

SECTION 2

POLICIES AND PROCEDURES

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SECTION 2 POLICIES AND PROCEDURES

PROGRAM OVERVIEW

ADMINISTRATION

The Medicaid Home Health program is administered in South Carolina by the South Carolina Department of Health and Human Services (SCDHHS). All home health agencies must contract with the SCDHHS prior to providing home health services to eligible Medicaid beneficiaries.

TERMS

A **home health agency** is a public agency or private organization or a part of an agency or organization that is primarily engaged in providing nursing services, aide services, supplies, and other therapeutic services in the patient's home. The function of a home health agency does not include care provided primarily for treatment of mental diseases.

Home health services are those services provided by a home health agency or individual provider to eligible beneficiaries who are affected by illness or disability at their place of residence, based on their physician's orders. A health care professional renders these services through visits to the residence.

A **residence** is the place where a patient dwells permanently or for an extended period of time. This does not include a hospital or skilled nursing facility.

A **visit** is a face-to-face encounter between a patient and any qualified home health professional whose services are reimbursed under the Medicaid program. When care is provided, the service a patient receives is counted in visits. For example, if a patient receives one home health service twice in the same day or two different types of home health services in the same day, two visits would be counted.

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PROGRAM REQUIREMENTS

PROVIDER QUALIFICATIONS

A home health agency must provide skilled nursing services, home health aide services, and at least one of the following optional professional services: physical, speech, or occupational therapy. In areas where it is not possible or feasible to obtain professional services on a salaried basis or through the staff of the agency, these services are arranged on an as-needed basis through the use of an individual or agency contract or agreement.

The agency must have policies established by a group of professional personnel, including one or more physicians and one or more registered professional nurses, to govern the services that it provides. Supervision of such services by a physician or registered professional nurse is required.

Licensure and Certification

The home health agency must be certified to participate under Title XVIII (Medicare), meet the conditions governing participation as certified by the South Carolina Department of Health and Environmental Control, and have an approved Certificate of Need (CON). The home health agency must also be in compliance with all federal, state, and local laws.

Any changes in licensure, certification, or ownership must be immediately reported to:

Department of Health and Human Services
Division of Contracts
Post Office Box 8206
Columbia, SC 29202-8206

Enrollment

All home health agencies must complete an enrollment form to participate in the South Carolina Medicaid program. Official notification of enrollment status will be returned to each provider. This process is described in detail in Section 1, "Requirements for Provider Participation."

Reimbursement

SCDHHS will reimburse the home health provider for services agreed to in the contract, according to the interim rates provided by the Department of Ancillary Reimbursements, Bureau of Reimbursement Methodology

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PROGRAM REQUIREMENTS

Reimbursement (Cont'd.)

and Policy of SCDHHS. Payment will be made at a fixed rate per visit for the following services:

1. Skilled Nursing visits
2. Home health aide visits
3. Therapy visits (Physical Therapy, Speech Therapy, and Occupational Therapy)
4. Social work services

Payment for allowable medical supplies is based on reasonable cost. The cost may not exceed the amount a prudent buyer would pay for the same item and is comparable to the cost of similar items to other medical providers. Medical supplies that are used in the provision of routine home health services are initially reimbursed based on charges; however, during the fiscal year-end cost settlement, an adjustment is made reflective of the cost-to-charges ratio for medical supplies.

Based on the availability of federal and/or state matching funds, the Medicaid reimbursement methodology used to determine the interim home health rates is the lesser of allowable Medicare costs, charges, or the Medicare cost limits by discipline. These interim rates are calculated based on the most recent Medicare cost report, Medicare cost limits, and charges as submitted by the provider to the Department of Ancillary Reimbursements. Home health agencies entering the Medicaid program for the first time will be reimbursed at the lesser of Medicare cost limit, charges, or the interim rates as established by the Medicare intermediary until the submission of actual cost data.

