Section (Primary Department) Health Care Management – Utilization Management	SUBJECT (Document Title) Home Health Services – LA

Effective Date	Date of Last Review	Date of Last Revision	Dept. Approval Date
~~January 1, 2021~~03/09/2021	~~3/9/2021~~		03/09/2021
Department Approval/Signature:			
Policy applies to health plans operating in the following State(s). Applicable products noted below.			

Products				
☒ Medicaid/CHIP	☐ Arkansas	☐ Iowa	☐ Nevada	☐ Tennessee
☐ Medicare/SNP	☐ California	☐ Kentucky	☐ New Jersey	☐ Texas
☐ MMP/Duals	☐ Colorado	☒ Louisiana	☐ New York – Empire	☐ Virginia
	☐ District of Columbia	☐ Maryland	☐ New York (WNY)	☐ Washington
	☐ Florida	☐ Minnesota	☐ North Carolina	☐ Wisconsin
	☐ Georgia	☐ Missouri	☐ South Carolina	☐ West Virginia
	☐ Indiana	☐ Nebraska		

POLICY:

A home health agency (HHA) provides patient care services in the enrollee's residential setting, under the order of a physician, that are necessary for the diagnosis and treatment of the enrollee's illness or injury. Such services include part-time skilled nursing services, extended skilled nursing services (for enrollees under twenty-one (21) years of age), home health aide services, physical therapy (PT), speech therapy (ST), occupational therapy (OT), and medical supplies recommended by the physician as required in the care of the enrollee and suitable for use in any setting in which normal life activities take place.

Healthy Blue shall cover the following home health services:

- Skilled nursing (intermittent or part-time);
- Home health aide services, in accordance with the plan of care (POC) as recommended by the attending physician;
- Extended skilled nursing services (also referred to as extended home health), as part of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, is extended nursing care by a registered nurse or a licensed practical nurse (LPN) and may be provided to enrollees under age twenty-one (21) who are considered "medically fragile;"
- Rehabilitation services are physical, occupational and speech therapies, including audiology services; and
- Medical supplies, equipment, and appliances, as recommended by the physician, required in the POC for the enrollee and suitable for use in any setting in which normal life activities take place are covered under the Durable Medical Equipment (DME) program and must be prior authorized.

Home health services are reimbursable only when ordered by a licensed physician who certifies that the beneficiary meets the medical necessity criteria to receive services in a residential setting on an intermittent basis. Medicaid recipients do not have to be homebound in order to receive home health services. Home health services can be provided

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in a recipient's residential setting, which is any non-institutional setting in which a recipient's normal life activities take place. The recipient's place of residence cannot be a hospital, nursing home, or intermediate care facility for individuals with intellectual disabilities (ICF-IID) (with limited exceptions). The attending physician must certify that the recipient meets the medical criteria to receive the service in the home and is in need of the home health service on an intermittent basis. This certification and physician's plan of care must be maintained in the recipient's record and on file at the HHA. The physician must review the POC every sixty (60) days.

A face-to-face encounter is required and it must be related to the primary reason the recipient requires home health services. A face-to-face encounter may be conducted by the recipient's physician or a Medicaid-allowed non-physician practitioner (NPP). Healthy Blue shall ensure that a face-to-face encounter between the patient and the physician or an allowed NPP occur no more than ninety (90) days prior to, or thirty (30) days after, admission to the HHA.

DEFINITIONS:

1915(c) Waiver – Refers to Medical Assistance Programs under Louisiana Medicaid approved by the Secretary of the United States Department of Health and Human Services that provide reimbursement for home or community-based services, other than room and board, pursuant to a written plan of care to individuals with respect to whom there has been a determination, but for the provision of such services, that the individual would require the level of care provided in a hospital, in a nursing facility, or in an intermediate care facility for the intellectually or developmentally disabled, the cost of which could be reimbursed under the Louisiana Medicaid State Plan. 1915(c) Waiver programs in Louisiana Medicaid include the Children's Choice Waiver, the New Opportunities Waiver, the Supports Waiver, and the Residential Options Waiver.

