



# Florida Medicaid

## HOME HEALTH SERVICES COVERAGE AND LIMITATIONS HANDBOOK

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Agency for Health Care Administration  
October 2014



# UPDATE LOG

## HOME HEALTH SERVICES

### COVERAGE AND LIMITATIONS HANDBOOK

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#### How to Use the Update Log

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##### Introduction

The update log provides a history of the handbook updates. Each Florida Medicaid handbook contains an update log.

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##### Obtaining the Handbook Update

When a handbook is updated, the Medicaid provider will be notified. The notification instructs the provider to obtain the updated handbook from the Medicaid fiscal agent's Web site at [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com). Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Medicaid providers who are unable to obtain an updated handbook from the Web site may request a paper copy from the Medicaid fiscal agent's Provider Services Contact Center at 1-800-289-7799.

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##### Explanation of the Update Log

Providers can use the update log below to determine if updates to the handbook have been received.

**Update** describes the change that was made.

**Effective Date** is the date that the update is effective.

UPDATE	EFFECTIVE DATE
Revised Handbook	March 2000
Revised Handbook	October 2003
Revised Handbook	July 2007
Revised Handbook	July 2008
Revised Handbook	December 2011
Revised Handbook	March 2013
Revised Handbook	_____

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## INTRODUCTION TO THE HANDBOOK

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### Overview

#### Introduction

This chapter outlines the three types of Florida Medicaid policy handbooks that all enrolled providers must comply with in order to obtain reimbursement. This chapter also describes the format used for the handbooks and instructs the reader how to use the handbooks.

#### Background

There are three types of Florida Medicaid handbooks:

- Provider General Handbook describes the Florida Medicaid program.
- Coverage and limitations handbooks explain covered services, their limits, who is eligible to receive them, and any corresponding fee schedules. Fee schedules can be incorporated within the handbook or separately.
- Reimbursement handbooks describe how to complete and file claims for reimbursement from Medicaid.

The current Florida Medicaid provider handbooks are posted on the Medicaid fiscal agent's Web site at [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com). Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

#### Federal and State Authority

The following federal and state laws govern Florida Medicaid:

- Title XIX of the Social Security Act
- Title 42 of the Code of Federal Regulations
- Chapter 409, Florida Statutes
- Rule Division 59G, Florida Administrative Code

#### In This Chapter

This chapter contains:

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**Handbook Use**

**Purpose**

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The purpose of the Medicaid handbooks is to educate the Medicaid provider about policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients.

The handbooks provide descriptions and instructions on how and when to complete forms, letters or other documentation.

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**Provider**

Term used to describe any entity, facility, person or group who is enrolled in the Medicaid program and provides services to Medicaid recipients and bills Medicaid for services.

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**Recipient**

Term used to describe an individual enrolled in Florida Medicaid.

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**Provider General Handbook**

Information that applies to all providers regarding the Florida Medicaid program, recipient eligibility, provider enrollment, fraud and abuse policy, and important resources are included in the Florida Medicaid Provider General Handbook.

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**Coverage and Limitations Handbook**

Each coverage and limitations handbook is named for the service it describes. A provider who provides more than one type of Medicaid service will have more than one coverage and limitations handbook with which they must comply.

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**Reimbursement Handbook**

Most reimbursement handbooks are named for the type of claim form submitted.

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## Characteristics of the Handbook

<b>Format</b>	The format of the handbook represents a reader friendly way of displaying material.
<b>Label</b>	Labels are located in the left margin of each information block. They identify the content of the block in order to help scanning and locating information quickly.
<b>Information Block</b>	<p>Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of the subject. Blocks are separated by horizontal lines.</p> <p>Each block is identified or named with a label.</p>
<b>Chapter Topics</b>	Each chapter contains a list of topics on the first page, which serves as a table of contents for the chapter, listing the subjects and the page number where the subject can be found.
<b>Note</b>	Note is used to refer the reader to other important documents or policies contained outside of this handbook.
<b>Page Numbers</b>	Pages are numbered consecutively within each chapter throughout the handbook. The chapter number appears as the first digit before the page number at the bottom of each page.
<b>White Space</b>	The "white space" found throughout a handbook enhances readability and allows space for writing notes.

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## Handbook Updates

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### Update Log

The first page of each handbook will contain the update log.

Every update will contain a new updated log page with the most recent update information added to the log. The provider can use the update log to determine if all updates to the current handbook have been received.

Each update will be designated by an “Update” and the “Effective Date.”

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### Handbook Update Classifications

The Medicaid handbooks will be updated as needed. Updates are classified as either a:

- Replacement handbook – Major revisions resulting in a rewrite of the existing handbook, without any underlines and strikethroughs throughout the rulemaking process.
  - Revised handbook – Minor revisions resulting in modification of the existing handbook identified during the rulemaking process by underlines and strikethroughs.
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### Handbook Effective Date

The effective date of a handbook is the month and year that will appear on the final published handbook. The provider can check this date to ensure that the material being used is the most current and up to date.

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### Identifying New Information

New information or information moved from one place to another within the handbook will be identified by an underline on draft versions of the handbook during the development and proposed stages of the rulemaking process (e.g., new information).

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### Identifying Deleted Information

Deleted information will be identified by a line through the middle of the selected text on draft versions of the handbook during the development and proposed stages of the rulemaking process (e.g., ~~deleted information~~).

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### Final Published Handbook

The adopted and published version of the handbook will not have underlines (indicating insertions) and text with strikethroughs (indicating deletions).

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CHAPTER 1  
QUALIFICATIONS, ENROLLMENT, AND REQUIREMENTS

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**Overview**

**Introduction**

This chapter describes Florida Medicaid's home health services, the specific authority regulating these services, and provider qualifications, enrollment, and requirements.

**Legal Authority**

Home health services are governed by Title 42, Code of Federal Regulations (CFR), Part 440.70.

Florida Medicaid home health services are authorized by Chapter 409, Florida Statutes (F.S.) and Chapter 59G, Florida Administrative Code (F.A.C.).

**In This Chapter**

This chapter contains:

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**Purpose and Definitions**

**Medicaid Provider Handbooks**

This handbook is intended for use by home health services providers that render services to Medicaid recipients. It must be used in conjunction with the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which contains information about specific procedures for submitting claims for payment, and the Florida Medicaid Provider General Handbook, which describes the Florida Medicaid program.

Note: The Florida Medicaid provider handbooks are available on the Medicaid fiscal agent's Web site at [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com). Select Public Information for Providers, then Provider Support, and then Provider Handbooks. All of the Florida Medicaid provider handbooks are incorporated by reference in Rule Division 59G, F.A.C.

**Purpose and Definitions**, continued

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**Purpose of Home Health Services**

The purpose of home health services is to provide medically necessary care to an eligible Medicaid recipient whose medical condition, illness, or injury requires the care to be delivered in the recipient's place of residence.

Note: See the Glossary in the Florida Medicaid Provider General Handbook for the definition of medically necessary.

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**Home Health Services**

Home health services are medically necessary services, which can be effectively and efficiently provided in the place of residence of a recipient. Services include home health visits (nurse and home health aide), private duty nursing and personal care services for children, therapy services, medical supplies, and durable medical equipment.

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**Personal Care Services**

Personal care services provide medically necessary assistance with activities of daily living (ADL) and age appropriate instrumental activities of daily living (IADL) that enable the recipients to accomplish tasks that they would normally be able to do for themselves if they did not have a medical condition or disability. Medicaid reimburses for these services provided to eligible recipients under the age of 21 years.

ADLs include:

- Eating (oral feedings and fluid intake)
- Bathing
- Dressing
- Toileting
- Transferring
- Maintaining continence (examples include taking care of a catheter or colostomy bag or changing a disposable incontinence product when the recipient is unable to control his bowel or bladder functions)

IADLs (when necessary for the recipient to function independently) include:

- Personal hygiene
- Light housework
- Laundry
- Meal preparation
- Transportation
- Grocery shopping
- Using the telephone to take care of essential tasks (examples include paying bills and setting up medical appointments)
- Medication management
- Money management

Skilled interventions that may be performed only by a licensed health professional are not considered personal care services.

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**Purpose and Definitions**, continued

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**Home Health Visit**

A home health visit is a face-to-face contact between a registered nurse, licensed practical nurse or home health aide and a recipient at the recipient's place of residence.

A home health visit is not limited to a specific length of time, but is defined as an entry into the recipient's place of residence, for the length of time needed, to provide the medically necessary nursing or home health aide service(s).

Medicaid reimbursement for a home health visit does not include travel time to or from the recipient's place of residence. Such expenses are administrative and not reimbursable by Medicaid.

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**Service Encounter**

A single entry into a recipient's place of residence, for the length of time needed, to provide the medically necessary private duty nursing, personal care, or home health visit service.

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**Place of Residence**

Place of residence is the location where a Medicaid recipient lives and can include:

- Recipient's private home
  - Assisted living facility (ALF)
  - Developmental disabilities group home
  - Foster or medical foster care home
  - Any home where unrelated individuals reside together in a group
- 

**Attending Physician**

The attending physician is the doctor in charge of the recipient's medical condition that determines the recipient's need for home health services.

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**Babysitting**

The act of providing custodial care, daycare, afterschool care, supervision, or similar childcare unrelated to the services that are documented to be medically necessary for the recipient.

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**Purpose and Definitions**, continued

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**Independent Personal Care Provider**

An independent personal care provider renders personal care services directly to recipients and does not employ others for the provision of personal care services.

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**Independent Personal Care Group Provider**

An independent personal care group provider is an unlicensed group (agency) enrolled to provide personal care services that has one or more staff employed to perform the services. All employees of the unlicensed group provider must meet the qualifications and requirements specified for the provision of personal care services and be enrolled in the Medicaid program as an individual personal care provider.

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**Geographic Service Area**

Geographic service area is an area, as specified by county(ies) on the license, in which the home health agency can send its personnel to provide home health services to recipients in their places of residence.

A geographic service area cannot encompass more than one Medicaid designated geographic area of the state.

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**Parent Office**

A parent office is a home health agency responsible for the services furnished to recipients and for implementation of the plan of care. Additionally, it is responsible for the development and administrative control of subunits and branch offices. A parent office must meet the Medicare Conditions of Participation.

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**Branch Office**

A branch office is a separately licensed location or site from which a parent home health agency provides services within a portion of its total geographic service area. A branch office is located sufficiently close to share administration, supervision, and services with the parent office. It is not required to independently meet the Medicare Conditions of Participation.

Offices of a corporate home health agency located in different geographic service areas are required to enroll in Medicaid as parent offices.

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**Purpose and Definitions**, continued

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<b>Subunit</b>	A subunit is a separately licensed, semi-autonomous organization that serves recipients in a portion of the geographic service area different from that of the parent office. A subunit must independently meet the Medicare Conditions of Participation because it is too far from the parent office to share administration, supervision, and services on a daily basis. A subunit can meet specified standards of the Medicare Conditions of Participation through its parent office.
<b>Quality Improvement Organization (QIO)</b>	The vendor contracted with the Agency for Health Care Administration (AHCA) to monitor the appropriateness, effectiveness, and quality of care provided to Medicaid recipients. The vendor also performs prior authorization of services based on medical necessity determinations.
<b>Intermittent Visits</b>	Services that are provided at intervals.
<b>Private Duty Nursing</b>	Private duty nursing services are medically necessary skilled nursing services that can be provided to recipients under the age of 21 in their home or other authorized settings to support the care required by their complex medical condition.  Private duty nursing is furnished for the purposes of performing skilled interventions or monitoring the effects of prescribed treatment.
<b>Provider</b>	An individual, such as a nurse, aide, or health professional who assists in the identification, prevention, or treatment of an illness or disability. This individual is usually an employee of an agency and provides care for compensation.

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## Qualifications

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### Home Health Agency Provider

To enroll as a Medicaid provider, a home health agency must be licensed in accordance with Chapter 400, Part III, F.S. and Chapter 59A-8, F.A.C., or applicable laws of the state in which the services are furnished.

The home health agency must either:

- Meet the Medicare Conditions of Participation as determined through a survey conducted by AHCA, Division of Health Quality Assurance (HQA); or
- Be accredited and deemed by the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO), the Community Health Accreditation Program (CHAP), or the Accreditation Commission for Health Care (ACHC) as meeting the Medicare Conditions of Participation.

Home health agencies receiving accreditation and deemed status by JCAHO, CHAP, or ACHC are responsible for providing accreditation documentation to HQA.

Independent personal care providers are exempt from this requirement for the provision of personal care services.

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### Independent Personal Care Provider

Medicaid reimburses independent personal care providers under their Medicaid home health provider number, for the provision of personal care services.

To enroll in the Medicaid program, independent personal care providers must:

- Be age 18 years or older.
  - Be trained in the areas of cardiopulmonary resuscitation (CPR), HIV/AIDS, and infection control.
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**Qualifications**, continued

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**Independent  
Personal Care  
Provider**, continued

- Have at least one year of experience working in a medical, psychiatric, nursing or child care setting or working with recipients who have a developmental disability. College, vocational, or technical training in medical, psychiatric, nursing, child care, or developmental disabilities equal to 30 semester hours, 45 quarter hours, or 720 classroom hours can be substituted for the required experience.

Independent personal care providers are responsible for meeting the experience and training requirements and must maintain on file documented proof of annual or required updated training. The documentation must verify the provider's and its employees' participation in the required training session, the date and location of the training, the name and signature of the trainer, and the name and signature of person(s) in attendance.

Independent personal care group providers must meet the home health licensure exemption requirements defined in section 400.464, F.S., in order to be reimbursed for personal care services provided to Medicaid recipients.

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**Physician**

The ordering or attending physician who orders these services must be licensed under Chapters 458, 459, or 461, F.S., or licensed in the state in which the attending physician practices.

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**Qualifications**, continued

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**Therapy Services**

Medicaid reimburses home health agencies, under their Medicaid home health provider number, for the following therapies:

- Occupational therapy
- Physical therapy
- Speech-language pathology services

To qualify to provide these therapies, the home health agency must list each therapy service on its application for licensure and certification. HQA determines if the agency meets licensure requirements for the provision of the therapy service(s).

Note: See the Florida Medicaid Therapy Services Coverage and Limitations Handbook for additional information.

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**Licensed to Cover County**

The parent office must be licensed to cover the county in which the branch office is located in order to receive Medicaid reimbursement for the home health services provided through the branch office.

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**Complaint Surveys**

Complaints of alleged violations of regulations are investigated by HQA.

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**Enrollment**

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**General Enrollment Requirement**

Home health providers must meet the general Medicaid provider enrollment requirements that are contained in the Florida Medicaid Provider General Handbook. In addition, home health providers must meet the specific enrollment requirements that are listed in this section.

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**Independent Personal Care Provider Enrollment**

Independent personal care providers must meet the general Medicaid provider enrollment requirements that are contained in the Florida Medicaid Provider General Handbook. In addition, independent personal care providers must follow the specific enrollment requirements that are listed in this section. Proof of training is required upon enrollment as a personal care provider.

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**Enrollment**, continued

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**Independent  
Personal Care  
Group Provider  
Enrollment**

An unlicensed independent agency or group provider enrolled in the Medicaid program to provide personal care services that employs one or more persons for the actual provision of services must enroll as a personal care provider group. In order to receive payment from Medicaid, each member of the group must enroll in Medicaid as an individual personal care services treating provider who performs services within the group. It is the responsibility of the individual treating provider to notify the Medicaid fiscal agent of all group practice affiliations. Individual treating providers who are terminating a relationship with a group must notify the Medicaid fiscal agent in writing of this termination in order to update their provider file.

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**Closure of a  
Branch Office or  
Subunit**

A home health agency must report any closure of a practice location and the effective date of the closure to the Medicaid fiscal agent and HQA in writing on office letterhead stationery. The letter must be sent 60 days prior to the closure.

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**Drop-Off Site**

Medicaid does not enroll drop-off sites since they are not considered to be places of service.

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**Surety Bond  
Requirements**

A surety bond is required for home health agencies if there have been (within the past five years) or currently are sanctions or terminations (voluntary or involuntary) involved. This requirement is applicable to future terminations or sanctions of a home health agency.

Note: See the Florida Medicaid Provider General Handbook for the surety bond requirements and exemptions.

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## Who May Provide Home Health Services

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### **Qualified Home Health Agency Staff**

Home health services are provided by qualified health care professionals.

The home health agency must ensure that all staff (employed or contracted) who provide home health services are qualified and licensed.