Each provider is required to submit to Medicaid a copy of their cost report (CMS 1728 or CMS 2552), with accompanying Medicaid data, no later than five months after the provider's financial year end. If the cost report is not submitted in a timely fashion, as stated in the contract, all funds may be withheld by SCDHHS. A desk review is done by the staff of the Division of Ancillary Reimbursements on the "As Filed" Medicare cost report and accompanying Medicaid data, and Medicaid statistics obtained from MMIS (Medicaid Management Information System). The initial cost settlement is determined based on the lesser of the allowable Medicare costs, charges, or the Medicare cost limits, in the aggregate, factoring in an

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Reimbursement (Cont'd.)

adjustment in accordance with Medicare cost charges ratio for medical supplies. A final settlement is made for each financial year based on the Medicare audit of the cost report. The Medicaid provider should notify the Division of Ancillary Reimbursements of the Medicare audit findings within 30 days of the receipt of the Medicare audit report, as these findings are utilized in determining the final Medicaid settlement. Final cost settlement and payment is limited to the lesser of allowable Medicare costs, Medicare cost limits, or charges in the aggregate.

Questions pertaining to interim reimbursement rates, cost reports, and cost settlements should be directed to the Division of Ancillary Reimbursements, South Carolina Department of Health and Human Services.

DOCUMENTATION REQUIREMENTS

Homebound Status

An individual does not have to be bedridden to be considered confined to the home. However, the condition of these patients should be such that there exists a normal inability to leave home and, consequently, leaving their home would require a considerable and taxing effort. If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive medical treatment.

Absences attributable to the need to receive medical treatment include attendance at adult day centers to receive medical care, ongoing receipt of outpatient kidney dialysis, and the receipt of outpatient chemotherapy or radiation therapy. It is expected that, in most instances, absences from the home that occur will be for the purpose of receiving medical treatment. However, occasional absences from the home for non-medical purposes, *e.g.*, an occasional trip to the barber, a walk around the block, or a drive, would not necessitate a finding that the individual is not homebound so long as absences are undertaken on an infrequent basis or are of relatively short duration and do not indicate that the patient has the capacity to obtain the health care provided outside rather than in the home.

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PROGRAM REQUIREMENTS

Homebound Status (Cont'd.)

Generally speaking, a beneficiary will be considered to be homebound if he or she has a condition due to an illness or injury that restricts the patient's ability to leave his or her place of residence, except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person; or, if he or she has a condition that is such that leaving the home is medically contraindicated. Below are some examples of homebound patients that illustrate the factors involved in determining whether a homebound condition exists:

1. A beneficiary paralyzed from a stroke who is confined to a wheelchair or who requires the aid of crutches in order to walk
2. A beneficiary who is blind or senile and requires the assistance of another person in leaving his or her place of residence
3. A beneficiary who has lost the use of his or her upper extremities and therefore is unable to open doors, use handrails on stairways, etc., and therefore requires the assistance of another individual in leaving his place of residence
4. A patient who has just returned from a hospital stay involving surgery who may be suffering from resultant weakness and pain and therefore is restricted by his or her physician to certain specified and limited activities, such as getting out of bed only for a specified period of time, walking stairs only once a day, etc.
5. A patient with arteriosclerotic heart disease of such severity that he or she must avoid all stress and physical activity
6. A patient with a psychiatric problem, if his or her illness is manifested in part by a refusal to leave the home environment or is of such a nature that it would not be considered safe for the patient to leave his or her home unattended, even if he or she has no physical limitations

The guidelines concerning homebound status for Medicaid clients are applicable to all dually eligible as well as regular Medicaid clients. Generally speaking, the following

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PROGRAM REQUIREMENTS

Homebound Status (Cont'd.)

criteria must be met when considering the homebound status for all beneficiaries:

- A physician must certify that a patient is confined to his or her home.
- Patients do not have to be bedridden; however, leaving home would require a considerable and taxing effort.
- Absences from the home are infrequent and of a short duration and may be to receive medical treatment.
- A condition due to an illness or injury restricts the beneficiary's ability to leave home.