Extended Home Health (EHH) – Refers to any Louisiana Medicaid State Plan service in which it is determined medically necessary for either a registered nurse (RN) or a licensed practical nurse (LPN) currently licensed to practice in Louisiana, to provide a minimum of three continuous hours per day of nursing services, as defined in the Louisiana Nurse Practice Act, pursuant to a written plan of care outside of an institutional setting. This term also refers to shift nursing care in the home and/or, as described in 42 USC §1396d(8) and 42 Code of Federal Regulations (CFR) §440.80, private duty nursing services for the purpose of caring for class members.

Home Health Care – Limited part-time or intermittent skilled nursing care and home health aide services, physical therapy (PT), occupational therapy (OT), speech-language therapy

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(ST), medical social services, durable medical equipment (DME), medical supplies, and other services.

Intermittent Nursing (IN) – Refers to the Louisiana Medicaid State Plan service that allows for the provision of a daily nursing visit lasting less than three (3) continuous hours. This service does not require prior authorization.

Prior Authorization or Prior Authorized (PA) – Refers to the request for services submitted by a health care provider participating in Louisiana Medicaid on behalf of the participant to Louisiana Medicaid and determined to be medically necessary in accordance with generally accepted, evidence-based medical standards prior to the delivery of the particular service.

Support Coordination (SC) Services – Refers to those services furnished by a support coordinator to assist participants in a 1915(c) Waiver under Louisiana Medicaid, who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, education, and other services in accordance with 42 CFR §§ 440.169 and 441.18. The assistance provided by support coordinators in assisting eligible participants is set forth in 42 CFR §440.169(d)-(e).

PROCEDURE:

Skilled Nursing Services
Nursing services provided on a part-time or intermittent basis by an RN or LPN that are necessary for the diagnosis and treatment of a beneficiary's illness or injury. Examples of skilled nursing services include but are not limited to the following:

- Frequently monitoring blood pressure, fluid status, or blood glucose;
- More rigorous assessment of symptoms, including pain, dyspnea, or constipation;
- Management of complex wounds;
- Patient education around therapy (e.g., home glucose monitoring and insulin administration); and
- Assessment of medication adherence.

These services shall be consistent with:

- Established Medicaid policy;
- The nature and severity of the beneficiary's illness or injury;
- The particular medical needs of the patient; and
- The accepted standards of medical and nursing practice.

The requested services must meet all of the following:

- Be ordered and directed by a treating practitioner or specialist (MD, DO);

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- Care must be delivered or supervised by a licensed professional in order to obtain a specific medical outcome;
- Services must be of skilled care in nature;
- Services must be part-time or intermittent; and
- Services must be clinically appropriate and not more costly than an alternative health service.

Psychiatric Services
Home health services provided to beneficiaries whose primary diagnosis is psychiatric must be
provided in accordance with state requirements as published in the Minimum Standards for HHAs. One requirement stipulates that only RNs shall make psychiatric nurse visits. RN qualifications for psychiatric home health visits are taken from the Minimum Standards for Licensing Home Health Agencies (LAC 48:1. Chapter 91). Only RNs who have these credentials shall make psychiatric nurse visits.

The services must be medically necessary and provided only to beneficiaries who meet Medicaid's medical necessity criteria for home health services.

Home Health Aide Services
In some situations, a dually eligible beneficiary (one who has coverage from both Medicare and Medicaid) requires only home health aide visits. Medicare will not pay for this service unless skilled services (skilled nursing service, PT, OT or ST) are also required. However, Medicaid will reimburse for home health aide visits if only home health aide visits are required.

Periodic on-site supervision with the home health aide present is part of the Minimum Standards for HHAs. It is required that if the beneficiary is receiving a skilled service (nursing, physical therapy, occupational therapy, or speech-language therapy), the beneficiary shall have a RN or appropriate therapist supervisory visit made randomly every fourteen (14) days.

Beneficiaries not receiving skilled services must have an RN supervisory visit at the beneficiary's residential setting at least once every sixty-two (62) days while the home health aide is present and providing care. Supervisory visits are not billable services.

Extended Home Health
Extended home health (EHH), also known as extended skilled nursing services (a minimum of three (3) or more hours of nursing services per day) may be provided to beneficiaries under the age of twenty-one (21) by the HHA if determined to be medically necessary, ordered by a physician, and prior authorized by Healthy Blue. The beneficiary must require

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skilled nursing care that exceeds the caregiver's ability to care for the beneficiary without the EHH services.

