Home Health Agencies

Page updated: October 2024

This section contains instructions for billing Home Health Agencies (HHA) services.

Program Coverage

‹‹The following services are reimbursable as an outpatient benefit when prescribed by a physician, nurse practitioner (NP), clinical nurse specialist, (CNS), or physician assistant and provided at the recipient's home in accordance with a written treatment plan reviewed by a physician, nurse practitioner, clinical nurse specialist, or physician assistant every 60 days. The NP, CNS, and physician assistant operate under the supervision of a licensed physician and are subject to the California Board of Registered Nursing (BRN) scope of practice guidelines or the California Physician Assistant Board.

The written treatment plan must indicate a need for one or more of the following:››

- Part-time or intermittent skilled nursing services by licensed nursing personnel
- In-home medical care services as defined in the *Welfare and Institutions Code* (W&I Code), Section 14132(t)
- Physical, occupational or speech therapy
- Medical social services
- Home health aide services
- Other home health services
- Medical supplies other than drugs and biologicals
- The use of medical appliances, provided for under an approved treatment plan

‹‹Durable Medical Equipment (DME)

A prescription, written by the treating practitioner, is required for authorization of purchase, rental, repair, or maintenance of DME, per CCR, Title 22, Section 51321. The following practitioners may prescribe DME: a physician, nurse practitioner, clinical nurse specialist or physician assistant. A copy of the signed and dated written prescription (or electronic equivalent) must accompany the TAR.

Prescribing practitioners must retain the prescription for their records.

For specifics of DME and *Treatment Authorization Requests* (TARs) see the Provider Manual part 2, *Durable Medical Equipment (DME): An Overview*.

For example, an infusion pump is reimbursable only when billed by a valid DME provider. DME cannot be billed by an HHA provider.››

Authorization/Frequency Limitations

For authorization requirements and limitations on the frequency for HHA services, refer to the chart in the *Home Health Agencies (HHA) Billing Codes and Reimbursement Rates* section in this manual.

Physician Treatment Plan

Authorization requests for services beyond the case evaluation requiring approval must include a written treatment plan that will be approved and signed by a physician within 30 working days of the treatment plan date. Since the ordering physician has 30 working days to sign a written treatment plan, an authorization request may be submitted to the TAR Processing Center with an unsigned written treatment plan, but must have a physician's verbal order for services, taken and recorded by a health care professional at the time services are ordered. A health care professional may be a registered nurse, qualified therapist, social worker or any other health professional responsible for furnishing or supervising care.

Upon request, the written treatment plan is to be available to the Department of Health Care Services' (DHCS') staff by the providing Home Health Agency, documenting evidence of the ordering physician's signature within 30 working days of the treatment plan date.

The treatment plan must include:

- The principal diagnosis and significant associated diagnoses
- Prognosis
- Date of onset of the illness
- Specific types of services to be rendered by each discipline
- Therapeutic goals to be achieved by each discipline and anticipated time for achievement of goals
- The extent to which HHA care has been previously provided, and benefits or improvements demonstrated by such care
- A description of the home situation, to include whether assistance is available from household members, homemakers, attendants or others

A re-authorization request must include a statement describing the recipient's progress toward achieving the therapeutic goals.

Face-to-Face Encounter

For all services delivered by a home health agency, a face-to-face encounter with a physician, nurse practitioner, clinical nurse specialist physician assistant or certified nurse midwife that is related to the primary reason the recipient requires the home health services is required. Face-to-face encounters may be done via telehealth.

The following conditions must be met in order for the face-to-face encounter to be satisfied:

- The provider performing the face-to-face encounter must communicate the clinical findings of that face-to-face encounter to the ordering physician.
- The clinical findings from the face-to-face encounter must be incorporated into a written or electronic document included in the recipient's medical record.
- The physician prescribing the home health agency services must document that the face-to-face encounter, which is related to the primary reason the recipient requires services by a home health agency, has occurred within 90 days prior to or within 30 days after the start of services.
- The physician writing the prescription for home health agency services must document who conducted the face-to-face encounter and the date of the encounter

‹‹Home Infusion Therapy Services

Home infusion therapy services (HCPCS codes G0088 and G0089) are reimbursable subject to authorization. Services are for treatment of a disease or condition, which is unresponsive to oral medications.

Authorization

Home infusion therapy services require a *Treatment Authorization Request* (TAR) for reimbursement. The TAR must document all of the following:

- The service is medically necessary.
- The diagnosis and prescription are written by a physician or licensed professional practitioner.
- The name of medication/solution, route, frequency, duration, strength and total units.
- A trained registered nurse or licensed health professional following the physician's orders provides the service, including documentation of patient status for the duration of treatment.

Note: These processes do not replace medication authorization that requires prior authorization through Pharmacy Benefits division.››

Same Day Services: Skilled Care Services

If it is necessary to perform one of the following skilled care services on the same date of service as the initial or six-month case evaluation (HCPCS code G0162 and revenue code 0583), both services must be billed on the same claim:

Skilled Care Services Codes

Service	HCPCS Code	Revenue Code
Physical therapy	G0151	0421
Occupational therapy	G0152	0431
Speech therapy	G0153	0441
Skilled nursing	‹‹G0299 or G0300››	0551
Medical social services	G0155	0561

When billing for one of these skilled care services on the same date as the initial or six-month case evaluation, both the evaluation and the skilled care services are reimbursable without authorization. If the skilled care service is billed separately, authorization is required.

