Claims/authorizations for dates of service on or after October 1, 2015 must use the applicable ICD-10 diagnosis code that reflects the policy intent. References in this manual to ICD-9 diagnosis codes only apply to claims/authorizations with dates of service prior to October 1, 2015.
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OVERVIEW

A Home Health Agency (HHA) enrolled in Louisiana Medicaid provides patient care services in the recipient’s home under the order of a physician that are necessary for the diagnosis and treatment of the recipient’s illness or injury. Such services include part-time skilled nursing services, extending nursing, aide, physical therapy (PT), speech therapy (ST), occupational therapy (OT) and medical supplies recommended by the physician as required in the care of the recipient and suitable for use in the home.

Home health services are reimbursable by Medicaid if the service is provided in the recipient’s home or place of residence. The recipient’s place of residence cannot be a hospital or nursing home. The attending physician must certify that the recipient meets the medical criteria to receive the service in the home and is in need of the Home Health service on an intermittent basis. This certification and physician’s plan of care must be maintained in the recipient’s record and on file at the Home Health Agency (HHA). The physician must review the plan of care (POC) every 60 days.

(Refer to the Minimum Standards for Licensing Home Health Agencies (LAC 48:1, Chapter 91) for details regarding HHA requirements).
DESCRIPTION OF SERVICES

Home health services are reimbursable only when ordered by a licensed physician who certifies that the recipient meets the medical necessity criteria (section 23.3) to receive services in the home on an intermittent basis. Home Health Services are reimbursable by Medicaid if the service is provided in the recipient’s home or place of residence. The recipient’s place of residence cannot be a hospital, nursing home, or intermediate care facility for individuals with intellectual disabilities. The certification and physician’s plan of care must be maintained in the recipient’s record and on file at the Home Health Agency (HHA). The physician must review the plan of care every 60 days.

Covered Home Health Services

Covered home health services include the following:

- **Skilled Nursing** (Intermittent or part-time)
- **Home Health Aide** is provided in accordance with the plan of care as recommended by the attending physician.
- **Extended Nursing** under the Early & Periodic Screening Diagnosis and Treatment (EPSDT) Program is extended nursing care by a registered nurse (RN) or a licensed practical nurse (LPN) and may be provided to children under age 21 who are considered “medically fragile.” These services must be prior authorized.
- **Rehabilitation Services** are physical, occupational and speech therapies.
- **Medical Supplies** as recommended by the physician, required in the plan of care for the recipient and suitable for use in the home are covered under the Durable Medical Equipment (DME) program when approved by the Prior Authorization Unit (PAU).

**NOTE:** Home health agencies that enroll as DME providers may bill the program for supplies used under that service designation using the DME claim form.

Skilled Nursing Services

Nursing services provided on a part-time or intermittent basis by a registered nurse or licensed practical nurse that are necessary for the diagnosis and treatment of a patient’s illness or injury.
These services shall be consistent with:

- Established Medicaid policy;
- The nature and severity of the recipient’s illness or injury;
- The particular medical needs of the patient; and
- The accepted standards of medical and nursing practice.

### Psychiatric Services

Home health services provided to recipients whose primary diagnosis is psychiatric must be provided in accordance with state requirements as published in the Minimum Standards for HHAs. One requirement stipulates that only registered nurses (RNs) shall make psychiatric nurse visits.

RN qualifications for psychiatric home health visits are taken from the Minimum Standards for Licensing Home Health Agencies (LAC 48: 1, Chapter 91). Only RNs who have these credentials shall make psychiatric nurse visits.

Additionally, experience must have been within the last five years or documentation must show psychiatric re-training, classes, or continued education units (CEUs) to update psychiatric knowledge.

RN requirements include:

- RN with a Master’s Degree in Psychiatric or Mental Health Nursing;
- RN with a Bachelor’s Degree in Nursing with one year of experience in an active treatment unit in a psychiatric or mental health hospital or outpatient clinic; or
- RN with a diploma or Associate Degree with two years of experience in an active treatment unit in a psychiatric or mental health hospital or outpatient clinic.

Furthermore, the services must be medically necessary and provided only to recipients who meet Medicaid’s Medical Necessity criteria for Home Health services.

### Home Health Aide Services Only

In some situations, a dually eligible (one who has coverage from both Medicare and Medicaid) recipient requires only home health aide visits. Medicare will not pay for this service unless skilled services (skilled nursing service, physical therapy, or speech pathology) are also required. However, Medicaid will reimburse for aide visits if only aide visits are required. Claims of this
nature must either have a cover letter attached explaining the reasons for the lack of Medicare coverage or include this explanation in the remarks section of the claim.

Supervision of Home Health Aides

Periodic on-site supervision with the home health aide present is part of the Minimum Standards for HHAs.

It is required that if the recipient is receiving a skilled service (nursing, physical therapy, occupational therapy, or speech-language therapy), the recipient shall have a RN or appropriate therapist supervisory visit made \textit{randomly every 14 days}.

Recipients not receiving skilled services must have an RN supervisory visit at the recipient’s home at least \textit{once every 62 days} while the aide is present and providing care. Supervisory visits are not billable services

Extended Home Health

Extended skilled nursing services (three or more hours of nursing services per day) may be provided to individuals under the age of 21 by the HHA if determined to be medically necessary, ordered by a physician, and prior authorized by the PAU. The recipient must require skilled nursing care which exceeds the caregiver’s ability to care for the recipient without the extended home health services.

\textbf{NOTE:} Skilled nursing services are to be conducted in the recipient’s home or place of residence. Home health services may be provided outside of the home when the nurse accompanies the recipient for medical reasons such as doctor appointments, treatments or emergency room visit. Medicaid cannot reimburse for skilled nurse services performed outside of state boundaries.

Rehabilitation Services

Physical, occupational and speech therapy services are covered when provided by the HHA. These services are covered with prior authorization.
Physical Therapy

Physical Therapy Services are rehabilitative services necessary for the treatment of the patient’s illness or injury or restoration and maintenance of function affected by the patient’s illness or injury. These services are provided with the expectation, based on the physician’s assessment of the patient’s rehabilitative potential, that:

- The patient’s condition will improve materially within a reasonable and generally predictable period of time; or
- The services are necessary for the establishment of a safe and effective maintenance program.

Physical Therapy Assistants

The use of Physical Therapy Assistants (PTA) is regulated in the minimum standards for Home Health Agencies. The PTA must be currently licensed by the Louisiana State Board of Physical Therapy Examiners and must be supervised by a licensed physical therapist. The PTA must have, at a minimum, one year of experience as a licensed PTA before assuming responsibility for a home health caseload.

The PTA’s duties must not include interpretation and implementation of referrals or prescriptions, performance evaluations, or the determination of major modifications of treatment programs.

Occupational Therapy

Occupational therapy is a medically prescribed treatment to improve or restore a function which has been impaired by illness, injury or, when the function has been permanently lost or reduced, to improve the individual’s ability to perform those tasks required for independent functioning.

Speech Therapy

Speech-Language Therapy Services are those services necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of a communication disability.
Medical Supplies

Medical Supplies recommended by the physician, required in the care of the recipient and suitable for use in the home are covered under the Durable Medical Equipment (DME) program when approved by the Prior Authorization Unit (PAU).

