

HOME HEALTH AGENCY SERVICES

ELIGIBLE PROVIDERS

In order to receive payment, all eligible servicing and billing provider’s National Provider Identifiers (NPI) must be enrolled with South Dakota Medicaid. Servicing providers acting as a locum tenen provider must enroll in South Dakota Medicaid and be listed on the claim form. Please refer to the [provider enrollment chart](#) for additional details on enrollment eligibility and supporting documentation requirement.

South Dakota Medicaid has a streamlined enrollment process for ordering, referring, and attending physicians that may require no action on the part of the provider as submission of claims constitutes agreement to the South Dakota Medicaid Provider Agreement.

Eligible providers must be recognized as a Medicare certified home health agency for each location enrolled.

ELIGIBLE RECIPIENTS

Providers are responsible for checking a recipient’s Medicaid ID card and verifying eligibility before providing services. Eligibility can be verified using South Dakota Medicaid’s [online portal](#).

The following recipients are eligible for medically necessary services covered in accordance with the limitations described in this chapter:

Coverage Type	Coverage Limitations
Medicaid/CHIP Full Coverage	Medically necessary services covered in accordance with the limitations described in this chapter.
Medicaid – Pregnancy Related Postpartum Care Only (47)	Coverage restricted to family planning and postpartum care only.
Qualified Medicare Beneficiary – Coverage Limited (73)	Coverage restricted to co-payments and deductibles on Medicare A and B covered services.
Medicaid – Pregnancy Related Coverage Only (77)	Coverage restricted to pregnancy related services only including medical issues that can harm the life of the mother or baby.
Unborn Children Prenatal Care Program (79)	Coverage restricted to pregnancy related services only including medical issues that can harm the life of the mother or baby.
Medicaid Renal Coverage up to \$5,000 (80)	Coverage restricted to outpatient dialysis, home dialysis, including supplies, equipment, and special water softeners, hospitalization related to renal failure, prescription drugs necessary for

dialysis or transplants not covered by other sources and non-emergency medical travel reimbursement to renal failure related appointments.

Refer to the [Recipient Eligibility](#) manual for additional information regarding eligibility including information regarding limited coverage aid categories.

COVERED SERVICES AND LIMITS

General Coverage Principles

Providers should refer to the [General Coverage Principles](#) manual for basic coverage requirements all services must meet. These coverage requirements include:

- The provider must be properly enrolled;
- Services must be medically necessary;
- The recipient must be eligible; and
- If applicable, the service must be prior authorized.

The manual also includes non-discrimination requirements providers must abide by.

Home Health Covered Services

Home health services must meet the following conditions:

- Provided by a home health agency employee who is qualified to perform the required service;
- Prescribed by the attending physician or other licensed practitioner and contained in the home health agency's written plan of care;
- Provided in the community or at the individual's place of residence, which does not include a hospital, penal institution, detention center, school, nursing facility, intermediate care facility for individuals with intellectual disabilities, or an institution which treats individuals for mental diseases; and
- Provided intermittently but not more than once a day and no more frequently than five days a week. Multiple visits of the same discipline on the same day are covered if the medical necessity for the multiple visits is documented by the attending physician or other licensed practitioner in the individual's medical record.

If Medicare denies payment for a service because the service is not medically necessary, the individual is ineligible for services under this chapter.

Initial Order for Services

Before a home health agency may begin providing services to an individual, it must have a physician or other licensed practitioner's order prescribing the needed services. For recipients in the Primary Care Provider (PCP) Program and Health Home (HH) Program, the services must be ordered or referred by their PCP/HH. The initial order for home health services must comply with [42 CFR 440.70](#). For the initial order for home health services, a physician or other licensed practitioner must document a face-

to-face encounter related to the primary reason the beneficiary requires the services. The encounter may occur through telehealth. The encounter must occur within the 90 days before or 30 days after the start of the services.

Plan of Care

The home health agency must prepare a plan of care for each Medicaid recipient served. The plan must be based on the care services prescribed by the attending physician or other licensed practitioner and the information obtained by the home health agency from the individual. The attending physician or other licensed practitioner must review and sign the plan.

The attending physician or other licensed practitioner must periodically review the individual's plan of care and recertify the need for services. For medical social work, the recertification must be completed at least every 30 days following service initiation. For nursing, home health aide, and therapy services, the recertification must be completed at least every 60 days following service initiation. The home health agency must obtain the recertification.

