

CHAPTER 67:16:05
HOME HEALTH SERVICES

Section

- [67:16:05:01](#) Definition of terms.
- [67:16:05:02](#) Repealed.
- [67:16:05:03](#) Individuals eligible for home health services.
- [67:16:05:04](#) Repealed.
- [67:16:05:05](#) Covered services -- Limits.
- [67:16:05:05.01](#) Service restrictions.
- [67:16:05:05.02](#) Physician's orders required before services begin -- Plan of care - Certification and recertification.
- [67:16:05:05.03](#) Supervisory visit required when home health aide services provided.
- [67:16:05:05.04](#) Repealed.
- [67:16:05:05.05](#) Respiratory therapy -- Limitations.
- [67:16:05:05.06](#) Postpartum services -- Limitations.
- [67:16:05:06](#) Services not covered.
- [67:16:05:06.01](#) Medical records.
- [67:16:05:07](#) Covered services -- Rate of payment.
- [67:16:05:07.01](#) Billing requirements.
- [67:16:05:07.02](#) Cost not to exceed institutional care.
- [67:16:05:07.03](#) Services provided outside South Dakota.
- [67:16:05:08](#) Utilization review.
- [67:16:05:09](#) Claim requirements.
- [67:16:05:10](#) Application of other chapters.
- [67:16:11:03.19](#) EPSDT Home health services.

67:16:05:01. Definition of terms. Terms used in this chapter mean:

- (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) "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 C.F.R. § 405.1201 (October 1, 1988). This does not include an agency or organization whose function is primarily the care and treatment of mental illness;
- (3) "Home health aide services," those nursing-related services not required to be performed by a licensed health professional but prescribed by a licensed physician and provided on an intermittent basis;
- (4) "Home health services" or "services," skilled nursing services, medical social services, or home health aide services provided by a home health agency;
- (5) "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;
- (6) "Plan of care," the plan developed by the home health agency in response to the attending physician's written orders to the agency prescribing the needed services and the duration of those services;
- (7) "Postpartum services," skilled nursing services following a child's birth;
- (8) "Skilled nursing services," those nursing services defined in SDCL 36-9-3 which are provided on a part-time or intermittent basis;
- (9) "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
- (10) "Visit," up to three consecutive hours of time spent providing services.

67:16:05:03. Individuals eligible for home health services. Home health services are available to an individual in the individual's place of residence. The individual must be eligible for medical assistance and the required services must meet the conditions of this chapter.

67:16:05:05. Covered services -- Limits. Home health services are limited to the following:

- (1) Skilled nursing services, which may include visits by a student nurse enrolled in a school of nursing;
- (2) Home health aide services limited to 60 visits per recipient per calendar quarter. Skilled nursing visits are not a prerequisite for the provision of home health aide services;
- (3) Medical social services provided by a licensed social worker who is not an employee of the department;
- (4) Medical supplies used incidental to the visit when necessary to administer the attending physician's prescribed plan of care;
- (5) Multiple visits of the same discipline on the same day if the medical necessity for the multiple visits is documented by the attending physician in the individual's medical record;
- (6) Daily visits if the medical necessity for the visits is documented by the attending physician 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 documents the need for the visits in the individual's medical record. A visit includes the home health agency's travel costs and time;
- (7) Therapy services unless restricted by § 67:16:05:05.05; and
- (8) Postpartum services meeting the requirements of § 67:16:05:05.06.

67:16:05:05.01. Service restrictions. Home health services must meet the following criteria:

- (1) They must be provided by a home health agency employee who is qualified to perform the required service;
- (2) They must be prescribed by the attending physician and contained in the home health agency's written plan of care;
- (3) They must be provided at the individual's place of residence, which does not include a hospital, penal institution, detention center, school, nursing facility, intermediate care facility for the mentally retarded, or an institution which treats individuals for mental diseases;
- (4) They must be provided to an individual who is confined to home, has a medical condition caused by an illness or injury, and for whom leaving the home would require a considerable effort and the assistance of another individual or the aid of supportive devices. This provision may be waived for postpartum services or when leaving the home is medically contraindicated by a physician. An individual's age alone does not qualify the person for home health services; and
- (5) They must be provided intermittently but not more than once a day and no more frequently than four days a week, except as specified by 67:16:05:05(6) & (7).

If Medicare denies payment for a service because there is no medical necessity or because the individual is not homebound, the individual is ineligible for services under this chapter.

67:16:05:05.02. Physician's orders required before services begin. Plan of care - Certification and recertification. Before a home health agency may begin providing services to an individual, it must have the physician's orders prescribing the needed services.

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

The attending physician 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.

67:16:05:05.03. Supervisory visit required when home health aide services provided. When home health aide services are being provided, the home health agency must conduct a supervisory visit at least once every two weeks to determine if the recipient's health care needs and goals as contained in the plan of care are being met. A registered nurse must conduct the visit unless only therapy services and home health aide services are being provided. In this instance, the therapist may conduct the supervisory visit in lieu of the registered nurse. The presence of the home health aide is not required.