Chronic Needs Cases

Chronic needs cases pertain to DME, Home Health, Personal Care Services (PCS), and Rehabilitation Services. The prior authorization process has been altered to allow designation of some recipients as a Chronic Needs Case Recipient. Prior authorized services are continuous and expected to remain at current levels based on their medical condition for these recipients. Once a recipient is deemed a Chronic Needs Case, providers must only submit a PA request form accompanied by a statement from a physician documenting that the recipient’s condition has not improved and the services currently approved must be continued at the approved level.

Request for an increase in these services will be treated as a traditional PA request and is subject to full review.

Recipients meeting the chronic needs case status will be notified of the designation and the PAU will send a copy of the letter to the provider of services.
SERVICE LIMITATIONS

Service Limitations

Home Health Services include part-time skilled nursing services, aide, physical therapy, speech and occupational therapy and medical supplies recommended by the physician as required in the care of the recipient and suitable for use in the home.

NOTE: Medicaid prohibits multiple professional disciplines in the home at the same time. This includes but is not limited to nurses, nurse’s aides, and therapists.

Service limits for Home Health services are as follows:

- **Birth through age 20:**
  - No annual service limits
  - Prior authorization is required for multiple visits on the same day when medically necessary.

- **Ages 21 or older:**
  - Medicaid will reimburse only one visit per day
  - Medicaid will reimburse up to 50 skilled nursing visits per calendar year for each recipient. ABSOLUTELY NO EXCEPTIONS.
  - Rehabilitation services are excluded from the service limits of up to 50 home health visits per calendar year for recipients age 21 and older. Service limitations are not applicable for the following:
    - Physical Therapy
    - Occupational Therapy
    - Speech Pathology
    - Audiology Services
RECIPIENT REQUIREMENTS

The Medicaid recipient must meet all eligibility requirements in order to qualify for home health services. Recipients are subject to service restrictions and limitations. The home health agency (HHA) providing the service is required to verify recipient eligibility, other insurance coverage and living arrangements before providing services.

Medical Necessity Criteria

Medical necessity for home health services must be determined by medical documentation that supports the recipient’s illness, injury and/or functional limitations. All home health services must be medically reasonable and appropriate. To be considered medically reasonable and appropriate, the care must be necessary to prevent further deterioration of a recipient’s condition regardless of whether the illness/injury is acute, chronic or terminal.

The services must be reasonably determined to:

- Diagnose, cure, correct or ameliorate defects, physical and mental illnesses, and diagnosed conditions of the effects of such conditions;

- Prevent the worsening of conditions or the effects of conditions, that endanger life or cause pain; results in illness or infirmity; or have caused, or threatened to cause a physical or mental dysfunctional impairment, disability or development delay;

- Effectively reduce the level of direct medical supervision required or reduce the level of medical care or services received in an inpatient or residential care setting;

- Restore or improve physical or mental functionality, including developmental functioning, lost or delayed as the result of an illness, injury, or other diagnosed condition or the effects of the illness, injury or condition;

- Provide assistance in gaining access to needed medical, social, educational and other services required to diagnose, treat, to support a diagnosed condition or the effects of the condition, in order that the recipient might attain or retain independence, self care, dignity, self-determination, personal safety and integration into family, community, facility environments and activities.

Home health skilled nursing and aide services are considered medically reasonable and appropriate when the recipient’s medical condition and records accurately justify the medical necessity for services to be provided in the recipient’s home rather than in a physician’s office, clinic, or other outpatient setting.
Home health services are appropriate when a recipient’s illness, injury, or disability causes significant medical hardship and will interfere with the effectiveness of the treatment if he/she has to go to a physician’s office, clinic, or other outpatient setting for the needed service. Any statement on the plan of care regarding this medical hardship must be supported by the totality of the recipient’s medical records.

The following circumstances are not considerations when determining medical necessity for home health services:

- Inconvenience to the recipient or the recipient's family;
- Lack of personal transportation;
- Failure or lack of cooperation by a recipient or a recipient's legal guardians or caretakers to obtain the required medical services in an outpatient setting.

Refer to Appendix C for a chart of home health procedure codes.
PROVIDER REQUIREMENTS

To participate in the Home Health Program the providing agency must be Medicare-certified for Medicare/Medicaid by the Licensing and Certification Unit of the Health Standards Section of the Louisiana Medicaid Bureau of Health Services Financing (BHSF). All providers enrolled in the Louisiana Medicaid Program must adhere to the conditions of participation as outlined in the provider agreement.

All home health services must be provided by staff employed by or under contract with the home health agency (HHA) (see LAC 48, Chapter 91). (Also refer to 42 CFR 417.416 and Sec 2194 of the State Operations Manual CMS Pub. 7 for specific requirements).

All staff must meet all required licensure requirements in accordance with Medicaid policies, federal, state and other applicable laws.

Provision of Services

Home health services include medically necessary skilled nursing, rehabilitation (physical, occupational and speech therapies), home health aide and medical supplies provided to recipients only if the service is provided in the recipient’s home or place of residence.

NOTE: The recipient’s place of residence cannot be a hospital or nursing home.

Plan of Care

The attending physician must certify that the recipient meets the medical criteria to receive the service in the home and is in need of the home health services on an intermittent basis. The attending physician must order all home health services and sign a plan of care (POC) submitted by the HHA on the CMS-485 form. For more information on the Form CMS-485 visit the Centers for Medicare and Medicaid Services (CMS) website (see Appendix D). This certification and the physician’s POC must be maintained in the recipient’s record and on file at the HHA.

Periodic Review of Plan of Care

The physician must reauthorize the POC every 60 days.
Required Assistance to Recipients

In an effort to assist recipients locating a provider to submit a prior authorization request for medically necessary home health and personal care services, the BHSF has implemented a new procedure whereby the recipient may contact Medicaid for assistance (see Contact/Referral Information, Appendix D).

In addition, the BHSF will begin conducting regular surveys with all recipients who have been authorized to receive extended home health services. The purpose of these surveys is to ensure that these prior authorized services are being received. If the services are not being provided, the Bureau will contact the appropriate provider to determine what additional assistance may be required to ensure access to the authorized services.

Emergency Preparedness Plan

The HHA must have an emergency preparedness plan that conforms to the current Louisiana Office of Emergency Preparedness (OEP) model plan. The plan is designed to manage the consequences of declared disasters or other emergencies that disrupt the HHAs ability to provide care and treatment or threaten the lives or safety of its clients.

The home health agency is responsible for obtaining a copy of the current Home Health Emergency Preparedness Model Plan from OEP (see Contact/Referral Information, Appendix D). At a minimum, the home health agency must have a written plan that includes:

- The evacuation procedures for agency clients who require community assistance as well as for those with available caregivers to evacuate to another location;
- The delivery of essential care and services to agency clients whether they are in a shelter or other locations;
- The provisions for the management of staff, including distribution and assignment of responsibilities and functions;
- A plan for coordinating transportation services required for evacuating agency clients to another location; and
- A declaration that the agency will notify the client’s family or caregiver if the client is evacuated to another location.