Medical necessity for extended skilled nursing services exists when the beneficiary has a medically complex condition characterized by multiple, significant medical problems that require nursing care in accordance with the Louisiana Nurse Practice Act (La. RS 37:911, et seq).

When requesting prior authorization (PA) for EHH, all hours of care must be included with the PA request. In addition, the physician's prescription and a copy of the POC must be attached to the appropriate PA form. Cases approved for EHH should be billed using appropriate codes for RN and LPN in conjunction with the total number of hours provided, indicating the units as hours.

Skilled nursing services are to be conducted in the beneficiary's residential setting. EHH services may be provided outside of the residential setting when the nurse accompanies the beneficiary for medical reasons such as doctor appointments, treatments or emergency room visit. Medicaid will not reimburse for skilled nursing services performed outside of state boundaries.

In order to provide continuity of care for beneficiaries, the following procedure will be used for beneficiaries requiring EHH care upon discharge from the hospital. Prior to hospital discharge, the PA process can begin. The following information must be submitted:

- **A letter of medical necessity from the primary physician;**
- **A signed prescription indicating the number of hours of EHH that are being requested;**
- **A copy of the admission assessment (history and physical);**
- **Progress notes;**
- **Discharge orders;**
- **A copy of the discharge summary, if available; and**
- **A copy of the unsigned POC. The unsigned POC will be accepted only if the beneficiary is being discharged from the hospital and is included with the above information. The POC assessment cannot be done in the hospital but must be done in the beneficiary's residential setting.**

Rehabilitation Services
Physical, occupational and speech therapy services are covered when provided by the HHA. These services are covered with PA. All rehabilitation services (except for initial evaluations and wheelchair seating evaluations, which are restricted to one evaluation per discipline per beneficiary every one hundred eighty (180) days) require PA. All evaluations must have a physician's prescription that must be kept in the beneficiary's file.

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All initial PA requests must include a copy of the physician's referral and the results of the evaluation of the beneficiary that documents the need for therapy. All renewal PA requests must include a copy of the physician's referral and progress notes that document the need for the continuation of therapy.

Physical Therapy (PT) services are rehabilitative services necessary for the treatment of the beneficiary's illness or injury, or restoration and maintenance of function affected by the beneficiary's illness or injury. These services are provided with the expectation, based on the physician's assessment of the beneficiary's rehabilitative potential, that:

- **The beneficiary's condition will improve materially within a reasonable and generally predictable period of time; or**
- **The services are necessary for the establishment of a safe and effective maintenance program.**

Occupational Therapy (OT) is a medically prescribed treatment to improve or restore a function which has been impaired by illness, injury or, when the function has been permanently lost or reduced, to improve the beneficiary's ability to perform those tasks required for independent functioning.

Speech Therapy (ST) services are those services necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of a communication disability.

Medical Supplies
Medical supplies recommended by the physician, required in the care of the beneficiary and suitable for use in any setting in which normal life activities take place are covered under the DME program when approved.

Routine supplies for which reimbursement is included as part of the reimbursement rate for the home health visit:

- **Blood drawing supplies**
- **Specimen containers**
- **Sterile specimen containers**
- **Vacutainer used for drawing blood**
- **Tourniquet**
- **Tubex holder**
- **Alcohol preps-swabs**
- **Surgical masks**
- **Bandage scissors**

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- Culturettes
- Disposable gloves – non-sterile
- Adhesive tape
- Paper tape
- Emesis basins
- Oral swabs/toothettes
- Alcohol
- Tape measure, all types
- Non-sterile cotton balls, buds
- Disposable gowns (plastic, paper)
- Disposable masks
- Goggles
- Disposable wash clothes
- Water soluble lubricant
- Thermometer with holder
- Thermometer cover
- Sharps container
- Self-assistive devices (long handle tongs and shoehorn stocking aide

Supplies covered only when provided in conjunction with a home health visit:
- Inflatable cushion (softcare mattress)
- Douche – betadine
- Enema – disposable enema administering kit
- Enema – fleets, mineral oil
- Facture pan, plastic
- Bed pan, plastic
- Urinal, plastic, male
- Urinal, female
- Commode urinary disposable collection device (HAT)
- Toppers, sterile
- Steri-strips
- Reston
- Telfa
- Skin staple remover
- Sterile applicators (tongue blades, sterile q-tips)
- Suture removal kit
- Sitz bath, portable, disposable
- Elastoplast
- Foam tape
- Pericare kit/supplies
- Bile bags

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- Therabands/putty
- Sterile irrigation solutions (GU irrigant, acetic acid and normal saline)
- Lymphedema pumps

When requesting PA for supplies, providers must submit a copy of the doctor's prescription or orders along with the home health POC.