Note: Only one skilled care service may be billed in conjunction with the initial evaluation.

TAR Requirements

Monthly case evaluation, extension of treatment plan and skilled care services (HCPCS code G0162 and revenue code 0589) are not subject to authorization; however, any other skilled care services billed with this code must be accompanied by an approved *Treatment Authorization Request* (TAR) on a separate claim form.

Same Day Services: Mother and Baby

Services for a mother and baby on the same day require separate UB-04 claims and separate TARs for each recipient. (Refer to *Figure 3*, “Services to Both Mother and Baby on Same Day” in the *Home Health Agencies (HHA) Billing Examples* section of this manual.)

Home Health Agency providers who render services to a mother and her newborn(s) during the neonatal period (month of delivery and subsequent month) may be reimbursed without authorization for only one initial skilled nursing visit (HCPCS code ‹‹G0299 or G0300›› and revenue code 0551). A case evaluation and initial treatment plan (HCPCS code G0162 and revenue code 0583) is reimbursable for the mother without authorization. A case evaluation and initial treatment plan (HCPCS code G0162 and revenue code 0583) for the newborn using the mother’s Medi-Cal ID number may be reimbursed without authorization when it is performed on a different date than the mother’s case evaluation and initial treatment plan. If more than one visit is necessary, or if services are rendered to mother and infant on the same date of service during the two-month period the infant is using the mother’s ID, authorization is required.

Refer to “Newborn Infant Using Mother’s ID” in the *Eligibility: Recipient Identification Cards* section of the Part 1 manual, for information about submitting claims for a newborn.

Home Health Psychiatric Nursing Services

Home Health Agency (HHA) services are excluded from coverage by the Mental Health Program (MHP) as set forth in the *California Code of Regulations* (CCR), Title 9, Section 1810355(a)(7)(F). However, home health psychiatric nursing is a skilled nursing service that may be provided by an HHA to a Medi-Cal recipient with a psychiatric illness or condition.

Diagnostic Criteria

To receive home health psychiatric nursing, recipients must have an Axis I diagnosis, defined in the *Diagnostic and Statistical Manual of Mental Health Disorders*, 4th edition (DSM-IV) as “…clinical disorders, other conditions that may be a focus of clinical assessment as opposed to personality disorders, mental retardation, dementia, active substance abuse, dementia of Alzheimer type (uncomplicated), psychosocial and environmental problems and global assessment of functioning.”

Psychiatric Nursing Services

The following are examples of psychiatric services that may be provided by a home health nurse:

- Make an initial evaluation using observation and assessment skills
- Evaluate, review and teach the use of medications, emphasizing compliance
- Administer IM or I.V. medication, if necessary
- Manage situational (or other) crises; perform suicidal assessments, as necessary
- Provide psychotherapeutic assessments as ordered by the physician, which may include supportive counseling, behavior modification (for obsessive-compulsive behaviors such as hand washing) and cognitive retraining (positive thinking process)
- Provide psychological education such as teaching/training with disease process, symptom and safety management, coping skills and problem solving

Authorization

HHA psychiatric nursing service visits require the submission of a TAR for approval. The TAR must be accompanied by a written plan of care approved by a physician every 62 days. A reauthorization request must include a statement describing the recipient's progress toward achieving the therapeutic goals.

A home visit by two nurses on the same day (one nurse who provides psychiatric nursing services and the other who provides non-psychiatric nursing services) is considered a single service and will be authorized and reimbursed as a single visit because both services constitute skilled nursing care and both can be provided by a single psychiatric nurse.

Home Health Aide Services

Home health aide services (HCPCS code G0156 and revenue code 0571) are both Medicare and Medi-Cal benefits. These services may include personal care and household services that must be billed as part of a physician-approved treatment plan and must be supervised by a registered nurse or therapist.

Personal care services include:

- Ambulation
- Bathing
- Catheter site care
- Feeding assistance
- Grooming
- Medical assistance
- Prescribed exercises assistance
- Range of motion exercises
- Skin care
- Transfers out of bed

Certain household services may also be included in the visit if they are incidental to medically necessary services and do not substantially increase the home health aide's service time.

‹‹Per Visit Allowance

Service time is measured in units of 15-minute increments.››

Four units equal one hour of service, which equates to one “per visit allowance.” Each “per visit allowance” billed represents a minimum of one hour of service to the recipient, with the exception of “Home Health Aide Services,” which represents a minimum of two hours of service to the recipient.