The HHA must submit the plan to the parish OEP for review. Refer to LAC 48:1.9121 for details regarding the minimum standards for HHA emergency preparedness.
PRIOR AUTHORIZATION

The home health agency must submit a plan of care (POC) and request prior authorization for extended home health services, multiple daily nursing visits, or rehabilitation services (therapies) only. Prior authorization (PA) approval must be received before additional services are provided.

NOTE: There is no benefit coverage for extended home health services or multiple daily nursing visits for persons age 21 or over.

Requests for Prior Authorization

Providers may submit requests for prior authorization using the Louisiana Requests for Prior Authorization Form. No other form or substitute will be accepted. Completed requests must be sent to the Prior Authorization Unit (PAU). Requests may be mailed, faxed or submitted electronically through electronic PA (e-PA). The preferred method is e-PA.

Electronic-PA is a web application that provides a secure web based tool for providers to submit prior authorization requests and to view the status of previously submitted requests. For more information regarding e-PA, visit the Louisiana Medicaid website (see appendix D) or call the PAU.

NOTE: Reconsideration requests are not accepted via e-PA. Submit these requests by mail.

To expedite the processing of emergency requests, it is necessary to limit fax requests to emergency or initial requests only. To ensure that emergency requests are received by PAU, providers are asked to contact the PAU and inform the unit when a fax for an emergency request is being transmitted.

The appropriate PA form, along with all necessary documentation to substantiate the medical necessity of the requested services, must be submitted to the PAU for approval.

Prior Authorization Forms

<table>
<thead>
<tr>
<th>Home Health Service</th>
<th>Form(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation Services (physical, occupational and speech therapy)</td>
<td>PA-01</td>
</tr>
<tr>
<td>Multiple and Extended Home Health Nursing Visits for recipients birth through age 20</td>
<td>PA-07</td>
</tr>
</tbody>
</table>
NOTE: Prior authorization forms can be found in Appendix B or on the Louisiana Medicaid website (see Appendix D for website). Prior authorization is required prior to claim submissions. Appendix C contains the procedures and descriptions, revenue codes appropriate to the service and the fees per unit that are necessary to complete the billing process.

For questions concerning the PA process, please contact the PAU (see Appendix D for Contact Information).

**Home Health Services**

Routine home health services prescribed by a physician for only one skilled nursing visit per day does not require prior authorization and no further action is needed when services are provided by an agency listed in the Medicaid Provider Directory. A request for prior authorization of services is required whenever the prescription of the physician includes multiple daily visits. Multiple visits in the same day are usually associated with IV therapy but prescriptions can also be for three or more hours per day to care for a recipient age birth through 20 meeting the criteria for this care.

**Rehabilitation Services**

All home health rehabilitation services (physical, occupational and speech therapy) require prior authorization. Rehabilitation services are excluded from the service limit of up to 50 home health visits per calendar year for recipients age 21 and older.

All rehabilitation services (except for initial evaluations and wheelchair seating evaluations, which are restricted to one evaluation per discipline per recipient every 180 days) require approval in advance from the PAU. All evaluations must have a physician’s prescription that must be kept in the recipient’s file.

To request prior authorization for home health rehabilitation services, providers must complete the PA-01 (Appendix B) using the appropriate procedure codes as listed in Appendix C. Refer to section 23.6 for claims filing information.

All initial requests for approval must include a copy of the physician’s referral and the results of the evaluation of the recipient that documents the need for therapy. All renewal requests for approval must include a copy of the physician’s referral and progress notes that document the need for the continuation of therapy.

**NOTE:** Medicaid prohibits multiple professional disciplines in the home at the same time. This includes but is not limited to nurses, nurse’s aides, therapists, etc.
Extended Nursing Care

Extended nursing services may be provided to a Medicaid recipient birth through 20 when it is determined to be medically necessary for the recipient to receive a minimum of three hours per day of nursing services. Medical necessity for extended nursing services exists when the recipient has a medically complex condition characterized by multiple, significant medical problems that require nursing care as defined by the Louisiana Nurse Practice Act §913(14)(15).

When requesting prior authorization for extended nursing care, all hours of care must be included with the PA request. In addition, the physician’s prescription and a copy of the Home Health POC must be attached to the appropriate PA form. Cases approved for extended nursing care should be billed using appropriate codes (see Appendix C) for an RN and LPN in conjunction with the total number of hours provided, indicating the units as hours.

NOTE: All extended nursing care and multiple visits require PA.

Prior Authorization Procedure of Extended Home Health Services at Hospital Discharge

In order to provide continuity of care for recipients, the following procedure will be used for recipients requiring extended home health care upon discharge from the hospital.

Prior to hospital discharge, the PA process can begin. The following information must be sent to the PAU:

- A letter of medical necessity from the primary physician;
- A signed prescription indicating the number of hours of extended home health that are being requested;
- A copy of the admission assessment (history and physical);
- Progress notes;
- Discharge orders;
- A copy of the discharge summary, if available; and,
- A copy of the unsigned POC. The unsigned POC will be accepted only if the recipient is being discharged from the hospital and is included with the above information. The POC assessment cannot be done in the hospital but must be done at the recipient’s home or place of residence.

NOTE: The home health agency must forward the signed POC to the PAU as soon as the signed copy is received from the physician.
The recipient must meet the criteria for extended home health services and be determined medically necessary in order for the PAU to approve the services. The extended home health request will be issued a PA number if the service has been approved. The agency can call the PAU to check the status of the request and to get the PA number in order to start immediately approved services.

The recipient will be prior authorized for only six weeks of extended home health services. This is to ensure the signed POC is on file with the PAU. Prior to the end of the six week prior authorized period, all of the requested information including the signed POC must be resubmitted to the PAU. The same information can be resubmitted unless there has been a change in the recipient’s condition.

**Multiple Same Day Visits**

Multiple nursing visits on the same date of service may be provided to a recipient age birth through 20 when the medical necessity criteria is met and these services cannot be provided during the course of one visit. Multiple same day visits must be prior authorized before services begin.

Extended and multiple daily visits must be authorized in accordance with the certifying physician’s orders and home health POC. All nursing services shall be provided in accordance with the Louisiana Nurse Practice Act.

A completed PA-07 must be submitted to the PA Unit indicating the additional visits requested for the same date of service. Appropriate service code indicators, procedure codes and modifier codes, when applicable, must be used on PA requests and claims to designate additional visits on the same date (see Appendix C).

The physician must issue orders detailing how many visits should be provided per day and the duration of time to provide the multiple visits, (i.e., 10 days, 2 weeks, 45 days, etc.).

When the agency receives the orders, they must obtain documentation to support the medical need for multiple daily visits along with the Plan of Care (POC) signed by the physician, and submit them with a completed PA-07 form to the PAU. The PA-07 form must include the modifier codes, U2 for second visits or U3 for third visits, in the second position of the modifiers. (see Appendix C)

The request shall be reviewed for medical necessity and when a decision is rendered a notice of the decision will be sent to the agency and the recipient. If the PA is approved, a PA number will be assigned and included in the prior authorization notice.
Visits for Multiple Recipients in the Same Home on the Same Day

Each recipient must have a PA in order for services to be billed. The procedures for requesting PA established above will work for multiple recipients in the same home. Special modifiers have been attached to codes to allow the correct payment to be made for this authorized service (see Appendix C).

