Home Health Services

CSHCN Services Program Provider Manual

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TEXAS
Health and Human
Services

HOME HEALTH SERVICES

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21.1 Enrollment

To enroll in the CSHCN Services Program, home health agencies providing home health services must be actively enrolled in Texas Medicaid, have a valid provider agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, be a licensed and certified home and community services support agency (HCSSA), and comply with all applicable state laws and requirements. Out-of-state home health providers must meet all these conditions, be located in the United States, within 50 miles of the Texas state border, and be approved by the Department of State Health Services (DSHS).

Important: *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

Refer to: Section 2.1, "Provider Enrollment" in Chapter 2, "Provider Enrollment and Responsibilities" for more detailed information about CSHCN Services Program provider enrollment procedures.

21.2 Benefits, Limitations, and Authorization Requirements

Home health services are a benefit of the CSHCN Services Program for clients requiring services for an acute condition or an acute exacerbation of a chronic condition that can be met on an intermittent or part-time basis.

Home health services are considered medically necessary for a client who:

- Requires skillful observations and judgment to improve health status, skilled assessment, or skilled treatments and procedures.
- Requires individualized, intermittent, or part-time acute skilled care.
- Requires skilled interventions to improve health status, and if skilled intervention is delayed, it is expected to result in:
  - Deterioration of a chronic condition.
  - Loss of function.
  - Imminent risk to health status due to medical fragility or risk of death.

Providers must be a licensed and certified home health agency enrolled in the CSHCN Services Program and must comply with all applicable federal, state, and local laws and regulations and CSHCN Services Program policies and procedures.

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A parent or guardian, primary caregiver, or alternate caregiver may not be reimbursed for skilled nursing (SN) services even if he or she is employed by an enrolled provider.

21.2.1 Prior Authorization Requirements for Home Health Services

Home health services require prior authorization. Prior authorization requests must be submitted on the CSHCN Services Program Authorization and Prior Authorization Request Form.

21.2.1.1 Authorization Requirements

Prior authorization of home health services is required. Medical necessity documentation must be submitted along with the prior authorization request. Requests may be submitted by any approved method to the claims administrator.

Verbal orders will not be accepted. All prior authorization requests must be signed and dated by the ordering practitioner.

> ***Note:*** *An advanced practice registered nurse (APRN) or a physician assistant (PA) may sign and date all documentation related to the provision of SN, HHA, or extended skilled nursing services on behalf of the client's physician when the physician delegates this authority to the APRN or PA.*

Prior authorization must be obtained before the start of care however, if the service is medically necessary, provided after hours or on a recognized holiday or weekend, services may be authorized when the request is submitted on the next business day. A completed CSHCN Services Program Home Health Skilled Nursing Request and Plan of Care Form and all other required documentation must be received within these deadlines for prior authorization to be considered. Dates of service requested before the submission date or the practitioner signature date will be denied as late submissions. Extensions to these deadlines are not given by the CSHCN Services Program for providers to correct incomplete prior authorization requests.

SN services or HHA services (procedure codes G0156, G0299, and G0300) will not be authorized during the same day as extended SN services (procedure codes S9123 and S9124).

SN and HHA services may not be provided during overlapping time periods (procedure codes G0156, G0299, and G0300), but can be requested for the same day.

SN services or HHA services (procedure codes G0156, G0299, and G0300) will not be authorized when the client is receiving PPECC services (procedure code T1026).

The initial nursing assessment is used to establish the POC and must support the medical necessity for the client to receive SN services, HHA services, extended SN services, PT services, OT services, speech-language pathology services, or medical nutritional counseling services. The provider must have an RN perform an initial client assessment or reassessment in the client's home. For initial prior authorization, providers must obtain prior authorization before the start of care (SOC). Initial prior authorization period may not exceed 60 calendar days.