Service Limitations

Home health services include part-time skilled nursing services, home health aide services, physical therapy, speech and occupational therapy, and medical supplies and equipment ordered by a physician as required in the care of the beneficiary and suitable for use in any setting in which normal life activities take place.

Note: Medicaid prohibits multiple professional disciplines in a beneficiary's residential setting at the same time. This includes but is not limited to nurses, home health aides, and therapists. However, multiple professionals may provide services to multiple beneficiaries in the same residential setting when it is medically necessary.

Service limits for home health services are as follows:

- Birth through age twenty (20):
  - No annual service limits;
  - PA is required for multiple visits on the same day when medically necessary; and
  - PA is required for EHH services.
- Ages twenty-one (21) or older:
  - Medicaid will reimburse only one (1) visit per profession per day.
  - PA is required for all nursing and rehabilitation services in a residential setting:
    - Skilled Nursing and Home Health Aide Services;
    - Physical Therapy;
    - Occupational Therapy; and
    - Audiology Services.

Beneficiary Requirements and Medical Necessity Criteria

The Medicaid beneficiary must meet all eligibility requirements in order to qualify for home health services. The HHA providing the service is required to verify beneficiary eligibility, other insurance coverage, and living arrangements before providing services.

The beneficiary cannot be in a hospital, nursing facility, ICF-IID, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

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Exception: In accordance with 42 CFR Part 483, Subpart I, there are situations in which a beneficiary residing in an ICF-IID may receive home health services. For example, short-term home health services may be provided to a beneficiary in an ICF-IID during an acute illness to avoid a beneficiary's transfer to a nursing facility.

Medical necessity for home health services must be determined by medical documentation that supports the beneficiary's illness, injury and/or functional limitations. All home health services must be medically reasonable and appropriate. To be considered medically reasonable and appropriate, the care must be necessary to prevent further deterioration of a beneficiary's condition regardless of whether the illness/injury is acute, chronic, or terminal.

The services must be reasonably determined to:

- **Diagnose, cure, correct, or ameliorate defects, physical and mental illnesses, and diagnosed conditions of the effects of such conditions;**
- **Prevent the worsening of conditions, or the effects of conditions, that endanger life or cause pain; results in illness or infirmity; or have caused, or threatened to cause a physical or mental dysfunctional impairment, disability or development delay;**
- **Effectively reduce the level of direct medical supervision required or reduce the level of medical care or services received in an inpatient or residential care setting;**
- **Restore or improve physical or mental functionality, including developmental functioning, lost or delayed as the result of an illness, injury, or other diagnosed condition or the effects of the illness, injury, or condition; or,**
- **Provide assistance in gaining access to needed medical, social, educational, and other services required to diagnose, treat, to support a diagnosed condition or the effects of the condition, in order that the beneficiary might attain or retain independence, self-care, dignity, self-determination, personal safety and integration into family, community, facility environments and activities.**

Home health skilled nursing and aide services are considered medically reasonable and appropriate when the beneficiary's medical condition and records accurately justify the medical necessity for services to be provided in the beneficiary's residential setting rather than in a physician's office, clinic, or other outpatient setting.

Home health services are appropriate when a beneficiary's illness, injury, or disability causes significant medical hardship and will interfere with the effectiveness of the treatment if the beneficiary has to go to a physician's office, clinic, or other outpatient setting for the needed service. Any statement on the plan of care (POC) regarding this medical hardship must be supported by the totality of the beneficiary's medical records.

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The following circumstances are not considerations when determining medical necessity for home health services:

- **Inconvenience to the beneficiary or the beneficiary's family;**
- **Lack of personal transportation; and,**
- **Failure or lack of cooperation by the beneficiary or the beneficiary's legal guardians or caretakers to obtain the required medical services in an outpatient setting.**

Plan of Care

The attending physician must certify that the beneficiary meets the medical criteria to receive the service in the beneficiary's residential setting and is in need of the home health services on an intermittent basis. The attending physician must order all home health services and sign a POC submitted by the HHA. The physician must reauthorize the POC every sixty (60) days.