NOTE: Nursing care in the home by a RN and LPN is defined to represent an actual hour of time in which services were given to multiple recipients.

Home Health Supplies

Home Health supplies are reimbursable under the Durable Medical Equipment (DME) Program. Approval of payment for covered supplies provided under the DME program must be obtained from the PAU.

Providers may either obtain these non-reimbursable supplies through a DME provider or provide the supplies through the DME program. Providers who opt to have the supplies provided by a DME provider must give the DME provider a copy of the physician’s orders for the supplies. The request must include the quantity and period of time the supplies are to cover. Home health providers who choose to provide these supplies can have their home health provider file updated to allow billing for these supplies.

A written request should be submitted to the Provider Enrollment Unit to have the provider type for DME added to the home health provider numbers. The forms and instructions required to obtain PA approval and codes to bill for the supplies are contained in Appendixes B and C.

HHAs often train recipients or their caregivers how to administer medications, or use certain equipment/supplies, in the provider’s absence. DME covered IV, or other home health supplies, may be provided to the agency for use in the recipient’s home when administration is monitored and home health services are provided.

When normal usage amounts are exceeded a request for approval must be submitted with documentation of medical necessity to justify the larger quantity.

Certain supplies for wound care and dressing will be covered under DME but will be authorized exclusively for the use of home health agencies when delivering a home health service.
Routine Supplies for which Reimbursement is Included as Part of the Reimbursement Rate for the Home Health Visit

- Blood drawing supplies
- Sterile specimen containers
- Tourniquet
- Alcohol preps-swabs
- Bandage scissors
- Disposable gloves-non-sterile
- Paper tape
- Oral swabs/toothettes
- Tape measure, all types
- Disposable gowns (plastic, paper)
- Goggles
- Water soluble lubricant
- Thermometer cover
- Self-assistive devices (long handle tongs and shoehorn stocking aide)

Supplies Covered only when Provided in Conjunction with a Home Health Visit

- Inflatable Cushion (Softcare mattress)
- Enema – disposable enema administering kit
- Fracture pan, plastic
- Urinal, plastic, male
- Commode urinary disposable collection device (HAT)
- Steri-strips
- Telfa
- Sterile Applicators (tongue blades, sterile q-tips)
- Sitz bath, portable, disposable
- Foam tape
- Bile bags
- Sterile irrigation solutions (GU irrigant, acetic acid and normal saline)

- Specimen containers
- Vacutainer used for drawing blood
- Tubex holder
- Surgical masks
- Culturettes
- Adhesive tape
- Emesis basins
- Alcohol
- Non-sterile cotton balls, buds
- Disposable masks
- Disposable wash clothes
- Thermometer with holder
- Sharps container

- Douche – Betadine
- Enema – Fleets, mineral oil
- Bed pan, plastic
- Female urinal
- Toppers, sterile
- Reston
- Skin staple remover
- Suture removal kit
- Elastoplast
- Pericare kit/supplies
- Therabands/putty
- Lymphedema pumps
Supplies through the Durable Medical Equipment Program

When requesting approval of payment for supplies, providers must complete the PA-01 and attach a copy of the doctor’s prescription or orders along with the home health POC and submit these documents to the PAU.

The date on the prescription should be the same date as the PA-01 date of signature. When DME requests are approved under home health, a PA number will be issued within 25 working days from the date the PAU receives the prescription and PA request. A letter containing the PA number, a listing of the approved supplies and the time-period for which approval is given will be mailed to the provider and the recipient.

NOTE: Upon approval of DME PA requests, a PA number is issued within 25 working days.

If additional supplies are required for this period, the provider is required to submit a PA-01 for reconsideration with a new prescription and documentation of medical necessity to the PAU. If approved, these supplies will be added to the list of supplies covered by the existing prior authorization number.

The PAU may authorize a 30-day increment of supplies by phone if a recipient is pending discharge from a hospital or on an emergency basis. A request for additional supplies must be submitted by fax, mail or e-PA.

Prior Authorization Decisions

Home health prior authorization decisions are issued within 10 days by letter to the provider, recipient and support coordinator, if applicable. Approval letters contain a nine-digit PA number. Denial letters include recipient appeal rights.
CLAIMS RELATED INFORMATION

Reimbursement requires compliance with all Medicaid guidelines.

Claim Related Responsibilities

All providers are responsible for filing the correct billing codes on a claim. If a licensed practical nurse (LPN) provides services, the provider must submit the appropriate LPN code for payment. Likewise, if a registered nurse (RN) delivers the service, the claim must identify the code associated with the appropriate service. Home health providers should perform a self-audit to identify claims paid incorrectly and report any overpayments to the fiscal intermediary (FI). All providers are responsible for assuring that their professional employees (i.e. RNs, LPNs, aides, etc.) are practicing within the limitations established by their licensing boards.

The home health agency (HHA) must provide the supporting documentation used to document medical necessity criteria (i.e. medical doctor’s prescription, etc.) which must be met in order to receive home health services upon request.

Claim Type

Home health agencies can submit claims either by paper or electronically. Home health providers who choose to submit their claims on paper forms must use the Centers for Medicare and Medicaid Services (CMS) standard UB-04 claim form.

The HHA must bill using its own Medicaid provider number and National Provider Identifier (NPI).

Diagnosis Codes to Support Medical Necessity

Providers must bill using the appropriate International Classification of Diseases, Tenth Edition, Clinical Modification, Tenth Revision (ICD-10-CM) diagnosis code(s), or its successor, that best describes the recipient’s illness, injury or medical condition.

Billing Codes

The procedure codes and revenue codes to be used for billing covered HHA services can be found in Appendix C in this manual chapter.
Billing Instructions for Home Health Services

The UB-04 claim form (hard copy) or 837I electronic transaction is required when filing for Medicaid reimbursement of services. All information, handwritten or computer generated, must be legible and completely contained in the designated area of the claim form.

As a reminder, the recipient’s attending physician’s name and/or provider number is always required when submitting for reimbursement of services. Please see chart below for correct placement of this information on the UB-04 Claim Form and 837I electronic format.

<table>
<thead>
<tr>
<th>UB-04 Claim Form</th>
<th>837I Electronic Format</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form Locator 76 – Attending Physician (Required)</td>
<td>Loop 2310A, REF02 segment OR Loop 2420A, REF02 segment</td>
</tr>
<tr>
<td>Enter the name or 7-digit Medicaid provider number of the physician ordering the plan of care.</td>
<td>Enter the name or 7-digit Medicaid provider number of the physician ordering the plan of care.</td>
</tr>
</tbody>
</table>

Billing Instructions for Multiple Same Day Visits

Prior authorization must be obtained from the Prior Authorization Unit (PAU) before any multiple same day visits are provided. When billing for the multiple daily visits, the claim form should have each visit listed on a separate line with the correct procedure code and modifier codes to reflect the multiple day visits. (See Appendix C of this manual chapter.)

Example:

Jane Doe needs a nurse to visit her three times a day, one RN and two LPAs. He/she will need these services on December 15, 2099.