Supervisory Visits

A supervisory visit by a registered nurse must be conducted at least once every two weeks to determine if the recipient's health care needs and goals contained in the plan of care are met. The presence of the home health aide is required during the supervisory visits. Supervisory and recertification visits are considered to be an overhead cost and may not be billed as a home health service.

Limits for Age 21 or Older

For recipients age 21 or older services are limited to the following:

- Skilled nursing services;
- Medical social services provided by a licensed social worker who is not an employee of the department;
- Medical supplies used incidental to the visit when necessary to administer the attending physician or other licensed practitioner's prescribed plan of care;
- Multiple visits of the same discipline on the same day if the medical necessity for the multiple visits is documented by the attending physician or other licensed practitioner in the individual's medical record;
- Daily visits if the medical necessity for the visits is documented by the attending physician or other licensed practitioner in the individual's medical record. The daily visits are limited to four weeks but may be extended beyond the four-week period if the attending physician or other licensed practitioner documents the need for the visits in the individual's medical record;
- Therapy services including respiratory therapy services that meet the requirements below; and
- Postpartum services that meet the requirements below.

Postpartum Service Limitations

Postpartum services are limited to one visit each day and may not be provided for more than four consecutive weeks following the child's birth. Any additional visits require a prior authorization. One of

the following risk factors must be present and must be documented in the physician or other licensed practitioner's written orders and the home health agency's plan of care:

- The mother has a documented prenatal or postpartum medical condition which threatens the mother's health or the health of the baby;
- The infant has a documented medical condition which requires skilled nursing intervention;
- There is documentation to support a finding that the family is at risk for child abuse or neglect;
- The family has previously experienced neonatal death, stillbirth, or sudden infant death syndrome;
- There is a documented history of alcohol or drug abuse in the family; or
- There is a documented history of noncompliance with medical treatment regimens, including prenatal care.

Respiratory Therapy

An individual receiving home respiratory therapy must meet the following requirements:

- Be medically dependent on a ventilator for life support at least six hours a day and have been dependent for at least 30 consecutive days;
- Except for the availability of these respiratory care services at home, would require respiratory care as an inpatient in a hospital, a skilled nursing facility, or an intermediate care facility and would be eligible for long-term nursing care under this article;
- Have adequate support services to be cared for at home; and
- Wish to be cared for at home.

Flu Vaccines

Home health agencies may provide flu vaccines to home health recipients. Home health agencies may also provide flu vaccines to other Medicaid recipients through a flu shot clinic. Please refer to the [Physician Services](#) fee schedule for covered vaccines and administration codes.

Out-of-State Services

Service provided outside of South Dakota are generally not covered due to the residence requirement. Services will be covered if all the following conditions are met:

- Services provided are covered per this manual;
- The home health agency has signed a provider agreement with the department;
- All [out-of-state prior authorization](#) requirements are met; and
- The home health agency is a participating provider in the Medicaid program in the state in which the services are provided.

Cost Not to Exceed Institutional Care

If the actual or projected cost of all home health services over a period of three months exceeds 135 percent of the cost of care if the individual was institutionalized in a long-term care facility, the department shall issue a notice of intent to discontinue or deny further service. The department shall send the notice to the home health agency and to the individual. If within 30 days after the notice the home health agency provides documentation that the future home health service costs will decline and be within 135 percent of the cost of long-term care, the department shall reconsider its decision.

Private Duty Nursing

For information regarding coverage of private duty nursing for children under 21 please refer to the [Private Duty Nursing](#) manual.

NON-COVERED SERVICES

General Non-Covered Services

Providers should refer to [ARSD 67:16:01:08](#) or the [General Coverage Principles](#) manual for a general list of services that are not covered by South Dakota Medicaid.

Home Health Non-Covered Services

The following services are not covered services:

- Physician or other licensed practitioner's medical or surgical services;
- Drugs and biologicals;
- Personal comfort items;
- General housekeeping services;
- Meals or other nutritional items delivered to the individual's home;
- Posthospital benefits which include services by a home health agency operating primarily for the treatment of mental illness;
- Visits by a dietician;
- Visits solely for the purpose of teaching the individual or the individual's caregiver;
- Services that are not medically necessary;
- Custodial care; and
- Mileage.

DOCUMENTATION REQUIREMENTS

General Requirements

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least 6 years after the last date a claim was paid or denied. Please refer to the [Documentation and Record Keeping](#) manual for additional requirements.

Home Health Documentation

A home health agency must maintain a medical record for each individual receiving services. The medical record must contain documentation verifying the claimed service was performed and was authorized by the attending physician or other licensed practitioner.