A physician's order must be submitted with the PA request. A POC will be accepted in lieu of a separate physician's order if the frequency of visits are specified. If providers are unable to obtain a signed POC for a reconsideration request, an unsigned POC may be submitted for reconsideration requests for a thirty (30) day period only. The signed POC must be submitted with the new PA request in order for services to be approved.

Face-to-Face Encounter Requirements

For the initiation of home health services, a face-to-face encounter with the physician and the beneficiary, or an allowed non-physician practitioner (NPP) and the beneficiary must occur no sooner than ninety (90) days prior to the start of home health services, or no later than thirty (30) days after the start of home health services.

Evidence of the face-to-face encounter is required for routine skilled nursing and home health aide services for beneficiaries age twenty-one (21) and older. If providers do not have this documentation prior to the initiation of services then the initial PA request must be for thirty (30) days only. Providers must submit documentation of the face-to-face encounter with the new PA request in order for services to be approved.

For the initiation of medical equipment, the face-to-face encounter must be related to the primary reason the beneficiary requires medical equipment and must occur no more than six (6) months prior to the start of services.

Any of the following will be accepted as evidence of a face-to-face encounter between a physician and the beneficiary, or an allowed NPP and the beneficiary:

- **A written statement on the certifying physician's letterhead or prescription pad attesting to a face-to-face encounter between the physician and the beneficiary or an allowed NPP and the beneficiary; or**

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- The HHA's face-to-face encounter form that the HHA requires the beneficiary's certifying physician to complete as a routine business practice; or
- Medical notes or documentation from the physician or an allowed NPP demonstrating evidence of a face-to-face encounter within the required timeframe.

Documentation of a face-to-face encounter as detailed above must be kept in the beneficiary's record for all home health service related requests, including therapy services, medical equipment and supplies, and services for beneficiaries under the age of twenty-one (21).

The face-to-face encounter may be conducted by one of the following practitioners:

- The beneficiary's physician;
- A nurse practitioner or clinical nurse specialist, working in collaboration with the beneficiary's physician;
- A physician assistant under the supervision of the beneficiary's physician;
- A certified nurse-midwife, as defined in section 1861(gg) of the Social Security Act; or
- The attending acute or post-acute physician for beneficiaries admitted to home health immediately after an acute or post-acute stay.

The allowed NPP performing the face-to-face encounter must communicate the clinical findings of the encounter to the ordering physician. Those clinical findings must be incorporated into the beneficiary's medical record. The physician responsible for ordering the services must:

- Document that the face-to-face encounter which is related to the primary reason the beneficiary requires home health services, occurred within the required and specified timeframes above;
- Identify the practitioner who conducted the encounter; and
- Indicate the date of the face-to-face encounter.

Home Health Modifiers

Modifiers are available for routine home health and EHH (recipients age zero (0) through twenty (20)), to reflect specific scenarios as indicated in the chart below. All modifier requests must be submitted with the PA and approved in order to be reimbursed. Refer to the Louisiana Medicaid Home Health Revenue and Procedure Codes Fee Schedules.

Modifier	Modifier Name
U2	Second Daily Visit
U3	Third Daily Visit
TT	Multiple Beneficiaries in the Same Setting
TG	High Complexity
TN	Rural/Outside Area

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TV	Weekends and Holidays
UH	Services Provided in the Evening
UJ	Services Provided at Night

Multiple nursing visits on the same date of service may be provided to a beneficiary age birth through twenty (20) when the medical necessity criteria is met and these services cannot be provided during the course of one (1) visit. Multiple same day visits must be prior authorized before services begin.

Extended and multiple daily visits must be authorized in accordance with the certifying physician's orders and home health POC. The physician must issue orders detailing how many visits should be provided per day and the duration of time to provide the multiple visits, (i.e., 10 days, 2 weeks, 45 days, etc.). When the HHA receives the physician's orders, the HHA must obtain documentation to support the medical need for multiple daily visits along with the POC signed by the physician.

Multiple beneficiaries may been seen in the same residential setting by the same provider, on the same day when medically necessary. Medical necessity will be determined by review of the clinical documentation for each beneficiary receiving services. Each beneficiary must have a PA in order for services to be billed.