A PA-07 request is completed by the provider requesting approval for the two additional visits a day and submitted to the PAU. Documentation, including the physician’s orders and the plan of care (POC) signed by the physician, is submitted to substantiate the medical necessity of the additional visits.
When the PA is approved, a prior authorization number is assigned and included in the notice authorizing the additional daily visits.

The 9-digit prior authorization number assigned by the PAU must be included in Form Locator 63 A of the UB-04 claim form or in the Prior Authorization Loop for EDI transmissions (see EDI Companion Guide for details).

A standard unit of service is 15 minutes. **Each unit** must be billed **individually** on a separate line of the claim form. Please be sure to use the correct procedure code and modifier (if applicable) for each line item. (See sample below.)

<table>
<thead>
<tr>
<th>Description</th>
<th>HCPCS</th>
<th>Modifier Code(s)</th>
<th>Service Date</th>
<th>Units</th>
<th>Total Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Visit</td>
<td>G0299</td>
<td>TD</td>
<td>12/15/2099</td>
<td>1</td>
<td>$15.70</td>
</tr>
<tr>
<td>Skilled Nursing Visit</td>
<td>G0300</td>
<td>U2</td>
<td>12/15/2099</td>
<td>1</td>
<td>$12.56</td>
</tr>
<tr>
<td>Skilled Nursing Visit</td>
<td>G0300</td>
<td>U3</td>
<td>12/15/2099</td>
<td>1</td>
<td>$12.56</td>
</tr>
</tbody>
</table>

Only one PA number may be entered per UB-04 claim form. Use of an incorrect PA number will cause the claim to deny.

**Billing Instructions for Rehabilitation Services**

The Medicaid Program provides coverage for speech therapy and occupational therapy, as well as physical therapy, through the Home Health Program. These services require prior authorization.

The service codes used for billing as well as the corresponding procedure codes and fees are listed in Appendix C. Reimbursement will be made at a flat fee for service.

Cardiac and Pulmonary/Respiratory therapy are not covered under the Medicaid Program. These services should not be prior authorized or billed using covered rehabilitation codes.

**NOTE:** Home Health agencies are not to bill Medicaid for rehabilitation in nursing homes. Per 42 CFR 440.70(c), “A beneficiary’s place of residence, for home health services, does not include a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities...”
Wheelchair Seating Evaluation

When billing for a wheelchair seating evaluation, a paper claim must be submitted with a copy of the doctor’s script attached to the claim, (8 ½ X 11 sheet), and the original script must be kept in the recipients’ file. Refer to Appendix C for procedure codes.

Rehabilitation Services Rendered To Dual Eligible Recipients

If a particular recipient is eligible for both Medicaid and Medicare services, the rehabilitation services provider rendering services to the recipient must be willing to accept the Medicare assignment in order for Medicaid to make crossover payment on the claim.

Rehabilitation providers must bill for Medicare/Medicaid crossovers on the UB-04 claim form and file the claim with Medicare first, ensuring that the recipient’s Medicaid identification number has been entered on the claim form. Once Medicare has processed the Medicare portion of the claim, the claim payment information must be sent to the PAU for processing.

Providers should receive Medicaid payment within six weeks after receiving payment from Medicare. If payment is not received from Medicaid, providers should submit the UB-04 claim form, along with the Medicare Explanation of Benefits (EOB), to the FI for processing.

Billing for Supplies through the Durable Medical Equipment Program

Foley and indwelling catheters may not be billed through the DME Program.

Reimbursement for supplies that are considered “routine supplies” are included as part of the home health visit rate and may not be billed to Medicaid nor to the recipient. The appropriate procedure code should be used for each supply requested. (See Appendix C of this manual chapter.)

Supplies included in the reimbursement for a Home Health Visit

Routine supplies, as determined by Medicaid, that are not reimbursed through the Medicaid Durable Medical Equipment and Supplies Program are considered included in the visit rate and will not be separately reimbursed.
ACRONYMS

CEUs – Continuing Education Units

CFR – Code of federal regulations

DME – Durable Medical Equipment

HHA – Home Health Agency

HIPAA – Health Insurance Portability and Accountability Act

RN – Registered Nurse

LPN – Licensed Practical Nurse

MST – Multi-Systemic Therapy

OASIS – Outcome and Assessment Information Set

OT – Occupational Therapy

PA – Prior Authorization

PAU – Prior Authorization Unit

PCS – Personal Care Services

POC – Plan of Care

PT – Physical Therapy

PTA – Physical Therapy Assistant

ST – Speech Therapy
REGULATORY REQUIREMENTS

OUTCOME AND ASSESSMENT INFORMATION SET

The Outcome and Assessment Information Set (OASIS) is a group of standard data elements developed, tested, and refined through a research and demonstration program funded primarily by the Centers for Medicare & Medicaid Services (CMS), (co-funded by the Robert Wood Johnson Foundation). The OASIS is a key component of Medicare’s partnership with the home care industry to foster and monitor improved home health care outcomes and is proposed to be an integral part of the revised Conditions of Participation (COP) for Medicare-certified home health agencies (HHAs).

The CMS OASIS website became available in July 1998 to store, disseminate policy and technical information related to OASIS for use by the home health care community. For the most recent and accurate OASIS regulations please visit the website at www.cms.hhs.gov/oasis.

NOTE: CMS rules for OASIS are published in the Federal Registers.

An online OASIS training program for providers and their employees is available at www.oasistraining.org.

HAVEN

HHAs must encode and transmit data using software available from CMS or software that conforms to CMS standard electronic record layout, edit specifications, and data dictionary, and must include the required OASIS data set. HAVEN is software provided free from CMS for HHAs to use to submit their OASIS data. More information regarding HAVEN software and installation instructions can be found at www.cms.hhs.gov/oasis/045_haven.asp.

For questions about HAVEN, please call the HAVEN Help Desk at 1-877-201-4721 or send an e-mail to help@qtso.com.

STATE AGENCY OASIS

State agency OASIS staff may be contacted by telephone or FAX for assistance with clinical questions regarding HAVEN and OASIS data submissions. The OASIS Education Coordinator may be contacted at the following numbers: 1-800-261-1318 (toll free), 225-342-2449 or by FAX at 225-342-5292.
### REQUEST FOR PRIOR AUTHORIZATION

**Continuation of Services:** YES NO

<table>
<thead>
<tr>
<th>Prior Authorization Type: (1)</th>
<th>Recipient 13-Digit Medicaid ID Number or 16-Digit CCN Number (2)</th>
<th>Social Security No. (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 - Outpatient Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>05 - Rehabilitation Therapy</td>
<td></td>
<td></td>
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<tr>
<td>09 - DME Equipment &amp; Supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99 - Outpatient Surgery Performed &amp; Other Specialized CPT Procedures</td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recipient Last Name</th>
<th>First</th>
<th>MI</th>
<th>Date of Birth (5)</th>
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<tbody>
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<table>
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<tr>
<th>Medicaid Provider Number (7-Digit) (6)</th>
<th>Begin Date of Service (MMDDYYYY) (7)</th>
<th>End Date of Service (MMDDYYYY) (8)</th>
<th>P.A. Nurse and/or Physician Reviewer’s Signature: &amp; Date (9)</th>
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<tbody>
<tr>
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**Diagnosis:**
- Primary Code & Description (10)
- Secondary Code & Description (11)