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### **Multiple Home Health Services Providers**

In situations which require more than one home health services provider in order to render all the care required by a recipient, Medicaid applies all of the following criteria for reimbursement:

- Medicaid will not reimburse duplicative nursing, or home health aide services.
- Each home health services provider is responsible for coordinating its plan of care with other involved home health services providers.
- Each home health services provider is responsible for noting on its plan of care the services being provided by another home health services provider.
- Each home health services provider is accountable for the provided services and billing pursuant to its plan of care.
- When requesting prior authorization, each home health services provider is responsible for informing the QIO of other home health services providers also rendering services to the recipient.

A home health services provider furnishing home health services without documented knowledge of other home health services providers furnishing services to its recipient is at risk for recoupment of reimbursement.

Note: Please refer to Procedure Code Modifiers in Chapter 3 and Appendix A for the valid procedure codes and modifiers.

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**Who May Provide Home Health Services**, continued

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**Nurse  
Qualifications**

Home health nursing services must be provided by a nurse licensed pursuant to Chapter 464, F.S., or applicable laws of the state in which the services are provided.

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**Home Health Aide  
Qualifications**

A home health aide must have successfully completed a training program that meets minimum standards for aide training as defined in 42 CFR 484.36(a)(1) and Chapter 400, F.S.

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**Personal Care  
Services**

Personal care services can be provided by either:

- Home health agencies, licensed in accordance with Chapter 400, part III, F.S.
  - Independent personal care providers who meet the experience and training requirements as described in this section and who are enrolled as home health personal care providers with a specialty code of 114
- 

**Skill Level of Staff**

The home health services provider must provide staff with the skill level designated or appropriate for each medically necessary covered home health service prescribed in the physician order and approved plan of care. Skill level designation must be reflective of the standards outlined in the Nurse Practice Act per Chapter 464, F.S. Requests for a skill level higher than the less costly alternative must justify the need.

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**Who May Provide Home Health Services**, continued

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**Staff Substitutions**

Whenever staff absences occur, the home health services provider is responsible for providing and assuring that appropriate staff substitutions are made.

Staff discipline must be equivalent to or above the discipline level as specified in the plan of care. Under no circumstances can staff of a lower discipline be substituted for staff of a higher discipline level than ordered. The staff substitution must be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide.

If a nurse is substituted for a home health aide, Medicaid will only reimburse at the home health aide rate. If a registered nurse is substituted for a licensed practical nurse, Medicaid will only reimburse at the licensed practical nurse rate.

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**Multiple Counties**

A parent agency can employ staff located in other counties listed on its license to serve the recipients in those counties (a facility cannot be set up in these counties) as long as they meet the qualifications for home health staff. All recipient records and documentation must be housed and maintained at the parent office, including all required home health record documentation, daily progress notes, plans of care, etc. This documentation must be original and must be signed and dated by the individual provider of service on the day the services were rendered. Medicaid does not pay for travel to and from the parent office to transmit this documentation.

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**Responsibilities**

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**Record Keeping Requirements**

In addition to the specific documentation that is required for the covered services listed in Chapter 2 of this handbook, home health providers must follow the record keeping requirements listed in the Florida Medicaid Provider General Handbook.

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**Chart Forms**

The home health services provider must ensure that all staff (employed or contracted) utilize the home health services provider's chart forms for documentation of home health services.

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**Accountability**

The home health services provider is accountable for all of the following criteria:

- Services provided by staff (employed or contracted)
  - Billing of the provided services
- 

**Providers Contracted with Medicaid Managed Care Plans**

The service-specific Medicaid coverage and limitations handbooks provide the minimum requirements for all providers. This includes providers who contract with Florida Medicaid managed care plans (e.g., provider service networks and health maintenance organizations). Providers shall comply with all of the requirements outlined in this handbook, unless otherwise specified in their contract with the managed care plan. The provision of services to recipients enrolled in a Medicaid managed care plan shall not be subject to more stringent criteria or limits than specified in this handbook.

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CHAPTER 2  
COVERED, LIMITED, AND EXCLUDED SERVICES

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**Overview**

**Introduction**

This chapter provides service coverage, limitations, and exclusions information. It also describes who can provide and receive services and any applicable service requirements.

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**In This Chapter**

This chapter contains:

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## General Coverage Information

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### Introduction

Medicaid reimburses home health services provided to an eligible Medicaid recipient when it is medically necessary to provide those services in the recipient's place of residence or other authorized setting.

Medicaid does not reimburse for home health services when the service duplicates another provider's service under the Medicaid program or other state or local program or if a comparable home and community-based service is provided to the recipient at the same time on the same day.

Home health services are not considered emergency services.

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### Medical Necessity

Medicaid reimburses services that are determined medically necessary and do not duplicate another provider's service.

Rule 59G-1.010 (166), Florida Administrative Code (F.A.C.) defines "medically necessary" or "medical necessity" as follows:

"[T]he medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider."

"(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service."

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**General Coverage Information**, continued

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**Exceptions to the Limits (Special Services) Process**

In accordance with federal law, AHCA will pay for such other necessary health care, diagnostic services, treatment, and other measures described in Section 1905(a) (42 USC 1396d(a)) of the Social Security Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the state plan.

Services requested for recipients under the age of 21 years in excess of limitations described within this handbook or the associated fee schedule can be approved, if medically necessary, through the prior authorization process described in this handbook.

The fact that the recipient is under 21 years of age does not eliminate the requirement for prior authorization through the Quality Improvement Organization (QIO).

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**Home Health Service Requirements**

In order to be reimbursed, home health services must be all of the following:

- Ordered by and remain under the direction of the attending physician (a doctor of podiatric medicine can only authorize plan of care services that are consistent with the functions he is authorized to perform under state law) licensed under Chapter 461, 458, or 459, Florida Statutes (F.S.), or licensed in the state in which the attending physician practices. The ordering physician cannot be employed by or under contract with the home health services provider that is rendering services, unless specifically exempted under section 409.905 (4)(c)(3), F.S.
  - Consistent with the individualized, written, and approved plan of care
  - Provided by qualified staff
  - Consistent with accepted standards of medical and nursing practice
-



**General Coverage Information**, continued

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**Who Can Receive In-Home Services**

Medicaid reimburses home health services for Medicaid recipients who are under the care of an attending physician. The recipient must meet all of the following requirements:

- Require services that, due to a medical condition, illness or injury, must be delivered at the place of residence rather than an office, clinic, or other outpatient facility because either:
  - Leaving home is medically contraindicated and would increase the medical risk for exacerbation or deterioration of the condition.
  - The recipient is unable to leave home without the assistance of another person.
- Require services that are medically necessary and reasonable for the treatment of the documented illness, injury or condition
- Require services that can be safely, effectively, and efficiently provided in the home
- Live in a residence other than a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities (ICF/IID) (See exceptions for ICF/IIDs in 42 CFR 483, Subpart I.)

Home health services rendered to recipients under the age of 21 years can be delivered at the recipient's place of residence or another authorized setting.

Medicaid does not reimburse home health services solely due to age, environment, convenience, or lack of transportation.

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**General Coverage Information**, continued

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**Physician  
Treatment Orders**

A written physician's order from the treating or attending physician is required to initiate or continue home health services. The treating or attending physician must provide a physical examination or medical consultation to the recipient within 30 days preceding the request for services and every 180 days thereafter.

A new physician's order must be obtained before the creation of each plan of care. The written physician's order must be dated within 30 days preceding the initial request for services. At a minimum, a new written prescription must be obtained for continued stay requests:

- Every 180 days thereafter for private duty nursing and personal care services.
- Every 60 days thereafter for home health visits.

At a minimum, the order must describe all of the following:

- Recipient's acute or chronic medical condition or diagnosis that causes a recipient to need home health care
- Documentation regarding the medical necessity for the service(s) to be provided at home
- Home health services needed
- Frequency and duration of the needed services
- Minimum skill level (nurse, home health aide) of staff who can provide the services

Physician orders to initiate or continue home health services must be signed and dated by the attending physician prior to the development of each plan of care and before submitting a request for prior authorization. The ordering physician's National Provider Identifier (NPI), Medicaid provider number, or medical license number must be written on the order.

Medicaid will reimburse home health services ordered by an advanced registered nurse practitioner or physician assistant only if the order has been countersigned by the attending physician.

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**Dually Eligible  
Medicare and  
Medicaid  
Recipients**

Medicaid cannot reimburse a home health provider for services that can be reimbursed by Medicare when a recipient is eligible for both Medicare and Medicaid services.

The home health provider is responsible for retaining documentation in the recipient's record that the service is not Medicare reimbursable.

Note: See the Florida Medicaid Provider General Handbook for information on Medicare crossover claims.

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**General Coverage Information**, continued

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**MediPass  
Recipients**

When a MediPass recipient is referred for home health services, the home health provider must obtain authorization (MediPass referral number) from the MediPass primary care provider. This does not eliminate the need to receive prior authorization through the Quality Improvement Organization (QIO).

The MediPass authorization number must be entered on the claim when billing the service.

Note: See the Florida Medicaid Provider Reimbursement Handbook, CMS 1500, for instructions on entering the MediPass authorization number on the claim.

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**Children’s Medical  
Services (CMS)  
Network Recipients**

When a CMS Network recipient is referred for home health services, the home health provider must obtain authorization (CMS referral number) from the CMS Network primary care provider (PCP). This does not eliminate the need to receive prior authorization through the QIO.

The CMS Network PCP authorization number must be entered on the claim when billing the service.

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**Health Plans**

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**Fee-For-Service  
(FFS) Provider  
Service Network  
(PSN) Private Duty  
Nursing, Personal  
Care Services and  
Home Health Visit  
Services**

Private duty nursing, personal care services, and home health visit services provided to a recipient enrolled in a FFS PSN are authorized and claims are processed through the FFS PSN only. These claims do not require approval by the QIO. Home health providers can contact the FFS PSN’s Provider Relations Unit for assistance as needed.

FFS PSNs are responsible for authorizing private duty nursing, personal care, and home health visit services claims and submitting PSN-approved claims directly to the Medicaid fiscal agent for reimbursement to the provider.

Private duty nursing, personal care services, and home health visit services claims for FFS PSN recipients that are submitted directly to the Medicaid fiscal agent are not allowable and will be denied or recouped.

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**Health Plans**, continued

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**Children’s Medical Services (CMS)-Specialty Plan Private Duty Nursing (PDN), Personal Care Services (PC), and Home Health Visit Services**

Private duty nursing, personal care services, and home health visit services provided to a recipient enrolled in a CMS-Specialty Plan are authorized and claims are processed through the CMS-Specialty Plan. These claims do not require approval by the QIO. Home health providers can contact the CMS-Specialty Plan’s Provider Relations Unit for assistance as needed.

The CMS-Specialty Plan is responsible for authorizing covered private duty nursing, personal care services, and home health visit services claims and submitting CMS-Specialty Plan approved claims directly to the Medicaid fiscal agent for reimbursement to the provider.

Private duty nursing, personal care services, and home health visit service claims for a CMS-Specialty Plan recipient that are submitted directly to the Medicaid fiscal agent are not allowable and will be denied or be recouped.

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**Capitated PSN PDN, PC, and Home Health Visits**

The home health provider of private duty nursing, personal care services, and home health visit services for recipients enrolled in a Capitated PSN must be authorized and reimbursed through the Capitated PSN only. These claims do not require approval by the QIO.

Capitated PSNs are responsible for authorization and reimbursing approved claims for covered private duty nursing, personal care services, and home health visit services.

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**Health Maintenance Organization (HMO) PDN, PC, and Home Health Visit services**

The home health provider of private duty nursing, personal care services, and home health visit services for recipients enrolled in an HMO must be authorized and reimbursed through the HMO only. These claims do not require approval by the QIO.

The HMOs are responsible for authorization and reimbursing approved claims for covered private duty nursing, personal care services, and home health visit services.

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**Plan of Care**

**Description**

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A plan of care (POC) is an individualized written program for a recipient that is developed by health care providers including the attending physician. The POC is designed to meet the medical, health, and rehabilitative needs of the recipient. The POC must identify the medical need for home health care, appropriate interventions, and expected health outcomes.

The home health services provider must provide a copy of the initial and subsequent POC to the attending physician for the medical record.

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**General Review Requirements**

All POC must contain current information concerning the recipient. Photocopies of previous POC are not acceptable and will result in denials of prior authorization requests.

Subsequent plans of care must include an assessment of all changes in the recipient's medical conditions including performance of activities of daily living and instrumental activities of daily living since the previous certification period. All applicable POC components must be included in each subsequent POC.

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**Required Document(s)**

Licensed home health agencies may use the Centers for Medicare and Medicaid Services (CMS) Form 485 (C-3)(02-94), Home Health Certification and Plan of Care, or providers may use their own form for the POC as long as their form reports the same information in the same order as the CMS Form 485.

Note: See Appendix B for CMS Form 485 and instructions. The form and instructions are available by photocopying them from the appendix. They are incorporated by reference in Rule 59G-4.130, F.A.C.

Independent personal care providers (including unlicensed agencies) are required to use the Personal Care Services Plan of Care form.

Note: See Appendix I for a copy of the Personal Care Services Plan of Care form and instructions, AHCA Form 5000-3506, Revised October 2014. The form and instructions are available by photocopying them from the appendix. They are incorporated by reference in Rule 59G-4.130, F.A.C.

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**Plan of Care**, continued

**Components**

The POC must include all of the following:

- Diagnosis(es), mental status, prognosis, rehabilitation potential, functional limitations, permitted activities, nutritional requirements, medications, and treatments
- Physician orders
- An explanation of the medical necessity of home health services
- Nursing services, home health aide services, or therapy to be provided
- Medical supplies, appliances, or durable medical equipment to be provided
- Start date, end date, and frequency of in-home services, including the level of staff necessary to perform the services required
- Safety measures to protect against injury
- Discharge plan
- Approval by the attending physician as evidenced by his dated signature
- Expected health outcomes

The physician can approve a POC by faxing a signed copy to the provider; however, the physician must retain the plan with the original signature in the recipient's medical record.

**Certification Period**

The "From" and "To" dates identify the period covered by the POC.

- The "From" date is the first day of the POC
- The "To" date is the last day of the POC
- The "To" date can include up to, but never exceed, 60 days (personal care services can be approved for up to 180 days if provided by an independent personal care services provider)
- On subsequent recertifications, the next sequential "From" date will be the day after the "To" date on the previous POC

**Example of Valid Dates for the Certification Period**

A physician's order specifies skilled nursing care twice per day from July 1, 2007 to August 29, 2007. The initial POC covers the period July 1, 2007 ("From" date) through August 29, 2007 ("To" date).

- The POC begins on July 1, 2007 and is effective through August 29, 2007
- A new POC is necessary to continue skilled nursing care on August 30, 2007
- August 30, 2007 is day one and the "From" date on the subsequent POC

**Plan of Care**, continued

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**Additional Review Requirements for Licensed Home Health Agencies**

For licensed home health agencies, the attending physician must review the POC at least every 60 days. The attending physician is required to indicate his approval by signing each POC. The attending physician must countersign an ARNP or physician assistant signature on a POC.

The POC must be reviewed and signed by the attending physician before submitting the prior authorization request. Payments of home health claims submitted without proper authorization or prior to the physician signing the POC are subject to recoupment.

Each POC must include as a separate document the physician order for home health services. A new physician's order must be obtained before the creation of each POC.

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**Additional Review Requirements for Independent Personal Care Providers**

For personal care services, the physician must review the POC at least every 180 days. The attending physician is required to indicate approval by signing each POC.

The POC must be reviewed and signed by the attending physician before submitting the prior authorization request. Payments of home health claims submitted without proper authorization or prior to the physician signing the POC are subject to recoupment. A new physician's order must be obtained before the creation of each POC.

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**Recipient's Copy of the Plan of Care**

The home health services provider must provide a copy of the initial and subsequent POC to the recipient or legal guardian, if requested.

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**Patient Condition Summaries**

Home health providers must provide the attending physician a summary of the recipient's condition at least every 60 days. This summary must include all necessary information to support the justification for continuation or termination of the home health services.

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**Plan of Care**, continued

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**Compliance Review**

The Agency for Health Care Administration (AHCA) or its designee will periodically conduct on-site or desk reviews of home health services providers for the purpose of determining compliance with Medicaid requirements.

During such reviews, AHCA or its designee will request from the provider copies of certain records.