The TG modifier may be authorized for recipients aged birth through twenty (20) with highly complex needs requiring EHH services. Examples of high complexity may include but are not limited to:

- **Repeated seizures requiring treatment, intervention or both;**
- **Frequent oropharyngeal or tracheostomy suctioning;**
- **With or without nebulization treatments, repeated administration of percussion physiotherapy, high frequency chest wall oscillation physiotherapy, or use of a cough assist device;**
- **Ventilator, CPAP or BIPAP dependence during the nurse's care hours;**
- **Continuous oxygen dependence with continuous oxygen saturation monitoring and frequent oxygen desaturations requiring intervention;**
- **Continuous or frequent tube feeding for a recipient with gastroesophageal reflux, recurrent aspiration, or recurrent nausea, vomiting or abdominal pain;**
- **Parenteral nutrition;**
- **Intravenous therapies; or**
- **Repeated or extensive care of complex wounds.**

This list does not guarantee authorization. Each request is considered on an individual basis, and reviewed based on medical necessity and documentation provided.

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The HHA may submit PA requests using the TN modifier to identify travel to EHH recipients who live in a rural area, or outside the providers' usual service area. A geographical area will be considered rural as defined by the United States Department of Commerce, Census Bureau as non-urbanized.

Emergency Preparedness Plan

The HHA must have an emergency preparedness plan that conforms to the current Louisiana Office of Emergency Preparedness (OEP) model plan. The plan is designed to manage the consequences of declared disasters or other emergencies that disrupt the HHAs ability to provide care and treatment or threaten the lives or safety of its clients. The HHA must submit the plan to the parish OEP for review.

Additionally, per CMS, the HHA must comply with the reporting requirements of the At-Risk Registry. The HHA shall update the "Louisiana At-Risk Registry" or other current state-required reporting mechanism as needed or as required.

At a minimum, the HHA must have a written plan that includes:

- The evacuation procedures for agency clients who require community assistance as well as for those with available caregivers to evacuate to another location;
- The delivery of essential care and services to agency clients whether they are in a shelter or other locations;
- The provisions for the management of staff, including distribution and assignment of responsibilities and functions;
- A plan for coordinating transportation services required for evacuating agency clients to another location; and
- A declaration that the agency will notify the client's family or caregiver if the client is evacuated to another location.

AJ v. LDH

This section explains the class-action lawsuit titled AJ, a minor child by and through his mother, Donnell Creppel, et al., versus the Louisiana Department of Health (LDH), et al., 3:19-CV-00324 (hereinafter, "AJ v. LDH") and the implementation and operation of key provisions of the settlement agreement in that litigation.

Class members in AJ v. LDH are defined as follows: All current and future Medicaid beneficiaries under the age of twenty-one (21) in Louisiana who are certified in the Children's Choice Waiver, the New Opportunities Waiver, the Supports Waiver, or the Residential Options Waiver who are also prior authorized to receive EHH or intermittent nursing (IN) services which do not require PA but are not receiving some or all of the hours of EHH or IN services as authorized by Louisiana Medicaid.

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AJ v. LDH, filed on May 22, 2019, seeks to enforce rights under the EPSDT and reasonable promptness mandates of Title XIX of the Social Security Act, the Americans with Disabilities Act [42 USC §12131, et seq.], and Section 504 of the Rehabilitation Act [29 USC §794] by compelling the Department to arrange for the in-home skilled nursing care prior authorized for Medicaid-enrolled, medically fragile children. Because of their medical needs, class members have been prior authorized to receive EHH services to be able to live in the community. Data reflect gaps between the EHH service amounts prior authorized and the EHH service amounts actually delivered to class members. Potential service gaps in medically necessary IN services to class members also fall under the scope of the litigation. The suit has been settled, and the corresponding settlement agreement was approved by the court on March 31, 2020.

Managed Care Organizations (MCOs) are prohibited from reducing prior approved EHH service amounts for class members to increase the percentage of prior approved EHH services actually delivered. Such reduction in the amount of services that have been prior approved is contrary to federal Medicaid law and would constitute a due process violation under the United States Constitution.

