medical power of attorney, guardian, etc.).

Misdemeanor: A less serious criminal offense than a felony which is punishable by a fine or imprisonment in jail.

Neglect: "The failure to provide the necessities of life to an incapacitated adult or child" or "the unlawful expenditure or willful dissipation of the funds or other assets owned or paid to or for the benefit of an incapacitated adult or child" ([WV State Code §9-6-1](#)). Neglect would include the lack of or inadequate medical care by the service provider and inadequate supervision resulting in injury or harm to the incapacitated member. Neglect also includes, but is not limited to: a pattern of failure to establish or carry out a member's individualized program plan or treatment plan that results in negative outcome or places the member in serious jeopardy; a pattern of failure to provide adequate nutrition, clothing, or health care; failure to provide a safe environment resulting in negative outcome; and/or failure to maintain sufficient, appropriately trained staff resulting in negative outcome or serious jeopardy. This may also include medication errors and dietary errors resulting in a need for treatment for the member.

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Sexual Abuse: Any act toward an incapacitated adult or child in which an individual engages in, attempts to engage in, or knowingly procures another person to engage in such act, notwithstanding the fact that the incapacitated individual may have suffered no apparent physical injury as a result of such conduct, e.g. sexual intercourse/intrusion/contact; and any conduct whereby an individual displays his/her sex organs to an incapacitated adult or child for the purpose of gratifying the sexual desire of that individual, of the person making such display, or of the incapacitated adult, or child, or for the purpose of affronting or alarming the incapacitated adult.

Sexual Exploitation: When an individual, whether for financial gain or not, persuades, induces, entices, or coerces an incapacitated adult or child to display his/her sex organs for the sexual gratification of that individual or third person, or to display his/her sex organs under circumstances in which that individual knows such display is likely to be observed by others who would be affronted or alarmed.

Skilled Nurse (SN): A person who is professionally licensed by the State of West Virginia as a Registered Nurse (RN) or a Licensed Practical Nurse (LPN)

Utilization Management Contractor (UMC): The UMC is authorized to grant prior authorization for services provided to West Virginia Medicaid members. The UMC utilizes nationally recognized medical appropriateness criteria established and approved by BMS for medical necessity reviews.

REFERENCES

The West Virginia state plan references Home Health Services and DMEPOS in sections [3.1-A\(7\)](#), [3.1-B\(7\)](#), [supplement 2 to 3.1-A and 3.1-B](#), and [4.19-B\(7\)](#).

CHANGE LOG

REPLACE	TITLE	CHANGE DATE	EFFECTIVE DATE
Entire Chapter	Home Health		June 1, 2015