At the time of the request, all records must be provided to AHCA or its designee regardless of the media format on which the original records are retained by the provider. All medical records must be reproduced onto paper copies, at the provider's expense.

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**Services**

Medicaid does not reimburse open-ended orders. (Examples: Skilled nursing visits 1 per month and PRN x 2 months for Foley catheter change or private duty nursing up to 24 hours a day up to 7 days a week.)

Medicaid can reimburse orders that reflect a limited range of visits or minimum and maximum number of hours to be provided. In order to be reimbursed, the order must include all of the following:

- Description of the recipient's medical signs and symptoms that require services
- Specific limit on the number of those visits to be made under that order
- Minimum and maximum number of hours per day

(Examples: Skilled nursing visits 1 x per month for 2 months for Foley catheter change and PRN x 2 visits for Foley catheter obstruction or 4 hours a day, 2 days a week.)

If more services are needed, an additional physician order must be obtained and an addendum reflecting the service(s) must be added to the current POC.

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## Covered, Limited, and Excluded Services

### Covered Services For Adults

Medicaid reimburses the following services provided to eligible recipients age 21 and older:

- Licensed nurse and home health aide visits
- Limited durable medical equipment and supplies
- Limited therapy evaluations

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### Covered Services For Children

Medicaid reimburses for the following services provided to eligible recipients under the age of 21 years:

- Licensed nurse and home health aide visits
- Private duty nursing
- Personal care services
- Occupational, physical, and speech-language pathology evaluations and treatments
- Durable medical equipment and supplies

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### Exclusions

Listed below are examples of services that are not reimbursable as a Medicaid home health service:

- Audiology services
  - Housekeeping (except light housekeeping), homemaker, and chore services, including any shopping except grocery shopping when provided as an IADL for recipients under the age of 21 years
  - Meals-on-wheels
  - Mental health and psychiatric services
  - Normal newborn and postpartum services, except in the event of complications
  - Respite care
  - Services which can be effectively and efficiently obtained outside the recipient's place of residence without any medical contraindications
  - Baby-sitting
  - Services to a recipient residing in a community residential facility when those services duplicate services the facility or institution is required to provide
  - Social services
  - Transportation services (except when necessary to protect the health and safety of the recipient and no other transportation service is available or when provided as an IADL for recipients under the age of 21 years)
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**Covered, Limited, and Excluded Services**, continued

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**Exclusions**,  
continued

- Escort services
- Care, grooming, or feeding of pets and animals
- Yard work, gardening, or home maintenance work
- Day care or after school care
- Assistance with homework
- Companion sitting or leisure activities
- Home health visits, private duty nursing, or personal care services furnished by parents, grandparents, stepparents, spouses, siblings, sons, daughters, relatives, household members, or any person with custodial or legal responsibility for a Medicaid recipient. Exceptions to this exclusion are for:
  - Parents or legal guardians authorized by AHCA to provide private duty nursing services to their children. See Private Duty Nursing Services in this chapter and Appendix C for a copy of the authorization form.
  - Children enrolled in the developmental disabilities home and community-based services Medicaid waivers under the 1915j State Plan amendment authorizing self-directed care, can receive personal care services provided by the relatives listed above who are also enrolled as state plan providers.
- Respiratory therapy (see the Florida Medicaid Therapy Services Coverage and Limitations Handbook for respiratory therapy provider enrollment requirements)
- Nursing assessments related to the POC
- Attending physicians for certifying the home health POC (see the Florida Medicaid Physician Services Coverage and Limitations Handbook for information on reimbursement of evaluation and management services)
- Services to an adult recipient enrolled in hospice when the services are related to the treatment of the terminal illness or associated condition. Recipients under the age of 21 years are exempt from this exclusion.

Some services listed in this section are reimbursable by Medicaid. Refer to the appropriate coverage and limitations handbook or the fee schedule for coverage information.

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**Covered, Limited, and Excluded Services**, continued

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**Out-of-State Services**

Medicaid reimburses out-of-state home health services that are prior authorized.

Whenever a Florida Medicaid recipient receives an out-of-state prior authorized Medicaid service, that recipient can be eligible to receive medically necessary home health services out-of-state.

All of the following requirements must be met in order for a recipient to qualify for out-of-state home health services:

- The recipient must meet all in-state home health program requirements.
- Out-of-state home health services must be prior authorized by the Florida Medicaid transplant coordinator or Medicaid out-of-state services coordinator.
- The home health agency must be a Medicaid or Medicare provider in the relevant state.
- The home health agency must enroll as a Florida Medicaid provider.

Out-of-state home health services must be coordinated through the authorized hospital, which must provide an anticipated plan of outpatient care that is signed and dated by the recipient's attending physician.

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**Infusion Therapy Services**

An infusion therapy service includes set-up, infusion, and take down time. It also includes recipient assessment time at the beginning and end of the procedure.

For adults, each single episode of infusion therapy service is reimbursed as a skilled nursing visit regardless of the length of time required for the infusion service.

For recipients under the age of 21, an infusion therapy service is reimbursed as one of the following:

- A skilled nursing visit if the length of time required for the service is less than two hours
- A private duty nursing service if the length of time required for the service is two hours or more

Drugs for infusion therapy services and formulae or solutions for nutrition-infusion services are reimbursed through Medicaid durable medical equipment and medical supply services and the Medicaid prescribed drugs.

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**Covered, Limited, and Excluded Services**, continued

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**Assisted Living Facility (ALF) Services**

Medicaid does not reimburse services that duplicate those an ALF provides to a resident in its contract and service plan with the resident.

Home health agencies are responsible for determining that the provided home health service is not included in the ALF resident contract and service plan.

Medicaid does not reimburse home health visit services provided to recipients living in an ALF when either of the following apply:

- The nurse or home health aide providing the service is an employee, directly or by contract, of both the home health agency billing for the service and the ALF.
  - The nurse or home health aide performs the home health visit service during a time period when he is also being paid or reimbursed for his services by the ALF.
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**Licensed Nurse and Home Health Aide Services**

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**Home Health Visit Limitations**

Home health visits are limited to a maximum of three intermittent visits per day for non-pregnant adults age 21 and older. The visits can be any combination of licensed nurse and home health aide visits.

The minimum length of time between home health visits provided to a recipient on the same day must be at least one hour.

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**Prior Authorization of Services**

All home health services must be prior authorized by the QIO prior to the delivery of services. Home health services are authorized by the QIO if the services are determined to be medically necessary.

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**Place of Service Exclusions**

Medicaid does not reimburse for home health services provided in any of the following locations:

- Hospitals
  - Nursing facilities
  - Intermediate care facility for individuals with intellectual disabilities (ICF/IID) (see exceptions for ICF/IIDs in 42 CFR 483, Subpart I)
  - Day care centers for children or adults
  - Prescribed pediatric extended care centers (PPEC)
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**Licensed Nurse and Home Health Aide Services**, continued

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**Exceptions to Place of Service Exclusions**

Short-term nursing services provided by an RN or LPN are allowed in an ICF/IID when the services are medically necessary to avoid transfer of the recipient to a nursing facility.

Short-term nursing means services provided for a time span limited by the nursing needs surrounding a specific acute medical event. Example: Orthopedic surgical procedure requiring more nursing intervention than is available in the ICF/IID during the initial recuperation period.

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**Home Health Nurse Visit Requirements**

Home health nurse visit services must be all of the following:

- Provided through home health visits
  - Medically necessary
  - Furnished by an RN or an LPN
  - Ordered by the attending physician and specified in the physician approved POC
- 

**Supervisory Requirement**

RNs must supervise home health services provided by an LPN or a home health aide in accordance with the standards defined in 42 CFR 484.36(d)2 and Rule 59A-8.008, F.A.C. If the recipient requires only nursing; or nursing and physical, respiratory, occupational or speech therapy services; or nursing and dietetic and nutrition services, case management shall be provided by a licensed RN directly employed by the agency. If the recipient is receiving only physical, speech, respiratory, or occupational therapy services or is receiving only one or more of these therapy services and home health aide services, case management shall be provided by the licensed therapist, who is a direct employee of the home health agency or a contractor.

The supervising RN must ensure all of the following:

- Tasks are assigned to LPNs and home health aides
- A medical record is maintained for each recipient
- Nursing progress notes are made in the recipient's medical record for each in-home visit
- All medical records are available when required for review by Medicaid, or agency designee

Medicaid does not reimburse for required RN supervision duties or visits.

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**Licensed Nurse and Home Health Aide Services**, continued

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**Skilled Nursing Services**

The following are examples of nursing services reimbursable by Medicaid:

- Administration of intravenous medication
- Administration of intramuscular injections, hypodermoclysis, and subcutaneous injections only when not able to be self-administered appropriately
- Insertion, replacement, and sterile irrigation of catheters
- Colostomy and ileostomy care, excluding care performed by recipients
- Treatment of decubitus ulcers when:
  - deep or wide without necrotic center
  - deep or wide with layers of necrotic tissue
  - infected and draining
- Treatment of widespread infected or draining skin disorders
- Administration of prescribed heat treatment requiring observation by licensed nursing personnel to adequately evaluate the recipient's progress
- Restorative nursing procedures (including related teaching and adaptive aspects of nursing), which are a part of active treatment and require the presence of licensed nurses at the time of performance
- Nasopharyngeal, tracheotomy aspiration, ventilator care
- Levin tube and gastrostomy feedings (excluding feedings performed by the recipient, family, parent or legal guardian)
- Complex wound care requiring packing, irrigation, and application of an agent prescribed by the physician

Medicaid does not reimburse skilled nursing services solely for the purposes of monitoring medication compliance or assisting with self-administered medication.

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**Home Health Aide Service Requirements**

Home health aide services can be reimbursed only when they are all of the following:

- Ordered by the attending physician
  - Documented as medically necessary
  - Provided by an appropriately trained aide
  - Consistent with the physician approved plan of care
  - Delegated in writing and provided under the supervision of a registered nurse
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**Licensed Nurse and Home Health Aide Services**, continued

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**Home Health Aide Services**

Home health aide services help maintain a recipient's health or facilitate treatment of the recipient's illness or injury. The following are examples of home health aide services reimbursed by Medicaid:

- Assisting with the change of a colostomy bag
- Assisting with transfer
- Reinforcing a dressing
- Assisting the individual with prescribed range of motion exercises that have been taught by the RN
- Measuring and preparing prescribed special diets
- Providing oral hygiene
- Bathing and skin care
- Assisting with self-administered medication

Home health aides must not perform any services that require the direct care skills of a licensed nurse.

---

**Types of Home Health Aide Visits**

Medicaid reimburses home health aide visits when they are either of the following:

- A home health aide visit that is associated with a skilled nursing service. The physician's order and POC must identify the recipient's need for both home health aide services and skilled nursing services in the home. The skilled nursing service must be provided in addition to the supervisory nursing service. This type of home health aide visit can be reimbursable by Medicare; and if so, the service must be billed to Medicare first for a dually eligible Medicare and Medicaid recipient.
- A home health aide visit that is not associated with a skilled nursing service. The physician's order and POC must identify the recipient's need for home health aide services only. This type of home health aide visit is not reimbursable by Medicare. Providers should bill this service for a dually eligible Medicare and Medicaid recipient directly to Medicaid, unless the recipient has other third party insurance.

Both types of visits must meet all the home health aide requirements including being provided under the supervision of a registered nurse.

Different procedure codes are used for these two types of visits, and a modifier must be added to the procedure code when billing for a dually eligible Medicare and Medicaid recipient.

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## Private Duty Nursing Services

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### Who Can Receive Private Duty Nursing

Medicaid reimburses private duty nursing services for recipients under the age of 21 who meet all of the following requirements:

- Have complex medical problems
- Require more extensive and continual care than can be provided through a home health nurse visit

Note: See the Glossary in the Florida Medicaid Provider General Handbook for the definition of medically complex.

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### Private Duty Nursing Requirements

Private duty nursing services must be all of the following:

- Ordered by the attending physician
  - Documented as medically necessary
  - Provided by a registered nurse or a licensed practical nurse
  - Consistent with the physician approved POC
  - Prior authorized before services are provided
- 

### Parental Responsibility

There are times during the day when skilled interventions are not required for a recipient receiving private duty nursing services. In these cases, parents or legal guardians must provide assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) for their child, to the fullest extent possible. If parents or legal guardians need training to safely perform these ADL and IADL tasks, the home health services provider must provide training and document the methods used to train the parent or legal guardian in the medical record. If the parents or legal guardians are willing and capable of providing more than ADL and IADL care, private duty nursing can be authorized to supplement the care provided by those parents or legal guardians.

Medicaid can reimburse services rendered to a recipient whose parent or legal guardian is not available or able to provide ADL or IADL care. Supporting documentation must accompany the prior authorization request in order to substantiate a parent or legal guardian's inability to participate in the care of the recipient (i.e., work or school schedules and medical documentation). If a parent or legal guardian is unable to provide a work schedule, a statement attesting to the work schedule must be presented to the QIO when requesting authorization.

To the extent that any portion of this handbook related to private duty nursing services conflicts with 59G-1.010(166)(a)(5), F.A.C., the provisions in this handbook control.

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**Private Duty Nursing Services**, continued

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**Parental  
Responsibility,**  
continued

Medicaid does not reimburse private duty nursing for respite care. Examples are parent or legal guardian recreation, socialization, and volunteer activities, or periodic relief to attend to personal matters unrelated to the medically necessary care of the recipient.

Note: See Appendices E, F, G, and H for copies of the parent or legal guardian medical limitations, work, and school schedule forms, AHCA-Med Serv Forms 5000-3501, Revised February 2013; -3503, Revised February 2013; -3504, Revised February 2013; and -3505, Revised October 2014. The forms are available by photocopying them from the appendices. They are incorporated by reference in Rule 59G-4.130, F.A.C.

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**Private Duty  
Nursing Provided by  
a Parent or Legal  
Guardian**

Medicaid will reimburse a home health agency for the provision of private duty nursing services to an eligible recipient by a parent or legal guardian who has a valid license as an RN or an LPN in the state of Florida and is employed by a Medicaid enrolled home health agency.

The home health agency is required to submit an Authorization for Private Duty Nursing Provided by a Parent or Legal Guardian, Form, AHCA Form 5000-3541, Revised February 2013 for approval when private duty nursing services are provided by a parent or legal guardian. Payments of home health claims for private duty nursing services provided by a parent or legal guardian without prior approval by Medicaid are subject to recoupment.

When private duty nursing services are provided by a parent or legal guardian employed by a home health agency, the home health agency's initial assessment and all subsequent POC recertification assessments must be completed by an RN that is not a household member.

Medicaid will only reimburse a home health agency up to 40 hours per week of private duty nursing services provided by a parent or legal guardian. Parents and legal guardians must participate in providing ADL and IADL care to the fullest extent possible and are expected to continue to provide non-reimbursed care as the primary parent or legal guardian.

Medicaid will not approve additional private duty nursing hours for the recipient so that the recipient's parent or legal guardian who is providing private duty nursing for the recipient can also work outside the home or for respite. The parent or legal guardian is not eligible to participate in this program if the required care cannot be provided because of a medical condition or disability of the parent or legal guardian.

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**Private Duty Nursing Services**, continued

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**Private Duty Nursing Provided by a Parent or Legal Guardian**, continued

Medicaid can authorize additional hours for the parent or legal guardian to sleep if the child's medical condition requires an awake parent or legal guardian to provide continuous or frequent intervention or medically necessary observation during the night.

Any other authorized private duty nursing hours must be provided by a non-relative RN or LPN employed by the home health agency.

Once the initial approval has been processed by AHCA, the home health services provider must obtain prior authorization through the QIO vendor.

The home health services provider must ensure current documentation related to the parent's or legal guardian's license and qualifications is kept on file.

Note: See Appendix C for a copy of the Authorization for Private Duty Nursing Provided by a Parent or Legal Guardian Form, AHCA Form 5000-3541, Revised February 2013. The form is available by photocopying it from the appendix. It is incorporated by reference in Rule 59G-4.130, F.A.C.

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**PPEC Services**

A recipient who is receiving PPEC services may also receive private duty nursing services in the home, if additional skilled nursing care is needed.

Note: For more information about PPEC services, see the Florida Medicaid Pediatric Prescribed Extended Care Services Coverage and Limitations Handbook.