**Prescription Date (9) (MMDDYYYY):**

**Status Codes:**
- 2 = Approved
- 3 = Denied

**Prescribing Physician's Name and/OR Number:**

**Description of Services**

<table>
<thead>
<tr>
<th>Procedure Code (12)</th>
<th>Modifiers (11A)</th>
<th>Description (11B)</th>
<th>Requested Units (11C)</th>
<th>Authorized Units</th>
<th>Authorized Amount</th>
<th>Status</th>
<th>P.A. Message/Denial Code (11D)</th>
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<tbody>
<tr>
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</tbody>
</table>

**Place of Treatment:**
- Recipient's Home
- Nursing Home
- ICF/MR Facility
- Outpatient Hospital / Clinic

**Case Manager Information:**

<table>
<thead>
<tr>
<th>Provider Name:</th>
<th>Case Manager Name:</th>
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</thead>
<tbody>
<tr>
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<table>
<thead>
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</table>

<table>
<thead>
<tr>
<th>City:</th>
<th>City:</th>
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</table>

<table>
<thead>
<tr>
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</table>

**Telephone:**

<table>
<thead>
<tr>
<th>Telephone:</th>
<th>Fax Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Provider Signature:**

**Date of Request:**

**PA-01 Form**
**REQUEST FOR PRIOR AUTHORIZATION**

**STATE OF LOUISIANA**  
DEPARTMENT OF HEALTH AND HOSPITALS  
Bureau of Health Services Financing Medical Assistance Program

**CONTINUATION OF SERVICES**  
YES  
NO

<table>
<thead>
<tr>
<th>PRIOR AUTHORIZATION TYPE:</th>
<th>06 - Home Health Services</th>
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</thead>
<tbody>
<tr>
<td>RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER</td>
<td>(2) Social Security No.</td>
</tr>
<tr>
<td>RECIPIENT LAST NAME</td>
<td>FIRST</td>
</tr>
<tr>
<td>MEDICAID PROVIDER NUMBER (7-DIGIT)</td>
<td>(6)</td>
</tr>
<tr>
<td>SERVICE TREATMENT PLAN (7)</td>
<td>IS RECIPIENT CURRENTLY RECEIVING THESE SERVICES</td>
</tr>
<tr>
<td>BEGIN DATE (MMDDYYYY)</td>
<td>END DATE (MMDDYYYY)</td>
</tr>
<tr>
<td>DIAGNOSIS: PRIMARY CODE &amp; DESCRIPTION</td>
<td>(10) PRESCRIPTION DATE</td>
</tr>
</tbody>
</table>
| SECONDARY CODE & DESCRIPTION | (MMDDYYYY) | STATUS CODES:  
2 = APPROVED  
3 = DENIED |
| DESCRIPTION OF SERVICES | (11) PRESCRIBING PHYSICIAN'S NAME AND/OR NUMBER: |
| PROCEDURE CODE (12) | MODIFIERS (12A) Mod Mod Mod Mod Mod | DESCRIPTION (12B) |
| REQUESTED UNITS (12C) | AUTHORIZED UNITS | STATUS |
| P.A. MESSAGE/DENIAL CODE (S) |

**FOR INTERNAL USE ONLY**

<table>
<thead>
<tr>
<th>(13) PROVIDER NAME:</th>
<th>(14) CASE MANAGER INFORMATION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME:</td>
<td>ADDRESS:</td>
</tr>
</tbody>
</table>
| ADDRESS: | CITY:  
STATE:  
ZIPCODE: |
| CITY: | STATE:  
ZIPCODE: |
| TELEPHONE: (__)  
FAX NUMBER: (__) | TELEPHONE (__)  
FAX NUMBER: (__) |

**P.A. NUMBER**

**MAIL TO:**  
Medina/ LA, Medicaid  
P.O. BOX 14919  
Baton Rouge, LA 70898-4919

**FAX TO:** (225) 237-3342
<table>
<thead>
<tr>
<th>REV Code Options ***</th>
<th>Standard Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>550 551</td>
<td>G0299**</td>
<td>Services of skilled nurse (registered nurse - RN) in home health setting, each 15 min.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Note:</strong> CMS HCPCS description indicates 15 min. is equal to one (1) unit.</td>
</tr>
<tr>
<td>550 551</td>
<td>G0299** plus Modifier of U2^</td>
<td>Services of skilled nurse (RN) in home health setting, each 15 min.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Note:</strong> CMS HCPCS description indicates 15 min. is equal to one (1) unit.</td>
</tr>
<tr>
<td>550 551</td>
<td>G0299** plus Modifier of U3^</td>
<td>Services of skilled nurse (RN) in home health setting, each 15 min.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Note:</strong> CMS HCPCS description indicates 15 min. is equal to one (1) unit.</td>
</tr>
<tr>
<td>550 551</td>
<td>G0299 ** plus Modifier of TT~</td>
<td>Services of skilled nurse (RN) in home health setting, each 15 min.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Services of skilled nurse in home health setting (LPN), each 15 min.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Note:</strong> CMS HCPCS description indicates 15 min. is equal to one (1) unit. Per LA Medicaid guidelines, one (1) unit equals one (1) visit regardless of the length of time the visit takes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Note#2:</strong> TD modifier must be appended first.</td>
</tr>
<tr>
<td>550 551</td>
<td>G0299** plus Modifier of TT and U2^</td>
<td>Services of skilled nurse (RN) in home health setting, each 15 min.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Note:</strong> CMS HCPCS description indicates 15 min. is equal to one (1) unit.</td>
</tr>
<tr>
<td>550 551</td>
<td>G0299 ** plus Modifier of TT and U3^</td>
<td>Services of skilled nurse (RN) in home health setting, each 15 min.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Note:</strong> CMS HCPCS description indicates 15 min. is equal to one (1) unit.</td>
</tr>
<tr>
<td>REV Code</td>
<td>Standard Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
<td>---------------</td>
<td>-------------</td>
</tr>
<tr>
<td>550 551</td>
<td>G0300**</td>
<td>Services of skilled nurse, (licensed practical nurse - LPN) in home health setting, each 15 min.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Note:</strong> CMS HCPCS description indicates 15 min. is equal to one (1) unit.</td>
</tr>
<tr>
<td>550 551</td>
<td>G0300** plus Modifier of U2^</td>
<td>Services of skilled nurse (LPN) in home health setting, each 15 min.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Note:</strong> CMS HCPCS description indicates 15 min. is equal to one (1) unit.</td>
</tr>
<tr>
<td>550 551</td>
<td>G0300** plus Modifier of U3^</td>
<td>Services of skilled nurse (LPN) in home health setting, each 15 min.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Note:</strong> CMS HCPCS description indicates 15 min. is equal to one (1) unit.</td>
</tr>
<tr>
<td>550 551</td>
<td>G0300** plus Modifier of TT~</td>
<td>Services of skilled nurse (LPN) in home health setting, each 15 min.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Note:</strong> CMS HCPCS description indicates 15 min. is equal to one (1) unit.</td>
</tr>
<tr>
<td>550 551</td>
<td>G0300** plus Modifier of TT and U2^</td>
<td>Services of skilled nurse (RN) in home health setting, each 15 min.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Note:</strong> CMS HCPCS description indicates 15 min. is equal to one (1) unit.</td>
</tr>
<tr>
<td>550 551</td>
<td>G0300** plus Modifier of TT and U3^</td>
<td>Services of skilled nurse (RN) in home health setting, each 15 min.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Note:</strong> CMS HCPCS description indicates 15 min. is equal to one (1) unit.</td>
</tr>
<tr>
<td>570 571</td>
<td>G0156**</td>
<td>Services of home health aide in home health setting, each 15 min.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Note:</strong> CMS HCPCS description indicates 15 min. is equal to one (1) unit.</td>
</tr>
<tr>
<td>570 571</td>
<td>G0156**</td>
<td>Services of home health aide in home health setting, each 15 min.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Note:</strong> CMS HCPCS description indicates 15 min. is equal to one (1) unit.</td>
</tr>
<tr>
<td>REV Code Options</td>
<td>Standard Code</td>
<td>Description</td>
</tr>
<tr>
<td>------------------</td>
<td>---------------</td>
<td>-------------</td>
</tr>
</tbody>
</table>
| 552              | S9123*        | Nursing care, in the home by RN, per hour  
(Only code to be used when reporting *extended* hours) |
| 582              | S9124*        | Nursing care, in the home by LPN, per hour  
(Only code to be used when reporting *extended* hours.) |
| 552              | S9123* plus Modifier of TG | Nursing care, in the home by RN, per hour  
(Only code to be used when reporting *extended* hours) |
| 552              | S9123* plus Modifier of TN | Nursing care, in the home; by RN, per hour  
(Only code to be used when reporting *extended* hours) |
| 582              | S9124* Plus Modifier of TN | Nursing care, in the home by LPN, per hour  
(Only code to be used when reporting *extended* hours) |
| 552              | S9123* plus Modifier of TT | Nursing care, in the home by RN, per hour  
(Only code to be used when reporting *extended* hours for multiple recipients in the same home) |
| 582              | S9124* plus Modifier of TT | Nursing care, in the home by LPN, per hour  
(Only code to be used when reporting *extended* hours for multiple recipients in the same home) |
| 552              | S9123* plus Modifier of TV | Nursing care, in the home by RN, per hour  
(Only code to be used when reporting *extended* hours) |
| 582              | S9124* Plus Modifier of TV | Nursing care, in the Home by Licensed Practical Nurse (LPN), per hour  
(Only code to be used when reporting *extended* hours) |
<table>
<thead>
<tr>
<th>REV Code Options</th>
<th>Standard Code</th>
<th>Description</th>
</tr>
</thead>
</table>
| **552** 582 | S9123* plus Modifier of UH  
S9124* plus Modifier of UH | Nursing care, in the home by RN, per hour  
(Only code to be used when reporting extended hours)  
Nursing care, in the home by LPN, per hour.  
(Only code to be used when reporting extended hours) |
| **552** 582 | S9123* plus Modifier of UJ  
S9124* plus Modifier of UJ | Nursing care, in the home by RN, per hour  
(Only code to be used when reporting extended hours)  
Nursing care, in the home by LPN, per hour  
(Only code to be used when reporting extended hours) |