REIMBURSEMENT AND CLAIM INSTRUCTIONS

Timely Filing

South Dakota Medicaid must receive a provider's completed claim form within 6 months following the

month the service was provided. Requests for reconsiderations will only be considered if they are received within the timely filing period or within 3 months of the date a claim was denied. The time limit may be waived or extended by South Dakota Medicaid in certain circumstances. Providers should refer to the [General Claim Guidance](#) manual for additional information.

Third-Party Liability

Medicaid recipients may have one or more additional source of coverage for health services. South Dakota Medicaid is generally the payer of last resort, meaning Medicaid only pays for a service if there are no other liable third-party payers. Providers must pursue the availability of third-party payment sources and should use the Medicare Crossover or Third-Party Liability billing instructions when applicable. Providers should refer to the [General Claim Guidance](#) manual for additional information.

Reimbursement

A claim submitted for services provided under the home health agency must be submitted at the provider's usual and customary charge and must contain the procedure codes listed on the Department's website. Payment for professional services is limited to the home health agency's usual and customary charge or the fee established in the fee schedule maintained on the Department's [website](#). Supervisory visits are considered to be an overhead cost and may not be billed as a home health service.

Claim Instructions

Health Home services must be billed on a CMS 1500 claim form or 837P. Refer to our [website](#) for claim instructions. Except for an electronic claim, if the individual is covered by Medicare or private health insurance, a copy of the denial or evidence of payment from Medicare or the insurance carrier must accompany the claim. For an electronic claim, the provider shall maintain and submit to the department on request evidence of claim payments or rejection.

If a registered nurse or a licensed practical nurse performs a home health aide service, the service must be billed as a home health aide service. If two or more persons of the same discipline simultaneously provide a single service, it is counted as one service and must be billed as a single service.

Units

For time-based codes one unit equals 15-minutes.

22 Modifier

Skilled nursing or aide visits requiring additional staff to provide the care which is an integral part of one visit must be billed with a modifier "22". The medical record must contain documentation verifying that the claimed service was authorized by the attending physician or other licensed practitioner and was actually provided. A procedure code billed with a modifier of "22" is reimbursed at 125 percent of the established rate.

DME

Medical equipment claims must be submitted by an enrolled durable medical equipment provider.

DEFINITIONS

1. "Attending physician," the individual's personal private physician or a physician assigned to care for the individual in the absence of a personal private physician;
2. "Custodial care," services that do not require nursing supervision and are designed to assist an individual perform the activities of daily living;
3. "Home health agency," an organization which is primarily engaged in providing skilled nursing, medical social services, or home health aide services and which meets the requirements of a home health agency under [42 CFR §§ 484.1 to 484.55](#), inclusive (October 1, 2005). This does not include an agency or organization whose function is primarily the care and treatment of mental illness;
4. "Home health aide services," those nursing-related services not required to be performed by a licensed health professional but prescribed by a licensed physician or other licensed practitioner and provided on an intermittent basis;
5. "Home health services" or "services," skilled nursing services, medical social services, or home health aide services provided by a home health agency;
6. "Medical social services," those services which contribute to the treatment of a patient's physical condition and are needed because social problems exist which impede the effective treatment of the patient's medical condition or the patient's rate of recovery;
7. "Other licensed practitioner" a physician assistant, nurse practitioner, clinical nurse specialist, nurse midwife, or nurse anesthetist who is licensed by the state to provide services and is performing within their scope of practice under the provisions of [SDCL title 36](#).
8. "Plan of care," the plan developed by the home health agency in response to the attending physician or other licensed practitioner's written orders to the agency prescribing the needed services and the duration of those services;
9. "Postpartum services," skilled nursing services following a child's birth;
10. "Skilled nursing services," those nursing services defined in [SDCL 36-9-3](#) which are provided on a part-time or intermittent basis;
11. "Therapy services," physical, respiratory, occupational, and speech therapy services provided by the home health agency either directly by or under contract with a qualified therapist acting within the therapist's scope of practice; and
12. "Visit," one encounter with a recipient for the purpose of delivering home health services.

REFERENCES

- [Administrative Rule of South Dakota \(ARSD\)](#)
- [South Dakota Medicaid State Plan](#)
- [Code of Federal Regulations](#)

QUICK ANSWERS

1. Do I have to enroll therapists who provide services for the home health agency?

Yes, therapists must be enrolled and their NPI must be listed as the servicing provider on claims for services they provide.