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**Flex Hours or Banking of Hours**

Medicaid does not allow "banking of hours" or "flex hours". Only the number of hours that are medically necessary can be approved. Home health service providers must request only the number of hours that are expected to be used and must indicate the times of day and days per week the hours are needed. If a recipient requires additional hours due to unforeseen circumstances or change in medical or social circumstances, the home health service providers should submit a modification request to the QIO for the additional hours needed.

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**Private Duty Nursing Services**, continued

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**Prior Authorization Process**

Private duty nursing services will be prior authorized by the QIO if the services are determined to be medically necessary. The request for the authorization must be submitted prior to the delivery of services.

Initial requests for private duty nursing will be authorized for up to 60 days to allow for reassessment of the recipient's condition. Services can be decreased over time if there is a documented change in the recipient's medical condition or there is a documented change in circumstances.

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**Medical Foster Care**

Medicaid will reimburse for private duty nursing to supplement medical foster care services.

Note: See the Florida Medicaid Medical Foster Care Services Coverage and Limitations Handbook for more information and the circumstances in which private duty nursing can be reimbursed for children in medical foster care.

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**Place of Service Requirement**

Private duty nursing services must be provided according to an individualized plan of care in the eligible Medicaid recipient's place of residence or, under authorized situations, outside the place of residence.

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**Place of Service Exclusions**

Medicaid does not reimburse for private duty nursing services provided in the following locations:

- Hospital
  - Nursing facility
  - Intermediate care facility for individuals with intellectual disabilities (ICF/IID)
  - Physician's office
  - Clinic
  - PPEC
- 

**Services Outside Place of Residence**

Medicaid only reimburses for private duty nursing services outside the place of residence if both of the following criteria are met:

- The services are unavailable through other public or private resources, including schools (documentation will be required).
  - The services are medically necessary while the child is outside the home.
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**Private Duty Nursing Services**, continued

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**School Services**

Private duty nursing services can be considered for the medically complex child at school if both of the following criteria are met:

- AHCA or the child's primary care physician considers going to school a viable option given the child's medical status.
  - The school system is not currently providing the intensity of nursing care required by the child, and private duty nursing services would enable the child to attend school (documentation will be required).
- 

**Training Exclusions**

Medicaid will not reimburse for professional development training for home health private duty nursing staff or other home health personnel.

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**Services Overlap Days**

When services begin one day and end the next day, billing should reflect the total number of care hours provided on each day. For example:

- Services begin at 11 p.m. on January 31 and continue to 7 a.m. on February 1
- Services begin again at 11 p.m. on February 1 and continue to 7 a.m. on February 2

Billing would be as follows:

- January 31 = 1 hour (11 p.m. to 12 midnight)
  - February 1 = 8 hours (12 midnight to 7 a.m. and 11 p.m. to 12 midnight)
  - February 2 = 7 hours (12 midnight to 7 a.m.)
-

## Personal Care Services

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### Who Can Receive Personal Care Services

Medicaid reimburses personal care services for recipients under the age of 21 who meet all of the following criteria:

- Have a medical condition or disability that substantially limits their ability to perform their ADLs or IADLs
- Have a physician's order for personal care services
- Require more individual and continuous care than can be provided through a home health aide visit
- Do not have a parent or legal guardian able to provide ADL or IADL care.

Medically necessary personal care services can be authorized when a recipient has a documented cognitive impairment which prevents the recipient from knowing when or how to carry out the personal care task. Assistance can be in the form of hands on assistance (actually performing the task for the person) or cuing along, with supervision, to ensure the recipient performs the personal care task properly. Additional supporting documentation can be required to substantiate the functional limitations associated with the cognitive impairment.

---

### Personal Care Services Requirements

Personal care services must be all of the following:

- Documented as medically necessary
  - Prescribed by the attending physician if provided through a home health agency
  - Supervised by a registered nurse if provided through a home health agency
  - Supervised by the parent or legal guardian if provided by a non-home health agency
  - Supervised by the recipient if the services are provided by a non-home health agency and the recipient is a legal adult between the ages of 18 and 21 with no legal guardian
  - Provided by a home health aide or independent personal care provider
  - Consistent with the physician approved plan of care
  - Authorized prior to providing services
-

**Personal Care Services**, continued

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**Parental  
Responsibility**

Personal care services can be authorized to supplement care provided by parents and legal guardians. Parents and legal guardians must participate in providing care to the fullest extent possible. Where needed, the home health service provider must offer training to enable parents and legal guardians to provide care they can safely render without jeopardizing the health or safety of the recipient. The home health services provider must document the methods used to train a parent or legal guardian in the medical record.

Medicaid can reimburse personal care services rendered to a recipient whose parent or legal guardian is not able to provide ADL or IADL care. Supporting documentation must accompany the prior authorization request in order to substantiate a parent or legal guardian's inability to participate in the care of the recipient.

Note: See Appendices E, F, G, and H for copies of the parent or legal guardian medical limitations, work, and school schedule forms, AHCA-Med Serv Forms 5000-3501, Revised February 2013; -3503, Revised February 2013; -3504, Revised February 2013; and -3505, Revised October 2014. The forms are available by photocopying them from the appendices. They are incorporated by reference in Rule 59G-4.130, F.A.C.

---

**Prior Authorization**

Personal care services will be prior authorized by the QIO if the services are determined to be medically necessary and meet all other criteria as specified in this chapter. The request for the authorization must be submitted prior to the delivery of services.

Initial requests for personal care services will be authorized for up to 60 days to allow for reassessment of the recipient's condition. Services will be decreased if there is a documented change in the child's medical condition or there is a documented change in circumstances.

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**Personal Care Services**, continued

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**Flex Hours or Banking of Hours**

Medicaid does not allow “banking of hours” or “flex hours”. Only the number of hours that are determined medically necessary by the QIO can be approved. Home health service providers must request only the number of hours that are expected to be used and must indicate the times of day and days per week the hours are needed. If a recipient requires additional hours due to unforeseen circumstances or change in medical or social circumstances, the home health service provider should submit a modification request to the QIO for the additional hours needed.

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**Place of Service Requirement**

Personal care services must be provided according to an individualized POC in the eligible Medicaid recipient’s place of residence or, under authorized situations, outside the place of residence.

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**Place of Service Exclusions**

Medicaid does not reimburse for personal care services provided in the following locations:

- Hospitals
  - Nursing facilities
  - Intermediate care facilities for individuals with intellectual disabilities
  - Physician offices
  - Clinics
  - Prescribed pediatric extended care centers
- 

**Services Outside Place of Residence**

Medicaid reimburses for personal care services outside the place of residence only if both of the following criteria are met:

- The services are unavailable through other public or private resources, including schools (documentation will be required).
  - The services are medically necessary while the child is outside the home.
-

## **Durable Medical Equipment and Therapy Services**

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### **Medical Supplies and Equipment**

Home health agencies, under their Medicaid home health provider number, can furnish medical supplies and durable medical equipment (DME) if they meet the DME provider enrollment criteria per the Durable Medical Equipment Coverage and Limitations Handbook. The medical supplies must be provided in accordance with the physician approved POC. All medical supplies provided must be related to the care of the patient that the agency is serving.

Home health agencies that provide DME must comply with the policies and procedures contained in this handbook and in the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook.

Medicaid reimburses home health agencies for DME services provided only at the recipient's place of residence.

Note: See the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook for additional information on service coverage and limitations and corresponding procedure codes.

Note: See the Florida Medicaid Provider General Handbook for information on billing the recipient for supplies and equipment not covered by Medicaid.

---

### **Occupational, Physical and Speech Therapy Services**

Medicaid reimburses home health agencies, under their Medicaid home health provider number, for occupational, physical, and speech therapy services furnished by qualified therapy providers in accordance with a physician approved POC. Medicaid reimburses home health agencies only for therapies prescribed by a physician.

Home health agencies that provide these therapy services must comply with the policies and procedures contained in the Florida Medicaid Therapy Services Coverage and Limitations Handbook and in this handbook.

Medicaid reimburses home health agencies for medically necessary therapy services provided to recipients under the age of 21 and only at the place of residence.

Note: See the Florida Medicaid Therapy Services Coverage and Limitations Handbook for additional information on service coverage and limitations and corresponding procedure codes.

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**Required Documentation**

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**Nursing Interventions and Outcomes**

Each clinical record must contain documentation of appropriate nursing interventions and expected health outcomes.

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**Required Reports and Records**

The home health services providers must maintain reports and medical records that accurately document the services provided to the recipient.

The medical record must indicate that services were provided in accordance with physician orders and the approved and current POC. All care provided to the recipient must be documented in the medical record and signed and dated by the individual who furnishes the care. These records will be used to evaluate any changes made to the POC.

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**Medical Record Release**

Upon request by AHCA (or its designee), the home health services provider must furnish all medical and Medicaid related records requested and determined to be relevant to the services or goods billed to the Medicaid program.

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**Required Documentation**, continued

**Medical Record Requirements**

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The home health agency must maintain the following documentation in the recipient's current medical record:

- Nursing notes of the initial assessment visit and subsequent visits by RNs
- Most current plan of care
- Most current physician's orders (signature and date are required)
- Progress notes
- Tasks and duties assigned to LPNs and home health aides
- Dates and signatures of individuals who render care
- Legal documents
- Consent forms
- Recipient and parent or legal guardian verification of services received

The independent personal care provider must maintain the following documentation in the recipient's current medical record:

- Most current physician's orders (signature and date required)
- Most current plan of care
- Progress notes which must contain the following:
  - Recipient's name
  - Recipient's Medicaid ID number
  - Date the service was rendered
  - Service start and end times
  - Identification of the setting in which the service was rendered
  - Identification of the service rendered, including the specific activities or tasks performed
  - Identification of the supplies or equipment used
  - Updates regarding the recipient's progress, if any, toward meeting the goals of the plan of care
  - Provider's name and Medicaid identification number
  - Name and signature of the direct care provider rendering the service
  - Recipient and parent or legal guardian verification of services received

Note: See the Florida Medicaid Provider General Handbook for additional record keeping requirements.

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## Prior Authorization for Home Health Services

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### Introduction

Prior authorization is the approval process required prior to providing certain services to recipients. Medicaid will not reimburse for these services without prior authorization when it is required. Home health service providers are required to adhere to the requirements outlined in this section in order to receive reimbursement for services. Failure to comply with the prior authorization requirements can result in the suspension of a provider's access to obtain new prior authorizations for Medicaid services until deficiencies are addressed.

---

### Services Requiring Prior Authorization

All of the following home health services require prior authorization for reimbursement:

- Home health visits (skilled nursing and home health aide services)
  - Private duty nursing
  - Personal care services
- 

### General Requirements

The following general requirements apply to prior authorization for home health services for all recipients:

- The request must be submitted to the QIO via its Web-based Internet system.
- All required documentation to support the request must be submitted directly to the QIO at the time of the request.
- For initial service requests, it is recommended that the home health services provider submit the request to the QIO at least ten business days prior to the start of care.
- For subsequent authorization requests (continued stay requests), the home health services provider must submit the request to the QIO at least ten business days prior to the start of the new certification period.
- The earliest effective date of the authorization is the date the request is received by the QIO.

Refer to the Enhanced Care Coordination section of this chapter for further details on the prior authorization requirements for private duty nursing services.

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**Prior Authorization for Home Health Services**, continued

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**Requesting Prior Authorization**

At a minimum, each prior authorization request must include all of the following:

- Recipient's name, address, date of birth, and Medicaid identification number
- Home health agency or independent personal care provider's Medicaid provider number, name, and address
- Procedure code(s) with modifier(s), if applicable, matching the services reflected in the POC
- Units of service requested
- Summary of the recipient's current health status, including diagnosis(es).
- Planned dates and times of service
- Ordering provider's Medicaid identification number, NPI or Florida Medical License number, name, and address
- The nursing assessment (for services provided by a licensed home health agency)
- A copy of the active POC signed by the attending physician
- Patient condition summaries that substantiate medical necessity and the need for requested services (such as a hospital discharge summary if services are being requested as a result of a hospitalization, physician or nurse progress notes, or history and physical)
- The physician's order

Note: See Appendix J for a copy of the Medicaid Physician's Written Prescription for Home Health Services Form, AHCA Form 5000-3525, Revised February 2013. The form is available by photocopying it from the appendix. It is incorporated by reference in Rule 59G-4.130, F.A.C.

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**Prior Authorization for Home Health Services**, continued

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**Requesting Prior Authorization,**  
continued

- A copy of the physician's visit assessment for home health visits, private duty nursing, or personal care services demonstrating the recipient has been examined or received medical consultation by the ordering or attending physician at least 30 days before initiating services and every 180 days thereafter.

Note: See Appendix D for a copy of the Physician Visit Documentation Form, AHCA Form 5000-3502, Revised February 2013. The form is available by photocopying it from the appendix. It is incorporated by reference in Rule 59G-4.130, F.A.C. (This form is required to document the physician visit assessment. The discharge summary for initial requests after a hospital discharge or a history and physical will be accepted).

- For personal care services, the following supportive documentation must be furnished regarding the parent or legal guardian's availability and ability to provide care, as applicable:
    - Medical information validating limitations in providing care  
Note: See Appendix E for a copy of the Parent or Legal Guardian Medical Limitations Form, AHCA-Med Serv Form 5000-3501, Revised February 2013. The form is available by photocopying it from the appendix. It is incorporated by reference in Rule 59G-4.130, F.A.C.
    - Work schedules  
Note: See appendices F and G for copies of the Parent or Legal Guardian Work Schedule Forms, AHCA-Med Serv Forms 5000-3503, Revised February 2013, and -3504, Revised February 2013. These forms are available by photocopying them from the appendices. They are incorporated by reference in Rule 59G-4.130, F.A.C.
    - School schedules  
Note: See Appendix H for a copy of the Parent or Legal Guardian School Schedule Form, AHCA-Med Serv Form 5000-3505, Revised October 2014. The form is available by photocopying it from the appendix. It is incorporated by reference in Rule 59G-4.130, F.A.C.
  - The QIO can request a copy of the assessment developed by the Florida Department of Health, Children's Medical Services (CMS) when private duty nursing or personal care services are requested for children who are enrolled in the CMS Network.
-

**Prior Authorization for Home Health Services**, continued

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**Review Criteria**

The QIO can use a national standardized set of criteria, or other set of criteria, approved by AHCA, as a guide to establish medical necessity for prior authorization of home health services at the first review nurse level. If services cannot be approved by the first level nurse review(er), the QIO's physician peer reviewer will determine medical necessity using his clinical judgment, acceptable standards of care, state and federal laws, and AHCA's medical necessity definition.

The QIO will utilize guidelines approved by AHCA for reviewing the parent or legal guardian responsibility in providing care for the recipient.

Note: See Appendix K for a copy of the Review Criteria for Private Duty Nursing Services, AHCA Form 5000-3543, Revised October 2014. The criteria are available by photocopying them from the appendix. They are incorporated by reference in Rule 59G-4.130, F.A.C.

Note: See Appendix L for a copy of the Review Criteria for Personal Care Services, AHCA Form 5000-3542, Revised October 2014. The criteria are available by photocopying them from the appendix. They are incorporated by reference in Rule 59G-4.130, F.A.C.

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**Approval Process**

The QIO will review each physician order and each prior authorization request and approve, deny, or request additional information to support the request.

Prior authorization requests for home health services that are less in level or different in kind from the physician's order or that appear to deviate from treatment norms, established standards of care, or utilization norms can be subject to a more intensified review by the QIO prior to rendering a determination. This can include a telephonic or face-to-face contact with the Medicaid recipient in the recipient's place of residence, interviews with the ordering physician, and a review of the recipient's medical record.

Where the prior authorization request is less in level than the physician's order, the QIO is not bound to the prior authorization request and may approve the physician's order or may approve a number of hours between the physician's order and the prior authorization request. It may also approve the prior authorization request or a fewer number of hours than stated in the prior authorization request, consistent with its own intensified review.

Where the prior authorization request is different in kind from the physician's order – for example, where the physician orders private duty nursing by a RN and the provider requests a LPN, or where the physician orders private duty nursing and the prior authorization requests home health aide – the QIO may approve either the physician's order or the prior authorization request, consistent with its own intensified review.

The QIO will post the status of the request on its Internet system. Providers must check the Internet system for the status of submitted prior authorization requests.

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**Prior Authorization for Home Health Services**, continued

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**Approved Request**

When the request is approved, the approval will contain a prior authorization number for billing and reference.

