



California
Department of
Health Services

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Department of Health Services



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TO: ALL COUNTY CALIFORNIA CHILDREN'S SERVICES (CCS) PROGRAM ADMINISTRATORS, MEDICAL CONSULTANTS, NURSING STAFF, STATE CHILDREN'S MEDICAL SERVICES (CMS) BRANCH AND REGIONAL OFFICE STAFF

SUBJECT: INTERMITTENT HOME HEALTH SERVICES PROVIDED BY A HOME HEALTH AGENCY (HHA)

I. Introduction

The purpose of this Numbered Letter (N.L.) is to provide CCS program staff with policy and guidelines for the review and authorization of medically necessary intermittent home health services for children through a HHA. This N.L. is the result of a joint CCS and HHA statewide committee effort and has been reviewed by CCS programs and statewide consultants.

II. Background

Intermittent home health services are medically necessary services provided in a patient's home, as prescribed by a physician in accordance with a written treatment plan, that must be renewed by a physician every 60 days (California Code of Regulations (CCR), Title 22, Section 51337). The treatment plan must indicate the need for one or more of the following services:

- Skilled nursing services by licensed nursing personnel
- Physical Therapy
- Occupational Therapy
- Speech Therapy

- Medical Social services by a Medical Social Worker (MSW)
- Home Health Aide
- Utilization of medical supplies, such as extensive dressings or specialty needles, other than drugs and biologicals
- Respiratory Care Therapy

The most common use of intermittent home health services for children is the provision of post hospitalization assistance with medically necessary services to complete the recovery or rehabilitation process at home. Prospective discharge planning should be done during hospitalization, and the discharge plan, including home health services should be in place before a child is discharged. However, in practice, home health services are often ordered at the last minute on the day the child is discharged.

A HHA must be an active Medi-Cal provider. CCS provider approval is not required for HHAs or staff employed by the HHA (i.e., Licensed Vocational Nurses, Occupational Therapists, Physical Therapists, Registered Nurses (RN), Speech Pathologists, Respiratory Care Practitioners, or Social Workers) for the purpose of authorizing services.

The initial evaluation/assessment for home health services is completed by the HHA RN for all requested services, unless the physician has requested services only for occupational therapy, physical therapy, or speech/language therapy. For these requests, the appropriate therapist may provide the initial evaluation.

Home Health Aide services may include personal care and household services. These services must be billed as part of a physician-approved treatment plan and supervised by a RN or therapist, as appropriate. Personal care services may include assistance with the following:

- Ambulation
- Bathing
- Catheter site care
- Feeding

- Grooming
- Prescribed exercises
- Range of motion exercises
- Simple skin/wound care
- Transfers in and out of bed

Certain household services to facilitate the patient's self-care, such as changing the bed, may also be included in the visit if they are incidental to medically necessary services and do not substantially increase the service time of the home health aide. Each "Per Visit Allowance" for the home health aide represents a minimum of two hours of service rendered to a patient.

For services provided by an agency, each "Per Visit Allowance" billed represents a minimum of one hour service provided to the patient, with the exception of the Home Health Aide service above.

Medical supplies left at the home by HHA personnel may be separately billed using the Miscellaneous Code (MC) Z6918, including:

- Supplies provided for the patient for later use:
- Costly medical supplies not routinely used during a visit; such as specialty needles or extensive dressings;
- Any medical supply requested by prescription or in accordance with the treatment plan.

Drugs and biologicals are not included in the reimbursement rate for a home health visit and should not be authorized to the HHA. These items may be authorized separately to the appropriate entity, per CCS protocol, to coincide with the authorization of the licensed skilled nursing visits.

III. Policy

- A. Home health services provided on an intermittent basis are benefits of the CCS program. CCS programs will provide authorizations for intermittent home health services for CCS-eligible children when medically necessary, regardless of the payer source.
- B. Each independent county CCS program and State Regional Office shall designate an HHA Nurse Liaison. The liaison will work with local HHAs to establish a relationship for coordination of care and to facilitate the resolution of related issues or problems. The liaison is not intended to be a substitute for the case management contact person for routine HHA requests.
- C. Authorization requirements for home health services:
 - 1. The county CCS program and State Regional Office shall authorize home health services when ordered by the attending physician, responsible for care during the inpatient hospital stay, regardless of whether the provider is CCS approved.
 - 2. The county CCS program on-site nurse representative shall actively collaborate with discharge planning staff to facilitate the discharge plan and authorization of medically necessary service(s) upon discharge.
 - 3. The county CCS program and State Regional Office shall authorize a minimum of a home health assessment and up to three follow-up visits for a CCS-eligible client, when identified as part of the hospital discharge plan or a HHA request.
 - 4. Issuance of the authorization shall not be delayed to wait for the physician's signed Plan of Treatment (POT). The CCS program does not require a physician's signature to authorize home health services.
 - 5. Documentation for the initial home health services request may include:
 - a. CCS referral
 - b. The suspected CCS medically eligible condition (i.e. history and physical, consultant report), if not previously known to the CCS program.