In accordance with the above guidelines, children in school settings or day care do not meet the homebound criteria. However, these children may be eligible to receive therapy services through the Medicaid Private Rehabilitative Therapy Services program.

Plan of Care

Covered services must be ordered by the beneficiary's attending physician or podiatrist as part of a written plan of care consistent with the functions the practitioner is legally authorized to perform. The practitioner must review and sign this plan of care at least every 60 days. The practitioner ordering home health services or reviewing the plan of care may not have a significant ownership interest in or a significant financial or contractual relationship with the home agency.

A practitioner has a significant interest if he or she owns 5% or more of the assets or is an officer, director, or partner of the home health agency. A significant financial or contractual relationship is defined as involving business transactions that amount to \$25,000 per year or 5% of the home health agency's operating expenses, whichever is less.

The plan of care should specify the treatment, services, supplies, items, or personnel needed by the patient, as well as the expected outcome. The care must be appropriate to the home setting and to the patient's needs. Goals and needs must also be documented. The objectives of the plan of care must be to improve the patient's level of health, relieve pain, and to prevent regression of the patient's

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PROGRAM REQUIREMENTS

Plan of Care (Cont'd.)

stable condition. The plan of care should restrict such care to the minimum number of visits necessary to meet these objectives. Records must be maintained that document the medical necessity of the care and detail the type and amount of care rendered. Records should also document improvement, or lack thereof. When changes in the plan of care are made, records should show the reasons for the change and the new care requirement.

PHYSICIAN'S ORIGINAL DRUG ORDERS AND CHANGES IN ORDERS

The following are signed by the physician and incorporated in the patient's records maintained by the home health agency:

- Original orders for drugs
- Changes in orders for the administration of narcotics, those drugs subject to the Drug Abuse Control Amendments of 1965, and other legend drugs

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PROGRAM SERVICES

COVERED SERVICES

Nursing Services

Nursing services provide direct patient care including, but not limited to, assessment, teaching, injections, changing dressings, catheter care, and skilled monitoring of symptoms. Nursing services must be provided to patients on a part-time or intermittent basis by registered nurses or licensed practical nurses. The nurse must be currently licensed by South Carolina and trained in administrative and clinical record keeping. The nursing care must be in accordance with written orders by the patient's physician and must be documented.

According to 42 CFR 440.70, nursing services must be provided on a part-time or intermittent basis. The South Carolina Medicaid program adopts the policy of intermittency as followed by the Medicare (Title XVII) intermediary. Services that medically meet the patient's need with a single visit are no longer covered for payment.

Reimbursement will not be made for nurses assisting with activities of daily living when a home health aide could perform such services. **Supervisory visits are non-billable.** According to 43 CFR 484.36(2), federal law requires that, in cases where a patient is receiving home health aide services, "the registered nurse, or appropriate professional staff member, if other services are provided, make a supervisory visit to the patient's residence at least every two weeks."

Nursing services are further defined for those dually eligible (Medicare/Medicaid) patients who still require nursing care at home but are denied Medicare coverage because their condition has stabilized. For such patients, nursing services can only be performed by a licensed nurse, must be prescribed by the attending physician, and must be included in the plan of care. Furthermore, the plan of care must reflect the fact that the patient is still homebound. The beneficiary's chart documenting nursing visits for a stabilized patient must reflect all of the following:

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PROGRAM SERVICES

Nursing Services (Cont'd.)

1. Reason for the visit and documentation of when skilled care changed to nursing visits for a stabilized patient
2. Medical condition and diagnosis
3. Last date of physician visit
4. Other disciplines of care currently rendered

S.C. Medicaid provides coverage for nursing services, nurse aide services, and medical supplies for dually eligible clients whose conditions have stabilized and who are no longer Medicare eligible.