An approved request is not a guarantee that Medicaid will reimburse the service. The provider and recipient must be eligible on the date of service, and the service must not have exceeded any applicable service limits.

---

**Content and Limitations on Approved Requests**

The approval of services is accessed via the Internet system and specifies all of the following:

- Procedure code
  - Units of service authorized
  - Dates of service
  - Discipline authorized to provide the service
  - Number of days for which the authorization is valid
- 

**Changes to Approved Requests (Modifications)**

For any requested change, the provider must submit via the Internet, additional new information, not previously submitted, documenting the need for the additional visits or hours.

When requesting additional visits or hours within a certification period, the provider should indicate that the request:

- Is for additional visits or hours or a change to an already requested certification period.
  - Includes the attending physician approved POC, new physician's orders, and a reason for the adjustment.
-

**Prior Authorization for Home Health Services**, continued

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**Medicaid Quality Improvement Organization (QIO) Decision Process**

If a physician denial or modified approval is proposed, the Quality Improvement Organization (QIO) informs the provider via the Internet. (In a modified approval, a portion of the requested visits or hours can be denied due to lack of medical necessity or can otherwise be changed based on QIO's intensified review, as set out on the "Approval Process" section of this chapter.)

The QIO will post the notice of denial or modified approval on its Internet system.

If the QIO physician determines that services are not medically necessary, the recipient and provider will be notified in writing that the services will be denied or reduced. The notification letter will include information regarding the recipient's appeal rights.

With respect to subsequent QIO determinations of medical necessity, there shall not be any reduction in the amount or duration of home health services unless:

- The reduction is to correct for factual errors or omissions in prior certifications.
- There is a documented improvement in the recipient's medical condition.
- There is a documented change in circumstances.

---

**Reconsideration Review**

If a denial determination is rendered, the provider, recipient, or physician can request reconsideration. If reconsideration is requested, additional information must be submitted to the QIO to facilitate the approval process.

A reconsideration review of the denial decision must be requested via the QIO Internet system within five business days of the date of the final denial or modified approval determination.

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**Prior Authorization for Home Health Services**, continued

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**Prior Authorization Number**

When the request is approved, the approval will contain a prior authorization number for billing and reference.

For Medicaid to reimburse the service:

- The prior authorization number must be entered on the claim form.
- The certification period, corresponding to the prior authorization number must match the dates of service shown on the claim.
- The Medicaid provider number and Medicaid recipient identification number on the claim form and the POC must match.

The Medicaid provider must not submit a claim prior to providing the services.

---

**Termination of Services**

A discharge request must be submitted to the QIO when a home health services provider terminates services. The discharge request must include, at a minimum, the last date that services were provided to the recipient and the number of units used on the prior authorization number up until the point of discharge. Failure to comply with this discharge procedure requirement can result in suspending a provider's access to obtaining new prior authorizations for Medicaid services until deficiencies are addressed.

---

**Submission of a Claim for Payment**

Providers must submit a claim for payment for a prior authorized procedure after the service has been approved and provided.

In order to receive reimbursement for the service, the provider must enter the prior authorization number on the claim.

Note: For additional information on completing the claim, see the Florida Medicaid Provider Reimbursement Handbook, CMS-1500.

---

**Medically Needy Prior Authorization**

The QIO cannot obtain a prior authorization number from the Medicaid fiscal agent for a medically needy individual who is in a period of ineligibility. If the individual becomes eligible for the dates that the services were rendered, the provider must notify the QIO via the Internet that the recipient is a medically needy individual and state the recipient's dates of eligibility for each month prior authorization is being requested.

Note: For more information about medically needy, see the Florida Medicaid Provider General Handbook.

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**Prior Authorization for Home Health Services**, continued

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**Enhanced Care Coordination**

The QIO will assign a care coordinator to each recipient receiving private duty nursing services. The QIO care coordinator will maintain regular monthly contact with the recipient and the recipient's parent or legal guardian to stay abreast of the recipient's condition. Every six months, the QIO care coordinator will convene a multidisciplinary team comprised of the recipient (if able), the parent or legal guardian, and other medical professionals and individuals involved in that recipient's care. The QIO will develop a service plan that includes all services and supports needed to meet the recipient's medical needs in order to safely remain in the home. All services, including private duty nursing, that are subject to prior authorization will be reviewed as a part of this multidisciplinary team process.

Home health service providers must submit the required documentation set out in the "Requesting Prior Authorization" section of this chapter to the QIO prior to the multidisciplinary team meeting.

If consensus cannot be reached by the team members regarding the number of private duty nursing hours to be authorized, the request will be forwarded to the QIO's physician peer reviewer. The physician peer reviewer will review all available information that has been collected as a part of the multidisciplinary team process and will also attempt to contact the child's treating physician to discuss the case. The physician peer reviewer will make the determination as described in the "Review Criteria" section of this chapter.

If the request is denied (in whole or in part), the recipient (or designee) has the right to request a reconsideration review through the QIO as described in this chapter or request a fair hearing with the Department of Children and Families, Office of Appeals.

For initial requests for private duty nursing services, the recipient's care coordinator must conduct a home visit to review the needs of the recipient.

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**Telephonic Home Health Services Delivery Monitoring and Verification (DMV) Program**

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**Program Description**

AHCA has contracted with a vendor to telephonically verify the delivery of home health services (i.e., home health visits, private duty nursing, and personal care services) provided to a Medicaid recipient in the recipient's place of residence or authorized setting. The intent of this program is to validate and ensure the timely utilization of home health services, which are prior approved and documented in the recipient's POC.

---

**Participation**

All Florida Medicaid enrolled home health service providers must comply with the requirements of the DMV program in order to receive reimbursement for home health visits, private duty nursing, or personal care services provided to Medicaid recipients.

In order to receive home health services reimbursed through the Medicaid program, Medicaid recipients must comply with the requirements of the DMV program.

---

**Requirements**

Home health service providers are required to enter, in the vendor's system, the home health service encounter schedules for each recipient served. Home health service encounter schedules must be entered in accordance with the recipient's approved POC.

Home health provider personnel (e.g., ARNP, RN, LPN, independent providers, and home health aides, etc.) who directly provide services to Medicaid recipients are required to call the vendor's toll-free line at the beginning and end of each home health service encounter to "check-in" and "check-out" using the Medicaid recipient's home telephone.

If the Medicaid recipient does not have a telephone in the place of residence, AHCA (or its designee) must be notified by the home health provider. Recipients without a telephone will be provided a Fixed Visit Verification Device (FVVD), which has the ability to confirm the beginning and end times of each service encounter. Home health service providers are required to contact AHCA (or its designee) promptly when an FVVD is defective or no longer used by the recipient.

Once the home health service encounter has been verified, a claim can be generated using the vendor's system in order to be reimbursed by the Medicaid program. The vendor will ensure that the service delivery information is consistent with the prior authorization file within the Medicaid system.

---

**Non-Compliance with Requirements**

Home health providers that fail to comply with the requirements of the DMV Program are subject to denial and non-payment of claims. Failure to comply with all program requirements can also result in the application of sanctions, which include, but are not limited to, fines, suspension, and termination.

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## CHAPTER 3

### REIMBURSEMENT AND FEE SCHEDULE

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#### Overview

#### Introduction

This chapter describes reimbursement and fee schedule information for home health services.

#### In This Chapter

This chapter contains:

TOPIC	PAGE
Overview	3-1
Reimbursement Information	3-1
How to Read the Fee Schedule	3-5
Procedure Code Modifiers	3-5

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#### Reimbursement Information

#### Who Can Be Reimbursed

Medicaid will only reimburse a home health agency for home health visit and private duty nursing services. Medicaid will reimburse a home health agency or an independent personal care services provider for personal care services. The nurse, home health aide, or independent personal care provider must be awake and actively providing care to the recipient during the hours billed to the Medicaid program.

#### Procedure Codes

The procedure codes listed in this handbook are Healthcare Common Procedure Coding System (HCPCS) Level II, which is a part of a nationally standardized code set. Level II of the HCPCS is a standardized coding system used primarily to identify products, supplies, and services not included in the CPT codes. HCPCS Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter (A – V) followed by four numeric digits. Please refer to the current HCPCS Level II Expert code book for complete descriptions of the standard codes. The HCPCS Level II Expert® code book is copyrighted by Ingenix, Inc. All rights reserved.

**Reimbursement Information**, continued

**Diagnosis Code**

When submitting claims for payment, providers must select the diagnosis codes that most accurately reflect the Medicaid recipient’s medical need for nursing or home health aide services.

The use of general or generic diagnosis codes such as “general debility” as the only primary diagnosis code is inappropriate and will result in further review by the Medicaid Quality Improvement Organization (QIO).

**Reimbursement for Home Health Services**

Medicaid reimbursement for home health services is the lesser of the following:

- Amount billed
- Maximum fee listed on the Home Health Services Fee Schedule
- Provider’s usual and customary charge

**Copayment**

Medicaid recipients, unless exempt, are responsible to pay a copayment of \$2.00 per home health provider, per day.

Note: For additional information about copayment requirements and categories of recipients who are exempt from copayment, see the Florida Medicaid Provider General Handbook.

**Visit Reimbursement**

Medicaid reimburses per home health visit. The staffing resources needed to provide a service are included in the visit reimbursement.

Medicaid does not reimburse per individual staff person(s) providing a home health visit.

**Home Health Visits for Multiple Recipients at One Location**

Home health visit services provided to two or more recipients with the same home address and share a dwelling space or within the same apartment building are reimbursed as follows:

- For the first recipient, Medicaid will reimburse the service at the established Medicaid visit rate.

**Reimbursement Information**, continued

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**Home Health Visits for Multiple Recipients at One Location**, continued

- For the second and any additional recipients, Medicaid reimburses the service at 50 percent of the established Medicaid visit rate.

The provider should bill using the appropriate TT procedure code modifier on all cases and should reduce their billing for each as indicated in policy for subsequent cases within the same setting.

Note: Please call your local Medicaid area office for billing instruction questions. The area offices' telephone numbers are listed in the Florida Medicaid Provider General Handbook and on the AHCA Web site at [www.ahca.myflorida.com](http://www.ahca.myflorida.com).

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**Private Duty Nursing and Personal Care Services for Multiple Recipients at One Location**

Private duty nursing and personal care services furnished by one nurse, home health aide or independent personal care provider to two or more recipients within the same setting is reimbursed as follows:

- For the first recipient, Medicaid reimburses the service at the established Medicaid rate.
- For the second recipient, Medicaid reimburses the service at 50 percent of the established Medicaid rate.
- For additional recipients, Medicaid reimburses the service at 25 percent of the established Medicaid rate.

A modifier must be added to the home health, private duty nursing or personal care visit procedure code to identify the service provided to more than one recipient in the same setting. The provider should bill using the appropriate TT modifier on all cases and should reduce their billing for each recipient as indicated in policy for subsequent cases within the same setting.

---

**Multiple Home Health Service Providers**

In situations that require services from more than one home health provider in order to provide all the care required by a recipient, each home health provider is responsible for coordinating its plan of care with the other involved home health providers. In addition, each home health provider is responsible for informing the QIO of the other home health providers that are also providing services to the recipient. A home health provider providing home health services without documented knowledge of other home health providers providing services to its recipient is at risk for recoupment of reimbursement.

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**Reimbursement Information**, continued

**Multiple Home Health Service Providers,**  
continued

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For billing purposes, the home health provider must add a UF modifier to the home health service procedure code to identify that services are being coordinated with another home health provider. A home health services provider furnishing home health services to a recipient that another provider is providing services to that does not adhere to the modified billing procedure is at risk for recoupment of reimbursement.

The second provider must use the UF procedure code modifier to bill for services provided on the same day as the discharging provider.

---

**Dually Eligible Recipients**

A dually eligible recipient is one who is enrolled in both Medicare and Medicaid.

A modifier must be added to the home health visit procedure code to identify a home health visit service provided to a dually eligible recipient. If a claim is submitted for a dually eligible recipient and the modifier is not added to the procedure code, the claim will deny.

Prior authorization requests submitted to the QIO must include the GY procedure code modifier if the recipient is dually eligible.

The home health services provider is responsible for retaining documentation in the recipient's record that the service is not Medicare reimbursable. (Medicaid is a secondary payer to Medicare.) A copy of the Medicare denial can be requested by the QIO prior to rendering a determination on requests for services for dually eligible recipients.

---

**Home Health Aide Visit Associated with Skilled Nursing Services**

A home health aide visit associated with a skilled nursing service must be billed to Medicare first for a dually eligible recipient.

A modifier must be added to the home health aide visit procedure code to identify that the home health aide visit service is associated with a skilled nursing service.

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## How to Read the Fee Schedule

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### Introduction

Procedure codes allowed for home health services are listed in the Home Health Services Fee Schedule in Appendix A.

The fee schedule includes the following information:

- Procedure codes associated with the type of service
  - Modifiers, if the procedure code requires one
  - Description of covered service
  - Maximum fee that will be reimbursed for the procedure
- 

### Procedure Code

The code in the fee schedule that corresponds to home health services.

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### Modifier

For certain types of services, a two-digit modifier must be entered on the claim form. Modifiers more fully describe the procedure performed so that accurate payment may be determined.

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### Description of Service

Describes the service to be reimbursed.

---

### Maximum Fee

Maximum amount that Medicaid will reimburse for the procedure code, per unit of service.

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## APPENDIX A

### HOME HEALTH SERVICES FEE SCHEDULE

## HOME HEALTH SERVICES FEE SCHEDULE

## HOME HEALTH VISITS

CODE	MOD 1	MOD 2	MOD 3	DESCRIPTION OF SERVICE	MAXIMUM FEE
T1030				Registered Nurse (RN) Visit	\$31.04/visit
T1030	TT			Registered Nurse (RN) Visit provided to more than one recipient in the same setting	\$31.04/visit - 1 <sup>st</sup> recipient \$15.52/visit – each additional recipient
T1031				Licensed Practical Nurse (LPN) Visit	\$26.19/visit
T1031	TT			Licensed Practical Nurse (LPN) Visit provided to more than one recipient in the same setting.	\$26.19/visit – 1 <sup>st</sup> recipient \$13.10/visit – each additional recipient
T1021				Home Health Aide (HHA) Visit-unassociated with skilled nursing services	\$17.46/visit
T1021	TD			Home Health Aide (HHA) Visit-associated with skilled nursing services	\$17.46/visit
T1021	TT			Home Health Aide (HHA) Visit-unassociated with skilled nursing services provided to more than one recipient in the same setting.	\$17.46/visit – 1 <sup>st</sup> recipient \$8.73/visit – each additional recipient
T1021	GY			Home Health Aide (HHA) Visit-unassociated with skilled nursing services to a Dually Eligible Recipient	\$17.46/visit
T1021	TD	TT		Home Health Aide (HHA) Visit-associated with skilled nursing services provided to more than one recipient in the same setting.	\$17.46/visit – 1 <sup>st</sup> recipient \$8.73/visit – each additional recipient
T1021	TT	GY		Home Health Aide (HHA) Visit-unassociated with skilled nursing services to a Dually Eligible Recipient provided to more than one recipient in the same setting.	\$17.46/visit – 1 <sup>st</sup> recipient \$8.73/visit – each additional recipient

## PRIVATE DUTY NURSING

CODE	MOD 1	MOD 2	DESCRIPTION OF SERVICE	MAXIMUM FEE
S9123			Private duty nursing rendered by a RN (2 to 24 hours per day)*	\$29.10/hr
S9123	TT		Private duty nursing rendered by a RN (2 to 24 hours per day)* provided to more than one recipient in the same setting.**	\$29.10/hr – 1 <sup>st</sup> recipient \$14.55/hr – 2 <sup>nd</sup> recipient \$7.28/hr – each additional recipient
S9123	UF		Private duty nursing rendered by a RN (2 to 24 hours per day)* provided by more than one provider in the same setting***	\$29.10/hr
S9123	TT	UF	Private duty nursing rendered by a RN (2 to 24 hours per day)* provided to more than one recipient by more than one provider in the same setting.******	\$29.10/hr – 1 <sup>st</sup> recipient**** \$14.55/hr – 2 <sup>nd</sup> recipient**** \$7.28/hr – each additional recipient****
S9124			Private duty nursing rendered by a LPN (2 to 24 hours per day)*	\$24.45/hr
S9124	TT		Private duty nursing rendered by a LPN (2 to 24 hours per day)* provided to more than one recipient in the same setting.	\$24.45/hr – 1 <sup>st</sup> recipient \$12.23/hr – 2 <sup>nd</sup> recipient \$6.11/hr – each additional recipient
S9124	UF		Private duty nursing rendered by a LPN (2 to 24 hours per day)* provided by more than one provider in the same setting	\$24.45/hr
S9124	TT	UF	Private duty nursing rendered by a LPN (2 to 24 hours per day)* provided to more than one recipient in the same setting.	\$24.45/hr – 1 <sup>st</sup> recipient**** \$12.23/hr – 2 <sup>nd</sup> recipient **** \$6.11/hr – each additional recipient****

\*Any portion of the hour that exceeds 30 minutes may be rounded up to the next hour, but the total may not exceed the daily authorized number of hours.