Implementation of the settlement by MCOs is discussed more fully below:

1) Crisis Response Team (CRT)
   a) Louisiana Medicaid has established a CRT, the primary responsibility of which is arranging for in-home nursing services for class members when such services are unavailable through existing Medicaid home health agencies within the class member's LDH region. Healthy Blue is responsible for accepting referrals from the CRT and arranging service fulfillment.
      i) Contact information for the CRT is published on LDH's website and is as follows:
         Telephone: (866) 729- 0017
         Email: crisisresponseteam@la.gov
   b) Support coordinators or case managers have the obligation promptly to make referrals to the CRT for any class member who, after making reasonable efforts to receive EHH or IN services:
      i) Has received less than ninety percent (90%) of his or her prior approved EHH or medically necessary IN services for at least two (2) consecutive weeks; or
      ii) Has been unable to locate a home health provider in his or her LDH Region or has been denied enrollment by all home health providers in his or her LDH Region; or
      iii) Is otherwise facing a serious risk of institutionalization due to lack of EHH or IN services.
   c) In addition, when a need for IN has been identified and a class member is being terminated from existing EHH services where the class member's LDH region does not have a provider for IN services on the date that the notice of denial has been sent, the class member must be immediately referred to the CRT. In such situations,

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a reasonable effort includes a reevaluation of whether or not the class member should have been found eligible for EHH services.

d) The CRT operates in addition to, and does not replace, the responsibilities of a class member's existing support coordinator or case manager.

e) Healthy Blue is responsible for submitting a weekly report to LDH documenting the actions taken to ensure service provision and fulfillment for CRT referral members. Healthy Blue is also responsible for submitting a monthly report detailing the hours and service provision for class members.

2) Class Member Denial Notices

a) Notices to class members denying EHH services must contain contact information for the CRT when there is an identified need for IN services, i.e., for in-home skilled nursing services of visits with a duration shorter than three (3) contiguous hours per day.

b) Additionally, in situations when a class member is being referred to the CRT due to the unavailability of a provider for IN services concurrent with a termination from existing EHH services, the notice of denial to the class member of the EHH services termination must also notify the class member of the referral to the CRT.

The settlement period for AJ v. LDH is scheduled to terminate on March 31, 2025, unless otherwise ordered by the court.

EXCEPTIONS:

Routine skilled nursing and home health aid services for beneficiaries who are age twenty-one (21) and older require PA. There is no benefit coverage for EHH services or multiple daily nursing visits for persons age twenty-one (21) and older.

PA is not required for a single, daily nursing visit for beneficiaries under the age of twenty-one (21) who are not receiving EHH. All EHH services for beneficiaries under the age of twenty-one (21) require PA. Daily nursing visits that are less than three (3) hours per day for beneficiaries under the age of twenty-one (21) who do not meet medical necessity criteria for EHH do not require PA.

PA is not required for routine home health visits for beneficiaries under the age of twenty-one (21). Routine home health services for beneficiaries under the age of twenty-one (21) must be prescribed by a physician for only one (1) skilled nursing visit per day. A request for PA of services is required whenever the prescription of the physician includes multiple daily visits for a beneficiary under the age of twenty-one (21). Multiple visits in the same day are usually associated with IV therapy.

All home health rehabilitation services (PT, OT, and ST) require PA.

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A face-to-face encounter form is not required for beneficiaries under the age of twenty-one (21), for rehabilitation services, or medical equipment and supplies provided through the DME program; however, documentation of the face-to-face encounter for these groups of services is required to be kept in the recipient's record.

All home health staff must meet all required licensure requirements in accordance with Medicaid policies, federal, state and other applicable laws. All nursing services shall be provided in accordance with the Louisiana Nurse Practice (La. R.S. 37:911, et seq).

REFERENCES:

Health Plan Advisory 16-3
Health Plan Advisory 16-9
Health Plan Advisory 16-13
Health Plan Advisory 19-8
Health Plan Advisory 20-16
Home Health Provider Manual
Louisiana Medicaid Managed Care Organization (MCO) Manual
Louisiana State Contract

RESPONSIBLE DEPARTMENTS:

Primary Department:
Health Care Management – Utilization Management

Secondary Department(s):
Claims
Health Care Management – Case Management

REVISION HISTORY:

Review Date	Changes
03/09/2021~~2/10/2020~~	• New; policy entirety comprised of state-specific language and requirements