Nursing and Dually Eligible Beneficiaries

Medicare remains the primary payer for dually eligible beneficiaries, and providers will remain obligated to comply with the requirements covering the coordination of benefits between the two programs. Medicaid. Agencies should carefully assess dually eligible clients who are stabilized and whose nursing visits may exceed four per month to determine whether they should be served under Medicare rather than Medicaid.

Nursing/DME Evaluation

A home health agency may evaluate a patient's need for Durable Medical Equipment (DME). This assessment should include the usefulness of the recommended equipment in the setting, consistent with the medical condition, at the lowest durable medical equipment cost, and the training of the patient in the utilization of equipment. This information is communicated to the attending physician who issues a referral, if deemed appropriate, to the home health agency. Evaluative visits may be incurred without a home health need; therefore, this benefit will characterize one visit per patient per 12-month period.

Stabilized and Durable Medical Equipment evaluation nursing visits shall be reimbursed at the respective agency's nursing care per visit cost.

Note: Medicaid does not cover any home health services during the same period home health benefits are being sponsored by Medicare, except as indicated above.

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PROGRAM SERVICES

Home Health Aide Services

Home health aide services are of a personal care nature, are medically oriented, are provided in the home, and include assistance in activities of daily living and retaining self-help skills; for example, helping with bathing, helping with prescribed exercises, or assisting in ambulation. Household services must be incidental and must not add appreciable time to the duration of the aide's presence. A visit by a registered nurse to supervise these home health aide services is not reimbursable.

These services must be prescribed by a physician in accordance with a plan of care and supervised by a registered nurse.

All home health aides must have completed a training and competency evaluation program in accordance with the requirements as stated in 42 CFR 484.4.

Therapy Services

All professional therapy services must be reasonable and necessary for the treatment of the patient's illness or injury to be considered for coverage. Therapies must be provided in the patient's place of residence by the home health agency or by a person or facility licensed by the state of South Carolina to provide medical rehabilitation services.

Therapy and Dually Eligible Beneficiaries

Because the Medicaid program utilizes the same criteria as Medicare for the provision of therapies (physical, speech pathology and audiology, and occupational), any therapy provided under these criteria should be billed to Medicare as the primary payer. If Medicare declines payment because the services did not meet the criteria, Medicaid will also deny payment for the same reason.

Physical Therapy

Physical therapy covers those generally recognized physical therapy services prescribed by a physician and provided by a qualified therapist. A qualified therapist is a graduate of a program approved by the American Physical Therapy Association or an equivalent program. The therapist must be licensed by the state of South Carolina.

There must be an expectation that the therapy will result in a significant practical improvement in the patient's functioning within a reasonable and predictable period of time.

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PROGRAM SERVICES

Physical Therapy (Cont'd.)

Types of services covered by physical therapists include:

1. Diagnosis and evaluation (including range of motion levels)
2. Teaching of task-oriented therapeutic activities and exercises to restore physical functioning

Teaching patient or non-agency caregivers necessary techniques, exercises, or precautions is covered to the extent that they are reasonable and necessary to treat the illness or injury.

Speech Pathology and Audiology Therapy

To be considered for coverage, speech therapy services must be reasonable and necessary for the treatment of speech and language disorders that result in a communication disability. A physician must prescribe services for individuals with speech, hearing, and language disorders.

These diagnostic, screening, preventive, or corrective services are covered when provided by or under the supervision of a speech pathologist or audiologist approved by the American Speech and Hearing Association or its equivalent, and who is licensed by the state of South Carolina.

There must be acute changes in the patient's language functioning and/or history of prior speech language pathology services for the condition currently being treated. In addition, there must be an expectation that the patient's language/communication ability will improve significantly in a reasonable and generally predictable period of time. If at any point during treatment of the disorder it is determined that the expectations for improvement will not be met, the services will no longer be considered reasonable and necessary.

Types of services covered by a speech language pathologist include:

1. Diagnosis and evaluation (including language assessment tests)
2. Therapeutic services for medical disorders and resulting communication disorders such as:

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PROGRAM SERVICES

Speech Pathology and Audiology Therapy (Cont'd.)