Supervisory visits are considered to be an overhead cost and may not be billed as a home health service.

67:16:05:05.05. Respiratory therapy -- Limitations. An individual receiving home respiratory therapy must meet the following requirements:

- (1) 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;
- (2) 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;
- (3) Have adequate support services to be cared for at home; and
- (4) Wish to be cared for at home.

67:16:05:05.06. Postpartum services -- Limitations. Postpartum services are limited to one visit each day, may not be provided for more than six consecutive weeks following the child's birth, and are subject to the provisions of this chapter with the exception of subdivision [67:16:05:05.01](#)(4). One of the following risk factors must be present and must be documented in the physician's written orders:

- (1) The mother has had an identifiable prenatal or postpartum medical condition which threatened or constitutes a threat to the health of herself or the infant;
- (2) The infant has an identifiable medical condition which requires skilled nursing intervention;
- (3) The family has been identified to be at risk for child abuse or neglect;
- (4) The family has previously experienced neonatal death, stillbirth, or sudden infant death syndrome;
- (5) There is a history of alcohol or drug abuse in the family; or
- (6) There is a history of noncompliance with medical treatments, including prenatal care regimens and medical appointments.

67:16:05:06. Services not covered. In addition to the other services not specifically listed in § 67:16:05:05, the following services are not covered under this chapter:

- (1) Physician's medical or surgical services;
- (2) Drugs and biologicals;
- (3) Personal comfort items;
- (4) General housekeeping services;
- (5) Meals or other nutritional items delivered to the individual's home;
- (6) Posthospital benefits which include services by a home health agency operating primarily for the treatment of mental illness; and
- (7) Visits by a dietician.

67:16:05:06.01. Medical records. A home health agency must maintain a medical record for each individual receiving services. The medical record must contain documentation verifying that the claimed service was performed and was authorized by the attending physician. The individual's medical record must be made available on request to the department, the Medicaid fraud control unit of the Attorney General's Office, or representatives of the United States Department of Health and Human Services. Medical records must be retained for six years.

67:16:05:07. Covered services -- Rate of payment. Covered home health services are limited to the procedures listed in this section. Payment is limited to the home health agency's usual and customary charge or the following table, whichever is lower:

CODE	PROCEDURE	FEE
A9195	Medical supplies	90 percent of usual and customary charge
W0200	Postpartum visits	67.60 a visit
W0310	Skilled nursing visits	67.60 a visit
W0320	Home health aide visits	43.70 a visit
W0330	Physical therapy	64.50 a visit
W0340	Speech therapy	72.80 a visit
W0350	Occupational therapy	67.60 a visit
W0360	Respiratory therapy	62.40 a visit
W0370	Medical social services	95.70 a visit

67:16:05:07.01. Billing requirements. A claim submitted for services provided under this chapter must be submitted at the provider's usual and customary charge and must contain the procedure codes listed in § 67:16:05:07.

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.

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.

67:16:05:07.02. Cost not to exceed institutional care. When 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 notice shall be sent to the home health agency and to the individual. If within 60 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.

67:16:05:07.03. Services provided outside South Dakota. Services provided outside South Dakota shall be covered if all of the following criteria are met:

- (1) The services provided are covered under this chapter;
- (2) The home health agency has signed a provider agreement with the department; and
- (3) The home health agency is a participating provider in the Medicaid program in the state in which the services are provided.

67:16:05:08. Utilization review. Home health services may be reviewed on the following levels:

- (1) Computerized claims processing;
- (2) Cost comparison to institutional care; and
- (3) Postpayment review.

67:16:05:09. Claim requirements. A claim for services provided under this chapter must be submitted on a form which contains the following information:

- (1) The recipient's full name;
- (2) The recipient's medical assistance identification number;
- (3) Third-party liability information required under chapter 67:16:26;
- (4) Date of service;
- (5) Place of service;
- (6) The provider's usual and customary charge. The provider may not subtract other third-party or cost-sharing payments from this charge;
- (7) The procedure codes for services covered under § 67:16:05:07;
- (8) The applicable diagnostic codes as contained in the ICD-9-CM;
- (9) The units of service furnished, if more than one; and
- (10) The provider's name and medical assistance identification number.

A separate claim form must be used for each recipient.

Note: The HCFA 1500 form substantially meets the requirements of this rule and its content and appearance are acceptable to the department.

67:16:05:10. Application of other chapters. In addition to the rules contained in this chapter, providers and recipients must meet the requirements of chapters 67:16:01, 67:16:26, 67:16:33, 67:16:34, and 67:16:35.

EPSDT for individuals under the age of 21 years

67:16:11:03.19. Home health services. Home health services are covered when the requirements of chapter 67:16:05 are met, with the following exceptions:

- (1) The child does not have to be confined to the home; however, the child must have a medical condition caused by an illness or injury which requires a considerable effort and the assistance of another individual or the aid of supportive devices to leave the home;
and
- (2) There is no limit on the number of home health aide services in each calendar quarter.