\*\*The provider should bill using the TT modifier on all cases, but should reduce their billing for each as indicated in policy for subsequent cases within the same residence.

\*\*\*The home health provider must add a UF modifier to the home health service procedure code to identify that services are being coordinated with another home health provider.

\*\*\*\*Per provider.

## PERSONAL CARE SERVICES

CODE	MOD 1	MOD 2	DESCRIPTION OF SERVICE	MAXIMUM FEE
S9122			Personal care rendered by a home health service provider (1 to 24 hours per day)*	\$15.00/hr
S9122	TT		Personal care rendered by a home health service provider (1 to 24 hours per day)* provided to more than one recipient in the same setting.	\$15.00/hr – 1 <sup>st</sup> recipient \$7.50/hr – 2 <sup>nd</sup> recipient \$3.75/hr – each additional recipient
S9122	UF		Personal care rendered by a home health service provider (1 to 24 hours per day)* provided by more than one provider in the same setting	\$15.00/hr
S9122	TT	UF	Personal care rendered by a home health service provider (1 to 24 hours per day)* provided to more than one recipient by more than one provider in the same setting.	\$15.00/hr – 1 <sup>st</sup> recipient \$7.50/hr – 2 <sup>nd</sup> recipient \$3.75/hr – each additional recipient

\*Any portion of the hour that exceeds 30 minutes may be rounded up to the next hour, but the total may not exceed the daily authorized number of hours.

## APPENDIX B

### CMS FORM 485 – HOME HEALTH CERTIFICATION PLAN OF CARE AND INSTRUCTIONS

## MEDICAID INSTRUCTIONS FOR CMS FORM 485 – PLAN OF CARE

### ITEM 1 – PATIENT’S HIC NUMBER

For Medicaid agencies, enter the patient’s Medicaid number.

### ITEM 2 – START OF CARE DATE (SOC)

This is the date service originally began. This date will remain the same on subsequent plans of care as long as the reason(s) for providing home health care remains the same.

### ITEM 3 – CERTIFICATION PERIOD

This identifies the period covered by the plan of care. Enter the six-digit month, day and year, i.e., MMDDYY

#### From Date

- The first day this POC covers includes this day.
- On the initial certification, the “FROM” date will be the same as start of care date.

#### To Date

- This is the end of the certification. The “TO” date is the last day of the plan of care.
- The “TO” date can include up to, but never exceed, 60 calendar days.
- On subsequent recertifications the next sequential “FROM” date will be the day after the “TO” date on the previous plan of care.

### ITEM 4 – MEDICAL RECORD NUMBER

No entry needed.

### ITEM 5 – PROVIDER NUMBER

Enter the provider number assigned by Medicaid. This number is comprised of nine digits.

### ITEM 6 – PATIENT’S NAME AND ADDRESS

Enter the recipient’s last name, first name, and middle initial as shown on the recipient’s Medicaid eligibility file. List the address where care is being rendered.

### ITEM 7 – PROVIDER’S NAME AND ADDRESS

Enter your agency’s name and address.

### ITEM 8 – DATE OF BIRTH

Enter the recipient’s date of birth in six-digit format, i.e., MMDDYY.

AHCA Form 5000-3544, Revised October 2014 (incorporated by reference in Rule 59G-4.130, F.A.C.)

**Medicaid Instructions for CMS Form 485 – Plan of Care, continued**

**ITEM 9 – SEX**

Check the appropriate box.

M – Male

F – Female

**ITEM 10 – MEDICATIONS**

Enter all medications including over-the-counter drugs.

Enter dosage, frequency and route of administration.

Enter an “N” after the medication(s) that are “new” orders for the current certification period.

Enter a “C” after the medication(s) that are “change” orders either in dose, frequency or route of administration for the current certification period.

(New or changed medications indicate and support changes or exacerbations in the recipient’s condition that may warrant additional or continuing home health services.)

Note: N = new medication within last 30 days.

C = changed medication (dosage, frequency, or route of administration) within last 60 days.

**ITEM 11 – PRINCIPAL DIAGNOSIS**

Enter a valid diagnosis code which best describes the principal reason for home health services. The code is the full diagnosis code including all digits.

If more than one diagnosis is treated concurrently, enter the diagnosis that represents the most acute condition and requires the most intensive services.

The principal diagnosis may change on subsequent forms only if the patient develops an acute condition or an exacerbation of a secondary diagnosis requiring intensive services different than those on the established plan.

Enter the date of onset or exacerbation in six-digit format (MMDDYY).

Indicate if the diagnosis is a new onset (“O”) or an exacerbation (“E”) of a pre-existing or chronic condition by placing an “O” or an “E” after the diagnosis date.

If the diagnosis is neither new nor an exacerbation or flare-up of a condition, enter the original date of onset of the condition.

Diagnosis date does not refer to dates of the certification period on the plan of care.

**ITEM 12 – SURGICAL PROCEDURE**

Enter a valid diagnosis surgical code and date of the surgical procedure. At a minimum, the month and year should be present for date of surgery.

This entry is only necessary if relevant to services being rendered or if the surgical procedure was within the last six months.

AHCA Form 5000-3544, Revised October 2014 (incorporated by reference in Rule 59G-4.130, F.A.C.)

**Medicaid Instructions for CMS Form 485 – Plan of Care, continued**

**ITEM 13 – OTHER PERTINENT DIAGNOSES**

Enter all pertinent diagnoses relevant to the care rendered. Place in order of seriousness to justify the discipline and services being rendered.

Other pertinent diagnoses are all conditions that coexisted at the time the plan of care was established or developed subsequently.

Enter the date of onset, if it is a new diagnosis, or the most recent exacerbation of a previous diagnosis. Enter the date in MMDDYY format.

**ITEM 14 – DME AND SUPPLIES**

List supplies and equipment needed for care.

**ITEM 15 – SAFETY MEASURES**

Enter the physician's instructions for safety measures or those identified by the home health agency.

**ITEM 16 – NUTRITIONAL REQUIREMENTS**

Enter the physician's orders for the diet including:

- Therapeutic diets;
- Specific dietary requirements; and
- Fluid restrictions or requirements.

Total parenteral nutrition (TPN) can be listed under this item or under medications.

**ITEM 17 – ALLERGIES**

Enter medicine allergies or other allergies or "NKA."

**ITEM 18A – FUNCTIONAL LIMITATIONS**

Check current limitations as assessed by the physician or home health agency. If "other" is checked, provide detail below other or in an addendum to the POC.

**ITEM 18B – ACTIVITIES PERMITTED**

Check all activities allowed by physician. If "Other" is checked, a narrative explanation is required.

**ITEM 19 – MENTAL STATUS**

Check the most appropriate blocks that describe the patient's mental status. If "Other" is checked, specify here.

AHCA Form 5000-3544, Revised October 2014 (incorporated by reference in Rule 59G-4.130, F.A.C.)



**Medicaid Instructions for CMS Form 485 – Plan of Care, continued**

**ITEM 20 – PROGNOSIS**

Check the box that specifies the most appropriate prognosis for the patient.

**ITEM 21 – ORDERS FOR DISCIPLINE AND TREATMENTS**

List the frequency and duration of visits for each discipline.

List all the services and treatments to be provided by each discipline.

Frequency denotes the number of visits per discipline to be rendered, stated in days, weeks, or months.

Duration identifies the length of time the services are to be rendered and may be expressed in days, weeks or months.

Note: If this field incorporates the physician treatment order (initial or continuation), it must include the requirements for physician treatment orders listed in Chapter 2 of the Home Health Services Coverage and Limitations Handbook.

**ITEM 22 – GOALS/REHABILITATION POTENTIAL/DISCHARGE PLANS**

Enter the physician’s description of achievable goals and the patient’s ability to meet these goals.

Address discharge plans, including plans for care after discharge.

Rehabilitation potential should include the expected health outcomes and the patient’s ability to achieve goals and estimate of time needed to achieve them. This information should be pertinent to nature of the patient’s condition and ability to respond and include more than words “Fair” or “Poor”.

**ITEM 23 – NURSE’S SIGNATURE AND DATE OF VERBAL START OF CARE**

This field identifies the person who spoke with the attending physician and received verbal authorization to either begin or continue services. Enter the date the verbal order was received. This date may precede the SOC date in Field 2 and may precede the “From” date in Field 3

**ITEM 24 – PHYSICIAN’S NAME AND ADDRESS**

Enter the name and address of the attending physician that established the plan of care.

**ITEM 25 – DATE HHA RECEIVED SIGNED POC**

Enter the date the agency received the signed, but *not dated*, POC. Enter “N/A” if Item 27 is completed.

It is recommended that agencies date stamp every plan of care upon return from the physician.

**ITEM 26 – PHYSICIAN CERTIFICATION STATEMENT**

No entry needed.

AHCA Form 5000-3544, Revised October 2014 (incorporated by reference in Rule 59G-4.130, F.A.C.)

**Medicaid Instructions for CMS Form 485 – Plan of Care, continued**

**ITEM 27 – ATTENDING PHYSICIAN’S SIGNATURE AND DATE SIGNED**

The form must be signed prior to submission of prior authorization request. If a rubber stamp signature is used, it must be initialed by the physician.

Faxed signatures are acceptable; however, the physician must retain the plan with his original signature in the recipient’s medical record. The home health agency is responsible for obtaining original signatures if an issue surfaces that would require verification of an original signature.

The plan of care may be signed by another physician who is authorized by the attending physician to care for his or her patients in his or her absence, i.e., partnership agreement.

Do not pre-date or write the date in this field. If the physician does not date his/her signature, leave it blank and document in Item 25.

**ITEM 28 – ANTI-FRAUD STATEMENT**

Department of Health and Human Services Centers for Medicare & Medicaid Services			Form Approved OMB No. 0938-0357		
<b>HOME HEALTH CERTIFICATION AND PLAN OF CARE</b>					
1. Patient's HI Claim No.	2. Start Of Care Date	3. Certification Period From: _____ To: _____	4. Medical Record No.	5. Provider No.	
6. Patient's Name and Address			7. Provider's Name, Address and Telephone Number		
8. Date of Birth			9. Sex <input type="checkbox"/> M <input type="checkbox"/> F		
11. ICD-9-CM	Principal Diagnosis	Date			
12. ICD-9-CM	Surgical Procedure	Date			
13. ICD-9-CM	Other Pertinent Diagnoses	Date			
14. DME and Supplies			15. Safety Measures:		
16. Nutritional Req.			17. Allergies:		
18.A. Functional Limitations			18.B. Activities Permitted		
1 <input type="checkbox"/> Amputation	5 <input type="checkbox"/> Paralysis	9 <input type="checkbox"/> Legally Blind	1 <input type="checkbox"/> Complete Bedrest	6 <input type="checkbox"/> Partial Weight Bearing	A <input type="checkbox"/> Wheelchair
2 <input type="checkbox"/> Bowel/Bladder (Incontinence)	6 <input type="checkbox"/> Endurance	A <input type="checkbox"/> Dyspnea With Minimal Exertion	2 <input type="checkbox"/> Bedrest BRP	7 <input type="checkbox"/> Independent At Home	B <input type="checkbox"/> Walker
3 <input type="checkbox"/> Contracture	7 <input type="checkbox"/> Ambulation	B <input type="checkbox"/> Other (Specify)	3 <input type="checkbox"/> Up As Tolerated	8 <input type="checkbox"/> Crutches	C <input type="checkbox"/> No Restrictions
4 <input type="checkbox"/> Hearing	8 <input type="checkbox"/> Speech		4 <input type="checkbox"/> Transfer Bed/Chair	9 <input type="checkbox"/> Cane	D <input type="checkbox"/> Other (Specify)
			5 <input type="checkbox"/> Exercises Prescribed		
19. Mental Status:			5 <input type="checkbox"/> Disoriented		7 <input type="checkbox"/> Agitated
	1 <input type="checkbox"/> Oriented	3 <input type="checkbox"/> Forgetful	6 <input type="checkbox"/> Lethargic	8 <input type="checkbox"/> Other	
	2 <input type="checkbox"/> Comatose	4 <input type="checkbox"/> Depressed			
20. Prognosis:			3 <input type="checkbox"/> Fair	4 <input type="checkbox"/> Good	5 <input type="checkbox"/> Excellent
21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)					
22. Goals/Rehabilitation Potential/Discharge Plans					
23. Nurse's Signature and Date of Verbal SOC Where Applicable:			25. Date HHA Received Signed POT		
24. Physician's Name and Address			26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.		
27. Attending Physician's Signature and Date Signed			28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.		
Form CMS-485 (C-3) (02-94) (Formerly HCFA-485) (Print Aligned)					

## APPENDIX C

### AUTHORIZATION FOR PRIVATE DUTY NURSING PROVIDED BY A PARENT OR LEGAL GUARDIAN

## AUTHORIZATION FOR PRIVATE DUTY NURSING PROVIDED BY A PARENT OR LEGAL GUARDIAN

Home Health Agency Name \_\_\_\_\_ Date of Request \_\_\_\_\_

Medicaid Provider Number \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_ County \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**This is to certify that**

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Child's Medicaid Number \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

has been evaluated and approved to receive private duty nursing services in the child's place of residence as outlined in the Florida Medicaid Home Health Services Coverage and Limitations Handbook. The private duty nursing services will be provided by a parent or legal guardian who meets the following criteria:

1. Has a valid license as a Registered Nurse (RN) or Licensed Practical Nurse (LPN) in the State of Florida; and
2. Employed by a Medicaid enrolled home health agency

Parent or Legal Guardian Name \_\_\_\_\_

Florida License Number (RN or LPN) \_\_\_\_\_ Expiration Date \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_

I certify that an initial assessment and all subsequent plan of care assessments for this child will be completed by a Registered Nurse that is not a household member while the parent or legal guardian is authorized to provide private duty nursing services. I understand that Medicaid will only reimburse a home health agency up to 40 hours per week of private duty nursing services provided by a parent or legal guardian. A non-relative RN or LPN employed by the home health agency must provide all other authorized private duty nursing hours above the 40 hour a week limit.

Home Health Agency Authorized Representative	Date
--	------

Parent or Legal Guardian	Date
--------------------------	------

Approval by Medicaid Representative	Date
-------------------------------------	------

Submit the form for approval to:  
 Bureau of Medicaid Services, MS #20  
 Quality Improvement and Rules Coordination Section  
 2727 Mahan Drive  
 Tallahassee, FL 32308

**This form must be filed in the child's medical record**

AHCA Form 5000-3541, February 2013 (incorporated by reference in Rule 59G-4.130, F.A.C.)

## APPENDIX D

### PHYSICIAN VISIT DOCUMENTATION FORM

## PHYSICIAN VISIT DOCUMENTATION FORM

This form must be completed by the Physician ordering home health services

Date: \_\_\_\_\_

Medicaid Recipient's Name: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Physician's Telephone Number: (    ) \_\_\_\_\_

Diagnosis(es): \_\_\_\_\_

Date of the recipient's last examination or consultation in your office: \_\_\_\_\_

Please describe the patient's ongoing need for home health services: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby certify that I have examined the above named recipient on \_\_\_\_\_ and have ordered home health services to treat the recipient's acute or chronic medical condition as described above.

Signature of Physician: \_\_\_\_\_

National Provider Identifier: \_\_\_\_\_

**Pursuant to 409.905 (4) (c), Florida Statutes: In order for Medicaid to reimburse for home health services, the physician ordering the services must have examined the recipient within the 30 days preceding the initial request for the services and biannually thereafter.**

**After completion of this form, please send directly to the recipient's home health agency**

AHCA Form 5000-3502, Revised February 2013 (incorporated by reference in Rule 59G-4.130, F.A.C.)