- a) Cerebral vascular disease (CVA) with dysphagia, aphasia, dysphasia, apraxia, and dysarthria
- b) Neurological diseases, which manifest with dysarthria, dysphasia, or inadequate respiratory volume/control
- c) Laryngeal carcinoma requiring laryngectomy and resulting aphonia

Occupational Therapy

To be considered for coverage, occupational therapy services must be reasonable and necessary for the treatment of the patient's illness or injury. There must be an expectation that the therapy will result in a significant practical improvement in the patient's functioning within a reasonable period of time. Therapy must be performed by a qualified occupational therapist (*i.e.*, one who is approved by the American Occupational Therapy Association).

Types of services covered by an occupational therapist include:

1. Diagnostic and prognostic tests to evaluate/re-evaluate a patient's level of functioning
2. Teaching of task-oriented therapeutic activities to restore physical function
3. Planning and implementing of tasks and activities to restore sensory-integrative function (*e.g.*, providing motor and tactile activities to increase sensory input and improve responsiveness for a stroke patient with functional loss resulting in a distorted body image)
4. Teaching activities of daily living and energy conservation to improve the level of independence for the patient's diagnosis and restorative condition
5. Designing, fabricating, and fitting orthotic devices related to the patient's condition
6. Planning, implementing, and supervising an individualized therapeutic activity program as a part of an overall "activity treatment" program

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PROGRAM SERVICES

Maintenance Therapy for Physical, Speech Pathology, Audiology, and Occupational Therapy

If full recovery or improvement is not possible, therapy may be authorized to allow the beneficiary to maintain his or her current function. There are three basic situations for which a beneficiary who is at a maintenance level may require one of the therapies:

1. The repetitive services designed to maintain function involve the use of complex and sophisticated procedures that may only be performed by a licensed therapist.
2. Special medical complications exist that necessitate therapists to perform or supervise the service or to observe the beneficiary.
3. A therapist is needed to manage and periodically re-evaluate the appropriateness of a maintenance program because of an identified danger to the patient.

Social Work Services

Social Work Services to Enhance the Effectiveness of Home Health may be provided to Medicaid home health recipients who are under the direct care of a Medicare-certified home health agency contracted with the State Medicaid agency.

Medical social service functions must be provided by a social worker with a graduate degree from an accredited school of social work. All practitioners must be licensed in accordance with federal and state requirements; be supervised by the clinical director of the home health agency; meet all requirements found in CFR440.60; and be employed by a Medicare certified home health agency that is contracted with SCDHHS to provide services.

Services provided must be identified during an assessment process of the social, emotional, and environmental issues and focused on the medical condition or the rate of recovery of the patient. The assessment must also include the relationship of the patient's medical and nursing requirements to the patient's home situation, financial resources, and availability of community resources.

Medical social services staff perform the following activities:

- Identify and obtain referrals to community resources on behalf of the patient

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PROGRAM SERVICES

Social Work Services (Cont'd.)

- Advocate through consultation, liaison, and interdisciplinary collaboration for patients whose risk status may interfere with the achievement of the home health goals
- Help resolve other identified problems

The medical social services staff will implement a continuous evaluation process to assess the achievement of specified goals and to address the impact of the patient's illness, need of care, response to treatment, and adjustment to care.

Medical social services may be furnished to the patient's family member or caregiver on a short-term basis when the home health agency can demonstrate that a brief intervention (two or three visits) by a medical social worker is necessary to remove a clear and direct impediment to the effective treatment of the patient's medical condition or to his or her rate of recovery. To be considered "clear and direct," the behavior or actions of the family member must plainly obstruct, contravene, or prevent the patient's medical treatment or rate of recovery. Medical social services that address general problems that do not clearly and directly impede treatment or recovery as well as long-term social services furnished to family members, such as ongoing alcohol counseling, are not covered.