> ***Note:*** *The initial RN assessment is an administrative cost and will not be reimbursed.*

The initial nursing assessment/reassessments must include, but are not limited to the following:

- Complexity and intensity of the client's care
- Stability and predictability of the client's condition
- Frequency of the client's need for SN care
- Identified medical needs and goals
- Description of wounds, if present
- Comprehension level of the client or parent, guardian or caregiver
- Receptivity to training and ability level of the client or parent, guardian or caregiver

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The initial assessment and any reassessments are performed by an RN. The initial assessment must be completed no earlier than five business days before the client's SOC. Reassessments are required when changes in the client's condition occur during the course of the prior authorization period and revision of the plan of care is needed. Revisions to the POC must be submitted as soon as the need is identified but no later than 3 business days from the date of the revision.

If there is no change in the client's condition, the reassessment must document medical necessity, as defined in the Statement of Benefits, to support continued and ongoing acute, intermittent, part-time SN or HHA visits services beyond the initial 60 calendar day prior authorization period. Requests received after the five business days allowed will be denied for dates of service that occurred before the revision is approved.

For extension of acute intermittent, part-time SN or HHA services, providers must obtain prior authorization on the CSHCN Services Program Home Health Skilled Nursing Request and Plan of Care Form before the end of the current prior authorization period. A new client assessment and a current POC must also be submitted. Extension requests that are received after the current prior authorization expires will be denied for dates of service that occur before the extension request is approved.

21.2.1.2 Plan of Care (POC)

A copy of the home health provider's POC must be submitted for documentation of the required information. The POC must be signed by the practitioner who is ordering home health services and who will provide ongoing supervision of the POC. The POC must be signed and dated no earlier than 30 days prior to the start of care, reviewed and signed every 60 days at a minimum by the ordering practitioner or sooner if the client's condition changes and a reassessment and revision of the plan of care is needed. Dates of service requested before the submission date or practitioner signature date will be denied.

Providers must obtain prior authorization no earlier than three business days before the start of care (SOC) for an initial authorization. The initial prior authorization period may not exceed 60 calendar days. For extensions, providers must obtain prior authorization within seven business days before the end of the authorization period.

Providers are required to deliver the requested services from the SOC date, which is the date agreed to by the ordering practitioner, registered nurse (RN), home health agency, client, parent or guardian. The SOC must be documented on the POC.

A provider requesting prior authorization for SN and HHA services must submit all of the following documentation:

- A completed CSHCN Services Program Home Health Skilled Nursing Request and Plan of Care Form
- A completed client nursing assessment
- The completed POC must be signed and dated by the assessing RN and the ordering practitioner.

Note: *Home health providers may submit a client nursing assessment and a POC on forms developed by the home health agency along with the prior authorization request. Home health agency forms must contain all criteria specified.*

The POC must be initiated and written in a clear and legible format by the assessing RN and include the following:

- The client's CSHCN number
- The ordering practitioner's license number
- The provider's NPI number
- Date the client was last seen by the ordering practitioner
- The start of care (SOC) date for home health services

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- All pertinent diagnoses
- The client's mental status
- The prognosis
- The types of service requested, including the number of visits and amount, duration, and frequency with measurable goals and objectives for each service provided
- The equipment and/or supplies required
- Rehabilitation potential
- Prior and current functional limitations
- Activities permitted
- Nutritional requirements
- Medications, including the dose, route and frequency
- Treatments, including amount and frequency
- Wound care orders and measurements
- Safety measures to protect against injury
- Instructions for timely discharge or referral

Requests must be based on the medical needs of the client. Documentation must support the quantity and frequency of intermittent or part-time SN or HHA visits or extended SN visits that will safely meet the client's needs. The amount and duration of SN, extended SN, or HHA visits requested will be evaluated by the claims administrator.

HHA services will not be prior authorized when the client is receiving extended SN services simultaneously but can be requested on the same day.

The home health agency must ensure the requested services are supported by the client assessment, POC, and signed and dated orders.

