Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XIII. Home Health Program
Subpart 1. Home Health Services

Chapter 1. General Provisions

§101. Definitions
[Formerly LAC 50:XIX.101]

A. The following words and terms, when used in this Subpart 1, shall have the following meanings, unless the context clearly indicates otherwise:

Home Health Aide Services—direct care services to assist in the treatment of the patient's illness or injury provided under the supervision of a registered nurse and in compliance with the standards of nursing practice governing delegation, including assistance with the activities of daily living such as mobility, transferring, walking, grooming, bathing, dressing or undressing, eating, or toileting.

Home Health Services—patient care services provided in the patient's home under the order of a physician that are necessary for the diagnosis and treatment of the patients illness or injury, including one or more of the following services:

a. skilled nursing;

b. physical therapy;

c. speech-language therapy;

d. occupational therapy;

e. home health aide services; or

f. medical supplies, equipment and appliances suitable for use in the home.

NOTE: Medical supplies, equipment and appliances for home health are reimbursed through the Durable Medical Equipment Program and must be prior authorized.

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

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

a. the patient's condition will improve materially within a reasonable and generally predictable period of time; or

b. the services are necessary for the establishment of a safe and effective maintenance program.

Skilled Nursing Services—nursing services provided on a part-time or intermittent basis by a registered nurse or licensed practical nurse that are necessary for the diagnosis and treatment of a patient's illness or injury. These services shall be consistent with:

a. established Medicaid policy;

b. the nature and severity of the recipient's illness or injury;

c. the particular medical needs of the patient; and

d. the accepted standards of medical and nursing practice.

Speech-Language Therapy Services—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.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:431 (March 2004).

§103. Requirements for Home Health Services
[Formerly LAC 50:XIX.103]

A. Home health services shall be based on an expectation that the care and services are medically reasonable and appropriate for the treatment of an illness or injury, and that the services can be performed adequately by the agency in the recipient's place of residence. A written plan of care for services shall be evaluated and signed by the physician every 60 days. This plan of care shall be maintained in the recipient's medical records by the home health agency.

B. Medicaid recipients who are linked to a CommunityCare primary care physician (PCP) must have a referral from the PCP for home health services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:431 (March 2004).

§105. Provider Responsibilities [Formerly LAC 50:XIX.105]

A. Home health agencies must comply with the following requirements as condition for participation in the Medicaid Program.

1. The home health agency must provide to the bureau, upon request, the supporting documentation verifying that the recipient meets the medical necessity criteria for services.

2. Home health services shall be terminated when the goals outlined in the plan of care have been achieved, regardless of the number of days or visits that have been approved.

3. The home health agency must ensure that the family is instructed on a home maintenance exercise program which has been established by the treating physical therapist.

4. The home health agency shall discharge a patient once it has been determined that the patient or his/her legally responsible caregiver is noncompliant with the treatment regimen, keeping medical appointments and/or assisting with medication compliance and med-pack setups.

5. The home health agency must report complaints and suspected cases of abuse or neglect of a home health recipient to the appropriate authorities if the agency has knowledge that a minor child, a non-consenting adult or a mentally incompetent adult has been abused or is not receiving proper medical care due to neglect or lack of cooperation on the part of the legal guardians or caretakers. This includes knowledge that a recipient is routinely taken out of the home by a legal guardian or caretaker against medical advice or when it is obviously medically contraindicated.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:431 (March 2004).

§121. Cost Reporting Requirements

A. Effective July 1, 2012, the department shall implement mandatory cost reporting requirements for providers of home health services. The cost reports will be used to verify expenditures and to support rate setting for the services rendered to Medicaid recipients.

B. Each home health agency shall complete the DHH approved cost report and submit the cost report(s) to the department no later than five months after the state fiscal year ends (June 30).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:509 (March 2013).