## APPENDIX E

### PARENT OR LEGAL GUARDIAN MEDICAL LIMITATIONS



## PARENT OR LEGAL GUARDIAN MEDICAL LIMITATIONS

**This form must be completed by the Parent or Legal Guardian's Physician.**

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Physician's Address: \_\_\_\_\_  
\_\_\_\_\_

Physician's Telephone Number: ( ) \_\_\_\_\_

Please describe any medical limitation or disability that the above named individual may have that would limit their ability to participate in the care of a patient with complex medical needs (e.g. lifting restrictions, developmental disorder, bed rest for pregnancy, etc.):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If limitation/disability is temporary, please document the expected timeframe for resolution.

\_\_\_\_\_

Signature of Physician: \_\_\_\_\_

National Provider Identifier: \_\_\_\_\_

Signature of Parent/Legal Guardian: \_\_\_\_\_

(By my signature, I am allowing release of this information to be used for the purpose of determining authorization for my child.)

**For use by the Provider**

Recipient's Name: \_\_\_\_\_ Recipient Medicaid ID: \_\_\_\_\_

AHCA Form 5000-3501, Revised February 2013 (incorporated by reference in Rule 59G-4.130, F.A.C.)

## APPENDIX F

### PARENT OR LEGAL GUARDIAN WORK SCHEDULE FORM

## PARENT OR LEGAL GUARDIAN WORK SCHEDULE

This form must be completed by a Supervisor at the place of employment.

Parent/Legal Guardian's Name: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

### Work Schedule:

(Include work hours for each day)

Monday: \_\_\_\_\_

Tuesday: \_\_\_\_\_

Wednesday: \_\_\_\_\_

Thursday: \_\_\_\_\_

Friday: \_\_\_\_\_

Saturday: \_\_\_\_\_

Sunday: \_\_\_\_\_

If employee works a variable work schedule, please indicate the average number of hours per week, this employee works: \_\_\_\_\_

Any person who makes, presents or submits a document that is false or fraudulent is subject to a reduction or termination of Medicaid services.

Supervisor Name: \_\_\_\_\_

Title: \_\_\_\_\_

Telephone Number: (     ) \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### For use by the Provider

Recipient's Name: \_\_\_\_\_ Recipient Medicaid ID: \_\_\_\_\_

AHCA Form 5000-3503, Revised February 2013 (incorporated by reference in Rule 59G-4.130, F.A.C.)

## APPENDIX G

### PARENT OR LEGAL GUARDIAN STATEMENT OF WORK SCHEDULE FORM

## PARENT OR LEGAL GUARDIAN STATEMENT OF WORK SCHEDULE

Recipient's Name: \_\_\_\_\_

Parent/Legal Guardian's Name: \_\_\_\_\_

### Statement of Work Schedule

Name of Employer: \_\_\_\_\_

Address: \_\_\_\_\_

### Work Schedule:

(Include work hours for each day)

Monday: \_\_\_\_\_

Tuesday: \_\_\_\_\_

Wednesday: \_\_\_\_\_

Thursday: \_\_\_\_\_

Friday: \_\_\_\_\_

Saturday: \_\_\_\_\_

Sunday: \_\_\_\_\_

My signature below certifies that I am self-employed and that the schedule above is true and accurate. I understand that any person who makes, presents, or submits documentation that is false or fraudulent is subject to a reduction or termination of Medicaid services.

Parent/Legal Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Telephone Number: ( ) \_\_\_\_\_

### For use by the Provider

Recipient's Name: \_\_\_\_\_ Recipient Medicaid ID: \_\_\_\_\_

## APPENDIX H

### PARENT OR LEGAL GUARDIAN SCHOOL SCHEDULE FORM

## PARENT OR LEGAL GUARDIAN SCHOOL SCHEDULE

This form must be completed by a School Advisor or representative.

Parent/Legal Guardian's Name: \_\_\_\_\_

Name of School: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Current School Term:  Fall  Spring  Summer Year: \_\_\_\_\_

Term Start Date: \_\_\_\_\_ Term End Date: \_\_\_\_\_

### School Schedule:

(Include school hours for each day)

Monday: \_\_\_\_\_

Tuesday: \_\_\_\_\_

Wednesday: \_\_\_\_\_

Thursday: \_\_\_\_\_

Friday: \_\_\_\_\_

Saturday: \_\_\_\_\_

Sunday: \_\_\_\_\_

Name of School Representative: \_\_\_\_\_

Title: \_\_\_\_\_

Telephone Number: (    ) \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### For use by the Provider

Recipient's Name: \_\_\_\_\_ Recipient Medicaid ID: \_\_\_\_\_

AHCA Form 5000-3505, Revised October 2014 (incorporated by reference in Rule 59G-4.130, F.A.C.)

## APPENDIX I

### PERSONAL CARE SERVICES PLAN OF CARE FORM AND INSTRUCTIONS



## INSTRUCTIONS FOR THE PERSONAL CARE SERVICES PLAN OF CARE

### ITEM 1 - ALLERGIES

Enter any known medicine or other allergies that the recipient has. If unknown, enter "NKA"

### ITEM 2 – CERTIFICATION PERIOD

This identifies the period covered by the plan of care. Enter the eight-digit month, day and year, (i.e., MMDDYYYY).

#### From Date

- The first day this POC covers includes this day.
- On the initial certification, the "FROM" date will be the same as start of care date.

#### To Date

- This is the end of the certification. The "TO" date is the last day of the plan of care.
- The "TO" date can include up to, but never exceed, 180 calendar days.
- On subsequent re-certifications the next sequential "FROM" date will be the day after the "TO" date on the previous plan of care.

### ITEM 3 – MEDICAID ID NUMBER

Enter the recipient's ten digit Medicaid identification number.

### ITEM 4 – MEDIPASS AUTHORIZATION NUMBER

If the recipient is enrolled in the MediPass program, enter the primary care physician's MediPass authorization number. This can be obtained by contacting the recipient's MediPass primary care physician.

### ITEM 5 – PATIENT'S NAME

Enter the recipient's last name and first name as shown on the recipient's Medicaid eligibility file.

### ITEM 6 – GENDER

Check the appropriate box.

### ITEM 7 – DATE OF BIRTH

Enter the recipient's date of birth in the eight-digit format, (i.e., MMDDYYYY).

### ITEM 8 – COUNTY OF RESIDENCE

Enter the county in which the recipient resides.

### ITEM 9 – PATIENT'S ADDRESS

Enter the recipient's address (street address, city, state, and zip code) where care is being provided.

AHCA Form 5000-3506, Revised October 2014 (incorporated by reference in Rule 59G-4.130, F.A.C.)

**Instructions for the Personal Care Services Plan of Care**  
For Use by Unlicensed Independent Personal Care Providers

**Personal Care Services Plan of Care Form and Instructions, continued**

**ITEM 10 – PHONE NUMBER**

Enter the recipient's home telephone number.

**ITEM 11 – MEDICAID AREA OFFICE**

Enter the recipient's local Medicaid area office.

**ITEM 12 – PROVIDER NAME**

Enter your name.

**ITEM 13 – PROVIDER MEDICAID ID NUMBER**

Enter your Medicaid provider ID number.

**ITEM 14 – PROVIDER ADDRESS**

Enter your address.

**ITEM 15 – TELEPHONE NUMBER**

Enter your telephone number.

**ITEM 16 – DIAGNOSIS(ES)**

Enter a valid ICD code which best describes the recipient's primary reason for needing personal care services on the first line. The code is the full ICD diagnosis code including all digits.

Enter all other pertinent diagnoses relevant to the care rendered. Other pertinent diagnoses are all conditions that coexisted at the time the plan of care was established or developed subsequently.

Enter the date of onset or exacerbation in eight-digit format (MMDDYY) for each diagnosis. The diagnosis date does not refer to dates of the certification period on the plan of care.

The diagnoses should come from the recipient's primary care physician and be documented on the written physician's order.

**ITEM 17 – MEDICATIONS**

Enter ALL of the recipient's medications including over-the-counter drugs.

Enter dosage (*mg, one, two, etc.*), frequency (*how often*) and route of administration (*oral, rectal, etc.*).

**ITEM 18 – DURABLE MEDICAL EQUIPMENT AND SUPPLIES**

List supplies and equipment needed for care. For example, gloves, wheel chair, commode, incontinence supplies (briefs), walker, cane, etc.

AHCA Form 5000-3506, Revised October 2014 (incorporated by reference in Rule 59G-4.130, F.A.C.)

**Instructions for the Personal Care Services Plan of Care**  
For Use by Unlicensed Independent Personal Care Providers

**Personal Care Services Plan of Care Form and Instructions, continued**

**ITEM 19 – NUTRITIONAL REQUIREMENTS**

Enter the physician's orders for the diet including any therapeutic diets or specific dietary requirements and restrictions (i.e., normal, soft, liquid).

**ITEM 20 – HOW DOES THE PATIENT EAT**

Check the appropriate box.

**ITEM 21 – FUNCTIONAL LIMITATIONS**

Check current limitations as assessed by the physician. If "Other" is checked, provide detail below other or in an addendum to the POC.

**ITEM 22 – SAFETY MEASURES**

Enter the physician's instructions for safety measures or those identified by your assessment of the recipient (i.e., keeping path ways clean and free of clutter, assisting with walking, etc.).

**ITEM 23 – PERMITTED PHYSICAL ACTIVITIES**

Check all activities allowed by the recipient's physician. If "Other" is checked, a detailed explanation is required.

**ITEM 24 – MENTAL STATUS**

Check the most appropriate box that describes the recipient's mental status. If "Other" is checked, specify.

**ITEM 25 – PARENT/GUARDIAN WORK AND SCHOOL SCHEDULE**

If applicable, enter the parent or legal guardian's work and school schedule (include the hours and days).

**ITEM 26 – PARENT/GUARDIAN PHYSICAL INFORMATION**

If applicable, enter any medical or physical limitations that the parent or legal guardian has that prevents participation in the child's care to the fullest extent possible.

**ITEM 27 – NUMBER OF OTHER CHILDREN IN THE HOME**

Enter the number of children who live in the same place of residence as the residence.

If recipient lives in a group home for children with special needs, enter "N/A".

**ITEM 28 – AGE OF OTHER CHILDREN IN THE HOME**

Enter the age of each of the children living in the home (from Item 27).

If recipient lives in a group home for children with special needs, enter "N/A".

AHCA Form 5000-3506, Revised October 2014 (incorporated by reference in Rule 59G-4.130, F.A.C.)

**Instructions for the Personal Care Services Plan of Care**  
For Use by Unlicensed Independent Personal Care Providers

**Personal Care Services Plan of Care Form and Instructions, continued**

**ITEM 29 – SPECIAL NEEDS OF OTHER CHILDREN IN THE HOME**

If applicable, enter the special needs of any other children who live in the same home with the recipient.

If recipient lives in a group home for children with special needs, enter that here.

**ITEM 30 – SPECIFIC HOURS PER DAY AND DAYS OF WEEK SERVICE WILL BE PROVIDED**

Enter the specific hours per day and days per week that you will be providing medically necessary personal care services, as prescribed by the recipient's physician.

**ITEM 31 – SERVICES PROVIDED**

Check all activities of living/self care tasks that you will be assisting the recipient to accomplish. If "Other" is checked, a detailed explanation is required.

**ITEM 32 – EXPECTED HEALTH OUTCOME/ REHABILITATION POTENTIAL**

Check the most appropriate box that describes the recipient's expected health outcome and the ability for the recipient to achieve goals (i.e., re-learn or acquire the ability to perform some or all of his self care tasks).

**ITEM 33 –DISCHARGE PLAN**

Address discharge plans (if applicable).

**PHYSICIAN CERTIFICATION**

Enter the name of the attending physician that prescribed the services. The plan of care must be signed and dated by the attending physician prior to submission of a prior authorization request.

Faxed signatures are acceptable; however, the physician must retain the plan with the original signature in the recipient's medical record. The provider is responsible for obtaining original signatures if an issue surfaces that would require verification of an original signature.

The plan of care may be signed by another physician who is authorized by the attending physician to care for his patients in his absence, (i.e., partnership agreement).

**SIGNATURES**

The plan of care must be signed and dated by the recipient's parent or legal guardian. A recipient 18 years of age or older who is capable of signing the plan of care may do so, instead of the parent or legal guardian.

Enter the parent or legal guardian's printed name (if applicable).

The plan of care must also be signed by the provider rendering care.

AHCA Form 5000-3506, Revised October 2014 (incorporated by reference in Rule 59G-4.130, F.A.C.)

**Personal Care Services Plan of Care**  
For Use by Unlicensed Independent Personal Care Providers

PATIENT INFORMATION		
1. <b>ALLERGIES:</b>	2. <b>Certification Request:</b> (check one) Initial <input type="checkbox"/> Re-certification <input type="checkbox"/>  Certification Period: __/__/____ __/__/____ From To <b>(Re-certification required every 180 days)</b>	
3. Medicaid ID Number (10 digits) _____	4. MediPass Authorization # (if applicable): _____ - ____	
5. Last Name: _____ First Name: _____	6. Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	
7. Date of Birth: __/__/____	8. County of Residence: _____	
9. Street Address: _____  City: _____ State: _____ Zip Code: _____	10. Phone # (____)____ - ____  11. Medicaid Area Office: _____	
PROVIDER INFORMATION		
12. Name: _____	13. Provider Medicaid ID Number: _____ - ____	
14. Street Address: _____  City: _____ State: _____ Zip Code: _____	15. Phone # (____)____ - ____	
PATIENT MEDICAL AND SOCIAL INFORMATION		
16. Diagnosis(es):		
ICD Code(s) (Provided by a Physician): ____ - ____	Written Description: _____	Date of Diagnosis: __/__/____
____ - ____	_____	__/__/____
____ - ____	_____	__/__/____
17. Medications (Dose/Route/Frequency): _____		
18. Durable Medical Equipment & Supplies Used by the Recipient: _____		
19. Nutritional Requirements: _____		
20. How Does the Patient Eat? (check one): Feeds Self <input type="checkbox"/> Needs Assistance <input type="checkbox"/> G-Tube <input type="checkbox"/>		
21. Functional Limitations (check all that apply):		
<input type="checkbox"/> Amputation (describe): _____ <input type="checkbox"/> Limited use of arms, hands, or feet <input type="checkbox"/> Hearing impaired <input type="checkbox"/> Requires assistance to ambulate <input type="checkbox"/> Shortness of breath/breathing difficulty (explain): _____	<input type="checkbox"/> Bowel/bladder incontinence (frequency): _____ <input type="checkbox"/> Paralysis <input type="checkbox"/> Tires easily when moving about <input type="checkbox"/> Speech difficulty <input type="checkbox"/> Legally blind <input type="checkbox"/> Other (explain): _____	
22. Safety Measures Required: _____		

AHCA Form 5000-3506, Revised October 2014 (incorporated by reference in Rule 59G-4.130, F.A.C.)

**Personal Care Services Plan of Care**  
For Use by Unlicensed Independent Personal Care Providers

23. Permitted Physical Activities (check all that apply):						
<input type="checkbox"/> Bed rest	<input type="checkbox"/> Exercises prescribed	<input type="checkbox"/> Assisted transfer from bed to chair				
<input type="checkbox"/> Up as tolerated	<input type="checkbox"/> Use of gait ball	<input type="checkbox"/> Other (specify): _____				
24. Mental/Neurological Status (check all that apply):						
<input type="checkbox"/> Alert/oriented	<input type="checkbox"/> Agitated	<input type="checkbox"/> Disoriented				
<input type="checkbox"/> Forgetful	<input type="checkbox"/> Depressed	<input type="checkbox"/> Lethargic				
<input type="checkbox"/> Combative	<input type="checkbox"/> Seizures (how often): _____	<input type="checkbox"/> Other (specify): _____				
25. Parent/Guardian Work/School Hours and Days (if applicable):						
26. Parent/Guardian physical limitations in caring for child (if applicable):						
27. Number of other children in the home:			28. Age of other children in the home:			
29. Special needs of other children in the home (if applicable):						
<b>SERVICE INFORMATION</b>						
30. Specific Hours/Days of Service (prescribed by the physician):						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
31. Services Provided (check all that apply):						
<input type="checkbox"/> Bathing and Grooming	<input type="checkbox"/> Toileting and Elimination			<input type="checkbox"/> Range of Motion and Positioning		
<input type="checkbox"/> Oral Hygiene	<input type="checkbox"/> Other _____					
<input type="checkbox"/> Oral Feedings and Fluid Intake						
32. Expected Health Outcome/Rehabilitation Potential (check one):			Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Poor <input type="checkbox"/>	Unchanged <input type="checkbox"/>
33. Discharge Plan:						
<b>PHYSICIAN CERTIFICATION</b>						
<b><i>I certify that personal care services are medically necessary for this individual, as furnished under this plan of care. This individual is under my care and I have examined him within the last 6 months.</i></b>						
Signature of Physician: _____					Date: __/__/__	
Physician Name: _____			Date Seen By Physician __/__/__			
<b>SIGNATURES</b>						
<b><i>I acknowledge that I have reviewed this plan of care and the information herein is accurate.</i></b>						
Signature of Recipient/Parent/Legal Guardian: _____					Date: __/__/__	
Legal Guardian Printed Name (if applicable): _____						
Signature of Personal Care Provider: _____					Date: __/__/__	

**ATTACH PRESCRIPTION**

AHCA Form 5000-3506, Revised October 2014 (incorporated by reference in Rule 59G-4.130, F.A.C.)