Physician orders must be submitted on the CSHCN Services Program Home Health Skilled Nursing Request and Plan of Care Form and include but are not limited to the following:

- Client name, date of birth, gender, and CSHCN Services Program Identification number
- Ordering practitioner name, contact information and NPI number
- Date last seen by the ordering practitioner
- Diagnoses and description of current medical condition
- Prognosis
- Mental status
- Documentation of medical necessity that the client requires part-time intermittent skilled nursing or ongoing extended skilled nursing services
- Nursing services required, i.e., RN, LVN, HHA
- Medication administration (dose/route/frequency), if applicable
- Treatments ordered
- Wound care, if applicable
- Other therapies if required
- Dietary and nutritional needs

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- Activity level
- Other services as needed
- Functional status
- Safety measures
- Equipment/supplies needed
- Rehab potential

If a provider or client discontinues SN or HHA visits, or extended services, during an existing prior authorized period and the client requests services through a new provider, the new provider must submit all of the following:

A new CSHCN Services Program Home Health Skilled Nursing Request and Plan of Care Form. A physician, APRN, or PA signature is required on the form.

- A new client assessment and a current POC,
- A change of provider letter signed and dated by the client, parent, guardian or caregiver documenting:
  - The date the client ended SN or HHA visits, or extended SN services, (effective date of change) with the previous provider,
  - The names of previous and new providers,
  - An explanation of why providers were changed.

Providers who terminate services must give reasonable notice to the client and must maintain documentation of the reason in the client's medical record.

Concurrent services for telemonitoring are allowed for distinctly different medical reasons. Duplication of services by any provider will not be prior authorized.

Refer to: Chapter 4, "Prior Authorizations and Authorizations" for additional information about authorization and prior authorization requirements.

21.3 Home Health Aide (HHA) Services

HHA visits (procedure code G0156) must be provided by a qualified HHA under the supervision of a qualified licensed individual (registered nurse [RN], physical therapist, occupational therapist) who is employed by the home health agency.

HHA services may include, but are not limited to, the following:

- Obtaining and recording the client's vital signs
- Observation, reporting, and documentation of the client's status and the care or service furnished
- Hygiene and grooming including, but not limited to:
  - Sponge, tub, or shower bath
  - Shampoo, sink, tub, or bed bath
  - Nail and skin care
  - Oral hygiene
- Toileting and elimination care
- Ambulation
- Exercise

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- Range of motion exercises
- Safe transfer
- Positioning
- Assisting with nutrition and fluid intake
- Household services essential to the client's health care at home
- Assisting client with his or her self-administered medication
- Reporting changes in the client's condition and needs
- Completing appropriate documentation

21.3.1 Supervision of Home Health Aides

When HHA services have been ordered, an RN or therapist (PT or OT) must provide the HHA written instructions and supervision for the tasks delegated to the HHA.

The requirements for HHA supervision are as follows:

- When HHA services are provided in addition to an SN service, an RN must make a supervisory visit to the client's residence at least once every two weeks. The supervisory visit must occur when the HHA is present and providing care to the client.
- When HHA services are provided in addition to PT or OT services, the appropriate therapist may make the supervisory visit at least every two weeks in place of an RN. The supervisory visit must occur when the HHA is present and providing care to the client.
- Documentation of HHA supervision must be maintained in the client's medical record.

21.3.2 Skilled Nursing and Home Health Aide Services

The following definitions apply to CSHCN Services Program home health skilled nursing (SN) and home health aide (HHA) services:

- **Acute** is defined as a condition or exacerbation that is anticipated to improve and reach resolution within 60 days.
- **Part-time** is defined as SN or HHA visits less than eight hours per day for any number of days per week. Part-time visits may be delivered in interval visits up to 2.5 hours (10 units) per visit, not to exceed a combined total of three visits per day (7.5 hours [30 units]).
- **Intermittent** is defined as SN or HHA visits provided for less than eight hours per visit and less frequently than daily. Daily visits may be considered for a short-term period (7 to 10 days) when medically necessary. Examples might include a new diabetic who is blind or may have cognitive difficulties. Intermittent visits are not to exceed a combined total of three visits per day (7.5 hours total [30 units]).