Chapter 3. Medical Necessity

§301. General Provisions [Formerly LAC 50:XIX.301]

A. Medical necessity for home health services is determined by the recipient's illness and/or injury and functional limitations. All home health services shall be medically reasonable and appropriate. To be considered medically reasonable and appropriate, the care must be necessary to prevent further deterioration of a recipient's condition regardless of whether the illness or injury is acute, chronic or terminal. The services must be reasonably determined to:

1. diagnose, cure, correct or ameliorate defects, physical and mental illnesses, and diagnosed conditions of the effects of such conditions; or

2. prevent the worsening of conditions, or the effects of conditions, that:

a. endanger life or cause pain;

b. result in illness or infirmity; or

c. have caused, or threatened to cause, a physical or mental dysfunction, impairment, disability, or developmental delay; or

3. 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; or

4. 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

5. provide assistance in gaining access to needed medical, social, educational and other services required to diagnose, treat, or support a diagnosed condition or the effects of the condition, in order that the recipient might attain or retain:

a. independence;

b. self-care;

c. dignity;

d. self-determination;

e. personal safety; and

f. integration into all natural family, community, and facility environments and activities.

B. Home health skilled nursing and aide services are considered medically reasonable and appropriate when the recipient’s medical condition and medical records accurately justify the medical necessity for services to be provided in the recipient’s home rather than in a physician’s office, clinic, or other outpatient setting according to guidelines as stated in this Subpart.

C. Home health services are appropriate when a recipient’s illness, injury, or disability causes significant

medical hardship and would interfere with the effectiveness of the treatment if he/she had to go to a physician's office, clinic, or other outpatient setting for the needed service. Any statement on the plan of care regarding this medical hardship must be supported by the totality of the recipient's medical records.

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

1. inconvenience to the recipient or the recipient's family;

2. lack of personal transportation; or

3. failure or lack of cooperation by a recipient or a recipient's legal guardians or caretakers to obtain the required medical services in an outpatient setting.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:431 (March 2004).

§303. Provisions for Infants and Toddlers [Formerly LAC 50:XIX.303]

A. For the purpose of this Subpart 1, *Infants or Toddlers* are defined as young children, up to age 3, who have not learned to ambulate without assistance.

B. Home health services are considered to be medically necessary for an infant or toddler when the primary care physician has advised against removing the infant or toddler from the home because it would:

1. place the infant or toddler at serious risk of infection;

2. greatly delay or hamper the recovery process;

3. cause significant further debilitation of an existing medical condition or physical infirmity;

4. seriously threaten to cause or aggravate a handicap or a physical deformity or malfunction;

5. cause great suffering or pain;

6. seriously endanger the well-being of the infant or toddler; or

7. otherwise be considered medically contraindicated.

C. The following circumstances are not considered when determining the medical necessity of home health services for infants and toddlers:

1. the provision of services in the home is solely a matter of convenience;

2. a lack of personal transportation; or

3. failure or lack of cooperation by the child=s legal guardian(s) to obtain the required medical services in an outpatient setting.

NOTE: The fact that an infant or toddler cannot ambulate or travel without assistance from another is not a factor in determining medical necessity for services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:432 (March 2004).

§305. Extended Nursing Services for Ages 0-21

A. Extended nursing services may be provided to a Medicaid recipient who is age birth through 21 when it is determined to be medically necessary for the recipient to receive a minimum of three hours per day of nursing services. Medical necessity for extended nursing services exists when the recipient has a medically complex condition characterized by multiple, significant medical problems that require nursing care as defined by the Louisiana Nurse Practice Act.

B. Multiple nursing visits on the same date of service may be provided to a recipient who is age birth through 21 when the medical necessity criteria for extended nursing services are met and these services cannot be provided during the course of one visit.

C. Extended and multiple daily nursing services must be prior authorized in accordance with the certifying physician's orders and home health plan of care. All nursing services shall be provided in accordance with the Louisiana Nurse Practice Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:406 (March 2006).

Chapter 5. Service Limitations

§501. Home Health Visits [Formerly LAC 50:XIX.501]

A. Home health services are limited to 50 skilled nursing and/or aide visits per year, one service per day for recipients who are 21 years of age and older.

B. The service limitation of 50 skilled nursing and/or aide visits per year, one service per day is not applicable for recipients who are from birth up to the age of 21. However, home health services provided to recipients up to the age of 21 are subject to post-payment review in order to determine if the recipient's condition warrants high utilization.

C. The service limitation of 50 home health visits per year is not applicable for rehabilitation services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:432 (March 2004).