## APPENDIX J

### PHYSICIAN'S WRITTEN PRESCRIPTION FOR HOME HEALTH SERVICES

## PHYSICIAN'S WRITTEN PRESCRIPTION FOR HOME HEALTH SERVICES

GENERAL INFORMATION														
1. <b>TODAY'S DATE:</b> __/__/_____	2. <b>Certification Request:</b> (check one) Initial <input type="checkbox"/> Re-certification <input type="checkbox"/>													
3. Date of last physician's office visit: __/__/_____	<b>(Re-certification required at least every 60 days for home health visits and at least every 180 days for private duty nursing and personal care services.)</b>													
PATIENT INFORMATION														
4. Medicaid ID Number (10 digits) _____	5. MediPass Authorization # (if applicable): _____ - ____													
6. Last Name: _____ First Name: _____	7. Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>													
8. Date of Birth: __/__/_____	9. Phone #(____) _____ - _____													
10. Street Address: _____  City: _____ State: _____ Zip Code: _____														
PATIENT MEDICAL AND SOCIAL INFORMATION														
11. Diagnosis(es):														
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">ICD Code(s) <i>(Provided by a Physician):</i></th> <th style="width: 50%;">Written Description:</th> <th style="width: 25%;">Date of Diagnosis:</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">____.____</td> <td></td> <td style="text-align: center;">__/__/__</td> </tr> <tr> <td style="text-align: center;">____.____</td> <td></td> <td style="text-align: center;">__/__/__</td> </tr> <tr> <td style="text-align: center;">____.____</td> <td></td> <td style="text-align: center;">__/__/__</td> </tr> </tbody> </table>	ICD Code(s) <i>(Provided by a Physician):</i>	Written Description:	Date of Diagnosis:	____.____		__/__/__	____.____		__/__/__	____.____		__/__/__		
ICD Code(s) <i>(Provided by a Physician):</i>	Written Description:	Date of Diagnosis:												
____.____		__/__/__												
____.____		__/__/__												
____.____		__/__/__												
12. Home Health Services ordered:														
13. Frequency and duration:														
14. Reason services must be provided (must be medically necessary):														
15. Skill level required (i.e. RN, LPN, or Aide): _____														
ORDERING PHYSICIAN INFORMATION														
16. Name: _____	17. Phone # (____) _____ - _____													
18. Street Address: _____  City: _____ State: _____ Zip Code: _____	19. Provider Medicaid ID Number: _____ - ____ OR Provider NPI Number: _____ OR Provider Medical License Number: _____													
PHYSICIAN'S SIGNATURE: I certify that home health services are medically necessary for this individual, as furnished in this written prescription for services. This individual is under my care and I have examined him within 30 days prior to the initiation of services or within the last 6 months for continuation of services.														
<b>Signature:</b> _____		<b>Date:</b> __/__/_____												

AHCA Form 5000-3525, Revised February 2013 (incorporated by reference in Rule 59G-4.130, F.A.C.)



## APPENDIX K

### MEDICAID REVIEW CRITERIA FOR PRIVATE DUTY NURSING SERVICES

## REVIEW CRITERIA FOR PRIVATE DUTY NURSING SERVICES

### Introduction:

- Private duty nursing (PDN) services provide skilled nursing services to a recipient under the age of 21 in the recipient's home or other authorized setting to support the care required by the child's medical condition.
- These services require more continuous care than can be provided through a skilled nursing visit.
- Home health agencies requesting PDN services must provide supporting documentation in accordance with Florida Medicaid's Home Health Services Coverage and Limitations Handbook to support the request.
- First level reviewers evaluate all information to ensure that requested services are appropriate for skilled nursing.

### Clinical Indicators for Private Duty Nursing (PDN)

The requested services must be medically necessary and all documentation must substantiate the need for skilled nursing services. The following clinical indicators must be present in the request for services before PDN services can be authorized.

1. Clinical Presentation (One or more of the following must be satisfied)
  - ▶ Illness/Injury/Exacerbation/Surgery
  - ▶ Discharge from Inpatient facility
  - ▶ Newborn/infant and poor weight gain
2. Skilled intervention required (One or more of the following must be satisfied)
  - ▶ Modification of initial or on-going treatment/medication regimen
  - ▶ Lack of adherence
  - ▶ Management of plan of care
  - ▶ Exacerbation of known illness
3. Care required in the home setting or other authorized setting (One or more of the following indicators must be satisfied)
  - ▶ Activity restrictions requiring  $\geq$  minimum assistance in transfer/bed mobility/locomotion to leave home/residence
  - ▶ Isolation and/or immunocompromised host/communicable disease

### Criteria for First Level Reviewers:

All requested services must meet the definition of medical necessity or the criteria set out in the Florida Medicaid Home Health Services Coverage and Limitations Handbook and be age-appropriate. This is especially important in the pediatric population because of changes in growth and development. Home health agencies must provide documentation that accurately reflects a recipient's specific diagnoses, system and organ function, home environment and necessary skilled nursing interventions. This documentation should include assessments from both the home health agency and the treating/attending physician. First level reviewers focus on how the requested services meet the needs of the recipient while conforming to the policies outlined in the Florida Medicaid Home Health Services Coverage and Limitations Handbook. First level reviewers will consider information that includes, but is not limited to the following:

AHCA Form 5000-3543, Revised October 2014 (incorporated by reference in Rule 59G-4.130, F.A.C.)

1. Provider assessment<sup>1,2</sup> of:
  - Home environment
  - Care required in the home or other authorized setting
  
2. Provider documentation of organ system dysfunction including but not limited to
  - Genitourinary system<sup>3</sup>
    - Initiate/continue teaching of self-catheterization and voiding schedule
    - Catheter change/irrigation/reinsertion
    - Postvoid residual
    - Suprapubic tube
  - Cardiovascular system
    - Significant arrhythmias
    - Blood pressure monitoring
    - Signs of congestive heart failure
  
3. Endocrine system
  - Fluid monitoring for diabetes insipidus<sup>4</sup>
  - Care for diabetes mellitus including
    - Insulin injections/pump
    - Blood sugar testing/monitoring
    - Diet/Meal planning
    - Eye/foot/skin care
  
4. Gastrointestinal system and nutrition<sup>5</sup>
  - Initiate/continue teaching of prescribed bowel regimen
  - Manual disimpaction
  - Aspiration precautions
  - Feeding tube care (includes pump management)
  - TPN
  - Formula medication administration
  - Site care/dressing
  
5. Hematologic system
  - Administration of injectable anticoagulants
  
6. Neurologic system<sup>6</sup>
  - Seizure precautions/interventions
  - Vagal nerve stimulator
  
7. Musculoskeletal system<sup>7</sup>
  - Cast care
  - Wound care
  - Decubiti/pressure ulcers
  
8. Respiratory system<sup>8,9</sup>
  - Tracheostomy care
  - Technology dependent child

AHCA Form 5000-3543, Revised October 2014 (incorporated by reference in Rule 59G-4.130, F.A.C.)

First level reviewers will approve the frequency and duration of services that are medically necessary. If additional hours are requested, the case will be referred to a physician reviewer for final determination.

### Citations

1. Cohen E, Kuo DZ, Agrawal R, Berry JG, Bhagat SKM, Simon, TD et al. Children With Medical Complexity: An Emerging Population for Clinical and Research Initiatives. *Pediatrics*. 2011;127:529-538.
2. Policy Statement: Care Coordination in the Medical Home: Integrating Health and Related Systems of Care for Children With Special Health Care Needs. Council on Children With Disabilities. *Pediatrics*. 2005;116:1238-1244.
3. Management of Neurogenic Bladder in Children. In: Tekgul S, Riedmiller H, Gerharz E, Hoebeke P, Kocvara R, Nijman R et al. Guidelines on paediatric urology. Arnheim, The Netherlands: European Association of Urology, European Society of Paediatric Urology; 2009 Mar p31-41. [83 references].
4. Ranadive SA, Rosenthal SM. Pediatric Disorders of Water Balance. *Endocrinol Metab Clin North Am*. 2009; 38: 663-72.
5. National Collaborating Centre for Women's and Children's Health. Constipation in children and young people. Diagnosis and management of idiopathic childhood constipation in primary and secondary care. London (UK); National Institute for Health and Clinical Excellence (NICE). 2010; May. 41 p. (Clinical guideline; no 99).
6. American Association of Neuroscience Nurses. Care of the patient with seizures. 2<sup>nd</sup> ed. Glenview (IL): American Association of Neuroscience Nurses. 2007; 23 p [152 references].
7. Wound, Ostomy, and Continence Nurses Society. Guideline for prevention and management of pressure ulcers. Mount Laurel (NJ); Wound, Ostomy, and Continence Nurses Society (WOCN); 2010 Jun 1. 96p (WOCN clinical practice guideline; no.2). [341 references].
8. Noyes, J. Comparison of ventilator-dependent child reports of health-related quality of life with parent reports and normative populations. *J Adv Nurs*. 2007;58:1-10.
9. Sherman JM, Davis S, Albamonte-Petrick S, Chatburn RL, Fitton C, Green CG et al. Care of the Child with a Chronic Tracheostomy. The Official Statement of the American Thoracic Society. *Am J Respir Crit Care Med*. 2000; 161: 297-398.

AHCA Form 5000-3543, Revised October 2014 (incorporated by reference in Rule 59G-4.130, F.A.C.)

## APPENDIX L

### MEDICAID REVIEW CRITERIA FOR PERSONAL CARE SERVICES

## REVIEW CRITERIA FOR PERSONAL CARE SERVICES

### Introduction:

Personal care services provide medically necessary assistance with activities of daily living (ADL) and age appropriate instrumental activities of daily living (IADL) that enable the recipient to accomplish tasks that they would normally be able to do for themselves if they did not have a medical condition or disability.

Medicaid reimburses personal care services for recipients under the age of 21 who have a medical condition or disability that substantially limits their ability to perform their ADLs or IADLs and for whom the parents or legal guardians are unable or unavailable to provide this care.

### Clinical Indicators for Personal Care Services (PC)

The following indicate the level of functional impairment of a recipient. All functional impairments must be age-appropriate and consistent with the level of functional impairment.

One of the following levels of functional impairment must be satisfied.

1. Minimal functional impairment  
(One of the following indicators must be satisfied)
  - ▶ ADL's requiring at least minimum assistance
  - ▶ Ambulates with assist of person/device
  - ▶ Transfers requiring at least minimum assistance
2. Moderate functional impairment  
(Two of the following indicators must be satisfied)
  - ▶ ADL's requiring at least minimum assistance
  - ▶ Ambulates with assist of person/device
  - ▶ Transfers requiring at least minimum assistance
3. Maximum functional impairment  
(All of the following indicators must be satisfied)
  - ▶ ADL's requiring total assistance
  - ▶ Non-ambulatory
  - ▶ Transfers requiring 1-2 person assist
4. Maximum and persistent functional impairment without available parent or legal guardian support  
(All of the following indicators must be satisfied)
  - ▶ ADL's requiring total assistance
  - ▶ Non-ambulatory
  - ▶ Transfers requiring 1-2 person assist
  - ▶ Attending/treating physician must certify that all of the above impairments are present

### Criteria for First Level Reviewers:

First level reviewers may approve requests for personal care services when the supporting documentation satisfies the following criteria:

AHCA Form 5000-3542, Revised October 2014 (incorporated by reference in Rule 59G-4.130, F.A.C.)

1. Personal care services
  - Medicaid reimburses for the following personal care services when they are medically necessary.
  - ADLS include:
    - Eating (oral feedings and fluid intake);
    - Bathing;
    - Dressing;
    - Toileting;
    - Transferring; and
    - Maintaining continence (examples include taking care of a catheter or colostomy bag or changing a disposable incontinence product when the recipient is unable to control his bowel or bladder functions).
  - IADLs (when necessary for the recipient to function independently) include:
    - Personal hygiene;
    - Light housework;
    - Laundry;
    - Meal preparation;
    - Transportation;
    - Grocery shopping;
    - Using the telephone to take care of essential tasks (examples include paying bills and setting up medical appointments);
    - Medication management; and
    - Money management.
  - The recipient must:
    - Require services due to a medical condition or disability which substantially limits the ability to perform the activities of daily living. This occurs when:
      - The recipient cannot independently perform the personal care tasks because of a physical and/or cognitive impairment\*;
      - The recipient would normally perform the (age-appropriate) personal care tasks without the medical condition or disability; and
      - A parent or legal guardian is not able to provide ADL or IADL care.
    - Require services that are medically necessary and reasonable for the treatment of the documented illness, injury or condition.
    - Recipient's parent or legal guardian must participate in providing care to the fullest extent possible.

**\*Note:** Medically necessary personal care services may be authorized when a recipient has a documented cognitive impairment that prevents knowing when or how to carry out the personal care task and when the recipient's parents or legal guardian is unable to provide services. Assistance may be in the form of hands on assistance (actually performing the task for the person) or cuing, along with supervision to ensure the recipient performs the personal care task properly. Additional supporting documentation may be required to substantiate the functional limitations associated with the cognitive impairment. In addition, one of the following indicators must be satisfied:

- Incapable of learning despite efforts to train in care task
- Memory deficit(s) prevents managing care task

2. Authorization of Hours

When requests for PCS meet the above criteria, first level reviewers may approve using the following guidelines. *If additional hours are requested, the case will be referred to a physician reviewer for final determination.*

Personal Care Task	General Time Allowances
<b>Bathing</b>	
<b>Full-body Bath:</b> Tub, shower or sponge/bed bath.	Up to 30 minutes. May rotate with partial bath based on recipient's needs.
<b>Partial Bath:</b> A sponge bath includes, at minimum, bathing of the face, hands, and perineum.	15–20 minutes per partial bath.
<b>Dressing</b>	
Laying out clothing, handing and retrieving clothing, putting clothes on and taking them off, including handling fasteners, zippers, and buttons.	15 minutes
Application of prosthetic devices or application of therapeutic stockings.	May add 15 minutes for applying hose and/or prosthesis
<b>Grooming/Skin Care</b>	
Brushing teeth, denture care, shaving, washing and drying face and hands. Applying lotion to non-broken skin.	15–30 minutes
Shampoo and comb hair, basic hair care, basic nail care.	15 minutes
<b>Positioning</b>	
Moving recipient to and from a lying position, turning side to side, and positioning recipient in bed.	10 minutes/every 2 hours when medically indicated
<b>Transfers</b>	
Moving recipient into and out of a bed, chair, or wheelchair. May include the use of assistive devices.	15 minutes/every 2 hours when medically indicated
<b>Toileting &amp; Maintaining Continence</b>	
Includes transfer on or off the toilet, bedside commode, urinal, or bedpan. Includes cleaning the perineum and cleaning after an incontinent episode. Includes taking care of a catheter or colostomy bag or changing a disposable incontinence product.	15–45 minutes
<b>Eating</b>	
Taking in food by any method. Extra time may be allowed for preparing a special diet.	30 minutes per meal
<b>Delegated Medical Monitoring and Activities</b>	
Non-skilled medical tasks that are delegated to the aide by the RN, in accordance with Florida laws and practice acts. The tasks include, but are not limited to, assisting recipient with pre-poured medications, monitoring vital signs, and measurement of intake/output.	15–30 minutes day for all monitoring tasks performed.

AHCA Form 5000-3542, Revised October 2014 (incorporated by reference in Rule 59G-4.130, F.A.C.)