**Valid Home Health Procedure Modifiers for Nurse and Aide Services:**
- TG = High Complexity
- TN = Rural, Outside Area
- TT = Multiple Recipients
- TV = Holiday/Weekend
- U2 = 2nd (second) Daily Visit
- U3 = 3rd (third) Daily Visit
- UH = Evening
- UJ = Night
- * Requires Prior Authorization
- ** Prior Authorization is only required for more than one service per day.
- *** When multiple revenue codes are listed, please choose the most appropriate revenue code from the options listed.
HOME HEALTH REHABILITATION

<table>
<thead>
<tr>
<th>REV Code Options **</th>
<th>Standard Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>444</td>
<td>92521-92524</td>
<td>Evaluation of Speech, Language, Voice, Communication, Auditory Processing and/or Aural Rehabilitation Status</td>
</tr>
<tr>
<td>440 441</td>
<td>G0153*</td>
<td>Services of Speech and Language Pathologist in Home Health Setting, each 15 min.</td>
</tr>
<tr>
<td>420 421</td>
<td>G0151*</td>
<td>Services of Physical Therapist in Home Health Setting, each 15 min.</td>
</tr>
<tr>
<td>424</td>
<td>97161 low 97162 mod 97163 high</td>
<td>Physical Therapy Evaluation: low, moderate or high complexity</td>
</tr>
<tr>
<td>430 431</td>
<td>G0152*</td>
<td>Services of Occupational Therapist in Home Health Setting, each 15 min.</td>
</tr>
<tr>
<td>434</td>
<td>97165 low 97166 mod 97167 high</td>
<td>Occupational Therapy Evaluation: low, moderate or high complexity</td>
</tr>
<tr>
<td>424</td>
<td>97161-97163 plus Modifier of UD</td>
<td>Physical Therapy Evaluation: low, moderate or high complexity</td>
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<tr>
<td>434</td>
<td>97165-97167 plus Modifier of UD</td>
<td>Occupational Therapy Evaluation: low, moderate or high complexity</td>
</tr>
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</table>

* Requires Prior Authorization

** When multiple revenue codes are listed, choose the most appropriate revenue code from the options listed.

UD = Wheelchair Seating Evaluation (State Assigned)

Providers should refer to the appropriate fee schedule for the reimbursement amounts associated with covered Home Health services on lamedicaid.com. The fee schedule for the revised procedure codes is available on lamedicaid.com by accessing the following link:
http://www.lamedicaid.com/provweb1/fee_schedules/Home_Health_FS.pdf
## CONTACT INFORMATION

Molina Medicaid Solutions

The Medicaid Program’s fiscal intermediary, Molina Medicaid Solutions can be contacted for assistance with the following:

<table>
<thead>
<tr>
<th>TYPE OF ASSISTANCE</th>
<th>CONTACT INFORMATION</th>
</tr>
</thead>
</table>
| e-CDI technical support | Molina Medicaid Solutions  
(877) 598-8753 (Toll Free) |
| Electronic Media Interchange (EDI)  
Electronic Claims testing and assistance | P.O. Box 91025  
Baton Rouge, LA 70898  
Phone: (225) 216-6000  
Fax: (225) 216-6335 |
| Pre-Certification Unit (Hospital)  
Pre-certification issues and forms | P.O. 14849  
Baton Rouge, LA 70809-4849  
Phone: (800) 877-0666  
Fax: (800) 717-4329 |
| Pharmacy Point of Sale (POS) | P.O. Box 91019  
Baton Rouge, LA 70821  
Phone: (800) 648-0790 (Toll Free)  
Phone: (225) 216-6381 (Local)  
*After hours, please call REVS* |
| Prior Authorization Unit (PAU) | Molina Medicaid Solutions – Prior Authorization  
P.O. Box 14919  
Baton Rouge, LA 70898-4919  
(800) 488-6334 |
| Provider Enrollment Unit (PEU) | Molina Medicaid Solutions-Provider Enrollment  
P.O. Box 80159  
Baton Rouge, LA 70898-0159  
(225) 216-6370  
(225) 216-6392 Fax |
| Provider Relations Unit (PR) | Molina Medicaid Solutions – Provider Relations Unit  
P.O. Box 91024  
Baton Rouge, LA 70821  
Phone: (225) 924-5040 or (800) 473-2783  
Fax: (225) 216-6334 |
| Recipient Eligibility Verification (REVS) | Phone: (800) 766-6323 (Toll Free)  
Phone: (225) 216-7387 (Local) |
<table>
<thead>
<tr>
<th>TYPE OF ASSISTANCE</th>
<th>CONTACT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medicaid Hotline</td>
<td>(888) 342-6207 (Toll Free)</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.lamedicaid.com">www.lamedicaid.com</a></td>
</tr>
<tr>
<td>Health Standards Section (HHS)</td>
<td>P.O. Box 3767</td>
</tr>
<tr>
<td></td>
<td>Baton Rouge, LA 70821</td>
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<tr>
<td></td>
<td>Phone: (225) 342-0128</td>
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<tr>
<td></td>
<td>Fax: (225) 5292</td>
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<tr>
<td>Louisiana Children’s Health Insurance Program (LaCHIP)</td>
<td>(225) 342-0555 (Local)</td>
</tr>
<tr>
<td></td>
<td>(877) 252-2447 (Toll Free)</td>
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<tr>
<td></td>
<td><a href="http://bhsfweb.dhh.louisiana.gov/LaCHIP/">http://bhsfweb.dhh.louisiana.gov/LaCHIP/</a></td>
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<tr>
<td>Office of Aging and Adult Services (OAAS)</td>
<td>P.O. Box 2031</td>
</tr>
<tr>
<td></td>
<td>Baton Rouge, LA 70821</td>
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<tr>
<td></td>
<td>Phone: (866) 758-5038</td>
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<tr>
<td></td>
<td>Fax: (225) 219-0202</td>
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<tr>
<td></td>
<td>E-mail: <a href="mailto:MedWeb@dhh.la.gov">MedWeb@dhh.la.gov</a></td>
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<tr>
<td></td>
<td><a href="http://new.dhh.louisiana.gov/index.cfm/subhome/12n/7">http://new.dhh.louisiana.gov/index.cfm/subhome/12n/7</a></td>
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<tr>
<td>Office of Management and Finance (Bureau of Health Services Financing)</td>
<td>P.O. Box 91030</td>
</tr>
<tr>
<td></td>
<td>Baton Rouge, LA 70810</td>
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<tr>
<td></td>
<td><a href="http://new.dhh.louisiana.gov/index.cfm/page/219">http://new.dhh.louisiana.gov/index.cfm/page/219</a></td>
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<tr>
<td>Office for Citizens with Developmental Disabilities (OCDD)</td>
<td>628 N. Fourth Street</td>
</tr>
<tr>
<td></td>
<td>Baton Rouge, LA 70802</td>
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<tr>
<td></td>
<td>Phone: (225) 342-0095 (Local)</td>
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<td></td>
<td>Phone: (866) 783-5553 (Toll-free)</td>
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<tr>
<td></td>
<td>E-mail: <a href="mailto:ocddinfo@la.gov">ocddinfo@la.gov</a></td>
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<tr>
<td>Rate Setting and Audit Hospital Services</td>
<td>P.O. Box 91030</td>
</tr>
<tr>
<td></td>
<td>Baton Rouge, LA 70821</td>
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<tr>
<td></td>
<td>Phone: 225-342-0127</td>
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<tr>
<td></td>
<td>225-342-9462</td>
</tr>
<tr>
<td>Recipient Assistance for Authorized Services</td>
<td>Phone: (888) 342-6207 (Toll Free)</td>
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### TYPE OF ASSISTANCE

**General Medicaid Hotline**

<table>
<thead>
<tr>
<th>CONTACT INFORMATION</th>
<th>P.O. Box 3767</th>
<th>Baton Rouge, LA 70821</th>
<th>Phone: (225) 342-0128</th>
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**Health Standards Section (HHS)**

<table>
<thead>
<tr>
<th>CONTACT INFORMATION</th>
<th>P.O. Box 2031</th>
<th>Baton Rouge, LA 70821</th>
<th>Phone: (866) 758-5038</th>
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**Louisiana Children’s Health Insurance Program (LaCHIP)**

<table>
<thead>
<tr>
<th>CONTACT INFORMATION</th>
<th>P.O. Box 3588</th>
<th>Baton Rouge, LA 70821</th>
<th>Phone: (225) 342-1376</th>
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**Office of Aging and Adult Services (OAAS)**

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<tr>
<th>CONTACT INFORMATION</th>
<th>P.O. Box 3767</th>
<th>Baton Rouge, LA 70821</th>
<th>Phone: (225) 342-0128</th>
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**Recovery and Premium Assistance**

<table>
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<th>CONTACT INFORMATION</th>
<th>P.O. Box 3588</th>
<th>Baton Rouge, LA 70821</th>
<th>Phone: (225) 342-1376</th>
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**Fraud hotline**

**Program Integrity (PI) Section**

<table>
<thead>
<tr>
<th>CONTACT INFORMATION</th>
<th>P.O. Box 91030</th>
<th>Baton Rouge, LA 70821-9030</th>
<th>Fraud and Abuse Hotline: (800) 488-2917</th>
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</table>

**To report fraud**

<table>
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<tr>
<th>CONTACT INFORMATION</th>
<th>Program Integrity (PI) Section</th>
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**Fraud hotline**

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### Appeals

<table>
<thead>
<tr>
<th>TYPE OF ASSISTANCE</th>
<th>CONTACT INFORMATION</th>
</tr>
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</table>
| To file an appeal                         | Division of Administrative Law (DAL) - Health and Hospitals Section  
Post Office Box 4189  
Baton Rouge, LA 70821-4189  
(225) 342-0443  
(225) 219-9823 (Fax) |

### Other Helpful Contact Information:

<table>
<thead>
<tr>
<th>TYPE OF ASSISTANCE</th>
<th>CONTACT INFORMATION</th>
</tr>
</thead>
</table>
| American Dental Association                                                      | 211 East Chicago Ave.  
Chicago, IL 60611-2678  
Phone: (312) 440-2500  
www.ada.org |
| Centers for Medicare and Medicaid Services OASIS, CMS-485 Form                   | www.cms.hhs.gov                                           |
| LSU School of Dentistry, Medicaid Dental Prior Authorization Unit  
Dental Prior Authorization ONLY                                                   | P.O. Box 19085  
New Orleans, LA 70719-9085  
Phone: (504) 941-8206 (Local)  
(866) 592-3299 (Toll Free)  
(504) 941-8209 (Fax) |
| Southeastrans Transportation Inc. Transportation Call Center                    | Phone: (855) 325-7576                                     |
UB-04 FORM AND INSTRUCTIONS

Claims for home health services must be filed by electronic claims submission 837I or on the UB-04 claim form.

The most recent instructions for completing the UB-04 form along with samples of UB-04 claim forms for home health services routine billing are located on the home page of the Louisiana Medicaid website. The billing instructions and examples may also be accessed by using the below hyperlink.

http://www.lamedicaid.com/provweb1/billing_information/Home_Health UB04.pdf