‹‹No less than the minimum “per visit allowance” may be billed, so if the service time is less, it may be rounded up. Any service time beyond the one hour minimum for “Skilled Care Services” or two hours minimum for “Home Health Aide Services” may be billed as additional units. The total number of services billed should be indicated in the Service Units field (Box 46) of the UB-04 claim in 15-minute increments. For example, one hour of service should be billed as “4” units, 1 ½ hours of service should be billed as “6” units, and two hours of service should be billed as “8” units. For rates regarding HHA services, refer to the chart in the *Home Health Agencies (HHA) Billing Codes and Reimbursement Rates* section in this manual.››

Medical Supplies Provided by HHA

Medical supplies given to Medi-Cal recipients by HHA personnel may be covered as separately reimbursable items subject to authorization. Supplies are separately reimbursable if:

- They are not used as part of a treatment visit (that is, they are left with the recipient for later use)
- They are provided in accordance with the recipient’s written treatment plan

The Medi-Cal payment rate for HHA treatment visits is intended to compensate the agency for all costs incidental to the visit, including usual transportation and necessary supplies. The rates are established in part by reference to the Medicare rates, which include the cost of medical supplies in computing allowable reimbursement. Under Medi-Cal, the medical supply used in connection with the treatment visit (for example, bandages used to change dressings) is included in the payment for the nursing visit. The payment is intended to include the cost of incidental supplies. Medical supplies can be considered separately payable only when they are left with the recipient.

Separately reimbursable medical supplies are subject to authorization regardless of their cost. These supplies should be billed as HCPCS code A9999 (miscellaneous supplies) and revenue code 0270 (medical/surgical supplies and devices, general classification). The written treatment plan must state that these supplies are consistent with the treatment proposed. HHA claims for medical supplies will be denied unless authorization has been granted.

Claims for as HCPCS code A9999 and revenue code 0270 must be billed "By Report." An invoice, an itemized list and a TAR should be attached to the claim. Claims without this documentation will be denied.

Medi-Cal Reimbursement

Medi-Cal reimbursement, with the exception of incontinence supplies, is limited to the lesser of the provider's usual and customary rate or Medi-Cal's rate on file plus a 23 percent dealer mark-up. Appropriate sales tax will also be added.

Medi-Cal reimbursement for incontinence supplies, including incontinence/ostomy creams and washes, is limited to the lesser of the provider's usual and customary rate or Medi-Cal's rate on file plus a 38 percent mark-up. Appropriate sales tax will also be added.

Other HHA Services

Other services provided by HHA personnel that do not apply to any of the previous categories may be separately reimbursable subject to authorization.

For example, respiratory therapist services should be billed as CPT® code 99600 (unlisted home visit service or procedure) and revenue code 0589 (visit/home health/other). Claims for CPT code 99600 and revenue code 0589 must be billed "By Report." An invoice, an itemized list and a TAR should be attached to the claim. Claims without this documentation will be denied. Refer to the *Home Health Agencies (HHA) Billing Examples* section of this manual for additional information.

Filling Diabetic Syringes

Home Health Agency visits for the purpose of filling insulin syringes are not covered under the Medi-Cal program except as skilled nursing visits for someone who is physically incapable of filling insulin syringes and who has no family member capable of performing this task. According to the Board of Registered Nursing, under California law, the filling of syringes is a Registered Nurse function that cannot be delegated to nonlicensed personnel.

Note: Medi-Cal and Medicare policies are different on this point.

Homebound Recipient: Medically Necessary Services

A homebound recipient is defined in *California Code of Regulations* (CCR), Title 22, Section 51146, as a recipient "who is essentially confined to his home due to illness or injury, and if ambulatory or otherwise mobile, is unable to be absent from his home except on an infrequent basis or for periods of relatively short duration; for example, for a short walk prescribed as therapeutic exercise."

Eligibility

Homebound Medi-Cal eligible recipients must have full-scope eligibility for the month(s) that the service is rendered.

Authorization Required

Home Health Agencies may render medically necessary services with authorization to recipients who are unable to travel to the provider of medically necessary services.

TAR Documentation

TARs must address the requirements, restrictions, and limitations (including time limits and lowest cost factors) as referenced in CCR, Title 22, Section 51337.

A statement providing documentation that the recipient is confined to home is not required.

Description Field of Claim Form

‹‹Home Health Agencies must include additional justification in the *Description* field (Box 43) of the claim or *Remarks* area of the ASC X12N 837 v.5010 claim when billing Medi-Cal for:››

- Multiple services that are billed with the same procedure code, same date of service, but at different times during the day. Enter the time the service was rendered in the *Description* field (Box 43).

  Use the *Description* field (Box 43) to identify the type of visit when billing for initial evaluation and skilled care service visits on the same date of service.

- “From-through” dates of service. “From-through” dates of service are billed on separate claim lines. On line one, enter the procedure code description in the *Description* field (Box 43) and the “from” date in the *Service Date* field (Box 45).

  On line two, enter the specific days the service was rendered in the *Description* field, the procedure code in the *HCPCS/Rates* field (Box 44), the “through” date in the *Service Date* field (Box 45), the total number of days in the *Service Units* field (Box 46) and the total charges in the *Total Charges* field (Box 47). Use the *Remarks* field (Box 80) to identify an attachment.

Refer to the *Home Health Agencies (HHA) Billing Examples* section of this manual for additional information.

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.