Medical Supplies

Medical supplies sponsored by Medicaid are items that, due to their therapeutic or diagnostic characteristics, are essential in enabling home health personnel to carry out effectively the care that the physician has ordered for the treatment or diagnosis of the patient's illness or injury. Certain items that by their very nature are designed only to serve a medical purpose are obviously considered to be medical supplies (*e.g.*, catheters, needles, syringes, surgical dressing, and material used in aseptic techniques). Other medical supplies include, but are not limited to, irrigating solutions, intravenous fluids, and colostomy supplies.

Other items may be considered medical supplies, but only where the following applies:

1. The item is recognized as having the capacity to serve a therapeutic or diagnostic purpose in a specific situation.

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PROGRAM SERVICES

Medical Supplies (Cont'd.)

2. The item is required as a part of the actual physician-prescribed treatment of a patient's existing illness or injury.

Items that generally serve a hygienic purpose (*i.e.*, soaps and shampoos, and underpads) and items that generally serve as skin conditioners (*i.e.*, baby oil, skin softeners, powders, lotions, etc.) would not be considered medical supplies unless the particular item is recognized as serving a specific therapeutic purpose in the physician-prescribed treatment of the patient's existing disease/injury.

A separate charge may be made for the reasonable costs of medical supplies that are not routinely furnished in conjunction with patient care visits. In order for a separate medical supply charge to be made, the item(s) must be:

- Ordered at the direction of the patient's physician
- Directly identifiable to an individual patient
- Specifically identified in the plan of care
- Used/expended during the actual course of a covered visit

The patient can obtain some of these items through other sponsored Medicaid programs such as the Durable Medical Equipment program.

A patient's record must include an itemized list of non-routine medical supplies charged per visit, to include type, quantity, and total amount charged for each type of supply.

Note: Non-routine medical supply charges are totaled by date of service on the CMS-1500 claim form.

Routine supplies are not billable as medical supplies. Routine supplies are those minor medical and surgical supplies frequently furnished to all patients or utilized in small quantities which would not be expected to be specifically identified in a physician's plan of care. Routine supplies are further defined as items that are used for all patients and purchased in bulk. The cost of these routine supplies are apportioned to all patients, and included in the reimbursement rate for covered visits. Examples of routine supplies include, but are not limited to, the following items:

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PROGRAM SERVICES

Medical Supplies (Cont'd.)

- Alcohol (Swabs/Prep)
- Applicators (tongue blades, cotton-tipped)
- Band Aids
- Cotton Balls
- Lubricants (K-Y Jelly, Vaseline)
- Thermometers

All home health agencies are expected to separately identify and maintain a record of medical supplies that are routinely furnished in conjunction with patient care visits and included in the overall allowable per visit costs.

Equipment and appliances covered under the Durable Medical Equipment program must be obtained through that program.

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UTILIZATION OF MEDICAL SUPPLIES

Supplies may be left in the patient's home when there is a physician's order for teaching the family how to perform a particular procedure. The teaching component must be included in the plan of care and the documentation must specify which family member the skilled nurse teaches during his or her visit. Follow-up supervision to ensure that proper procedures are followed is allowable. The time frame for teaching should be short-term and supplies may be left while the family is learning care procedures. Once the family can effectively demonstrate proper technique, supplies should no longer be left in the home.

Medicaid beneficiaries are eligible to receive bulk supplies to be used in the home when ordered by a physician. Families should be advised and assisted by the teaching nurse in obtaining bulk supplies, which may be provided by the Durable Medical Equipment (DME) provider with a physician's order.

NON-COVERED SERVICES

Services not covered by the Medicaid Home Health program include:

1. Services not reasonable and necessary for diagnosis or treatment of illness or injury
2. Full-time nursing care
3. Drugs and biologicals
4. Meals delivered to the home
5. Homemaker services
6. Care primarily for treatment of mental diseases
7. Separate medical rehabilitation facilities
8. Routine supplies
9. Supervisory nurse visits