- c. Physician discharge orders
 - d. POT/justification for the intermittent home health services
 - e. Date of discharge from hospital
 - f. Dates of Service (DOS)
 - g. Anticipated total number of visits, if not included in the discharge orders or CCS referral
 - h. Request for medical supplies
6. Subsequent request(s) for additional or extension of visits shall include:
- a. Current nursing evaluation or summary
 - b. Current POT/justification for additional visits
 - c. DOS
 - d. Anticipated number of visits
7. Authorizations for requested drug, biologicals and medical supplies that relate to the delivery of home health services shall be issued to the appropriate provider simultaneously with the authorization of HHA services.

IV. Policy Implementation

- A. Criteria for review and authorization of medically necessary HHA request(s) for a CCS-eligible child:
- 1. The provision of home health services following hospital discharge may begin prior to the receipt of a request, including the initial assessment and up to three follow-up visits. If the CCS enrollment is retroactive, the child's enrollment date must be recorded in the CCS case management system prior to the start of service date.

2. When a need for home health services is anticipated without a hospitalization, the initial assessment and up to three follow-up visits may be authorized to an identified HHA when the requesting provider is CCS approved or is a Special Care Center. An exception to this requirement may be made for an emergency situation when requested by a non-CCS approved provider. (See "[This Computes! #158](#) for physician provider authorization/claiming instructions.)
 3. CCS timeliness of referral provisions for CCS-only and CCS/Healthy Families as defined in Title 22, California Code of Regulations, Section 42180, shall apply. However, per Welfare and Institutions Code, Section 14133.05, for full scope no share of cost Medi-Cal beneficiaries, the CCS program cannot deny requests for medically necessary services solely on the basis that the request does not meet CCS timeliness requirements.
 4. Requests for service or discharge plans and supporting documentation that justify a need for more than an assessment and three visits shall be authorized.
- B. Authorizations for HHA services shall include the following information and instructions to the provider, as applicable:
1. The type of service authorized;
 2. The number of visits approved (e.g., four skilled nursing visits);
 3. The effective beginning and ending date during which the services may be provided; and
 4. The Healthcare Common Procedure Coding System (HCPCS) codes specific to the service authorized, as listed in Attachment A.
 5. Instructions to the provider for billing/claiming may be added to the special instructions box on the authorization, if appropriate.
 6. Authorization(s) for related medical supplies using Miscellaneous "By-Report" HCPCS code Z6918 shall be issued separately as follows:

- a. Supplies provided for the patient for later use
 - b. Costly medical supplies not routinely used during a visit, such as specialty needles or extensive dressings
 - c. Any supply requested by prescription or in accordance with the treatment plan
 - d. Instruct the provider to submit the following information with the claim:
 1. Copy of this SAR, and
 2. As required for medical supply claims, all manufacturer codes and catalog numbers must be documented. Please refer to the Medical manual for billing instructions.
 - e. Include the following Special Instructions statement on the authorization: *Claiming for HCPCS code Z6918 requires "By Report" documentation included with claim submission.*
- C. Separate authorizations supporting the HHA request issued to other providers:
1. For requested drugs, biologicals or medical supplies not furnished by the HHA (e.g. pharmacy),
 2. For requested Durable Medical Equipment items related to the delivery of home health services.

If you have any questions regarding this policy, please contact your Regional Office Medical Consultant or Nurse Consultant.

Original signed by Harvey Fry for Marian Dalsey, M.D., M.P.H.

Marian Dalsey, M.D., M.P.H., Acting Chief
Children's Medical Services Branch

ATTACHMENT A

		Per Visit
<u>Service</u>	<u>HCPCS Code</u>	<u>Allowance (time)</u>
Case evaluation and initial treatment plan	Z6914	One hour
Monthly case evaluation – extension of treatment plan	Z6916	One hour
Skilled nursing services	Z6900	One hour
Physical therapy services	Z6904	One hour
Occupational therapy services	Z6906	One hour
Speech therapy services	Z6908	One hour
Medical social service	Z6910	One hour
Respiratory care services	Z6918	One hour
Home health aide services	Z6902	Two hours
Early discharge follow-up visit post Inpatient delivery services	Z6920	One hour
Unlisted services (“By-Report”) (medical supplies)	Z6918	