SN visits are nursing services ordered by a physician, included in the CSHCN Services Program Home Health Skilled Nursing Request and Plan of Care Form, and provided by a registered nurse (RN) or licensed vocational nurse (LVN) under the supervision of a licensed RN. SN visits may be considered when a client requires nursing services for an acute condition or an acute exacerbation of a chronic condition that can be met on an intermittent or part-time basis and typically is expected to resolve in less than 60 calendar days.

> ***Note:*** *Providers must bill procedure codes G0156, G0299, or G0300 for conditions which are expected to resolve in 60 calendar days or less.*

HHA visits are services ordered by the physician, included on the CSHCN Services Program Home Health Skilled Nursing Request and Plan of Care Form, and are services the HHA is permitted to perform under State law. HHA visits may be considered when a client requires assistance with activities

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of daily living for an acute condition or an acute exacerbation of a chronic condition that can be met on an intermittent or part-time basis and typically is expected to resolve in less than 60 calendar days. HHA visits will not be considered unless the client also requires SN or therapy services. HHA visits may be provided on consecutive days.

Note: *An advanced practice registered nurse (APRN) or a physician assistant (PA) may sign and date all documentation related to the provision of SN and HHA services on behalf of the client's physician when the physician delegates this authority to the APRN or PA.*

21.3.2.1 Medical Necessity

SN and HHA Services are considered medically necessary for a client who:

- Requires the skills of a nurse to perform observations and judgments to improve health status, skilled nursing assessments, or skilled treatment or procedures;
- Requires individualized, intermittent, or part-time acute skilled care;
- Requires skilled interventions to improve health status, and if skilled intervention is delayed, it is expected to result in:
  - Deterioration of a chronic condition
  - Loss of function, or
  - Imminent risk to health status due to medically fragility, or risk of death

Home health extended SN services are medically necessary when a client is medically fragile and has a disability, or chronic condition that requires ongoing skilled nursing beyond the level of intermittent part-time acute care. Medical necessity is defined by the following criteria:

- The client must require ongoing skilled nursing services provided by a RN or LVN
- The client must have a serious, chronic condition or disability that requires ongoing and complex SN interventions and monitoring beyond the level of intermittent part-time acute skilled care
- The client's care requires the routine use of a medical device or assistive technology to compensate for the loss of a body function needed to participate in activities of daily living
- The client lives with an ongoing threat to his or her continued well-being, deterioration of his or her condition and risk of death.

21.3.3 Skilled Nursing Services

Home health SN services are a benefit of the CSHCN Services Program when a client requires nursing services for an acute condition or an acute exacerbation of a chronic condition that can be met on an intermittent or part-time basis. SN services are intended to provide SN care to promote independence and support the client living at home.

SN services are limited to SN procedures performed by a registered nurse (RN) or licensed vocational nurse (LVN) licensed to perform these services under the *Texas Nursing Practice Ac*t and include the following:

- Direct SN care and parent, guardian, or caregiver training and education
- SN observation, assessment, and evaluation by an RN, provided that the ordering practitioner specifically requests that the nurse visit the client for this purpose and the signed and dated orders reflect the medical necessity for the visit.
- Supervision of delegated services provided by an HHA or others over whom the RN is administratively or professionally responsible.

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Skilled nursing visits (procedure codes G0299 and G0300) are limited to procedures performed by an RN or licensed vocational nurse (LVN) licensed to perform these services under the *Texas Nursing Practice Act* and 42 Code of Federal Regulations §§ 409.32, 409.33, and 409.44. These services include the following:

- Direct skilled nursing care, training, and education for parents, guardians, and caregivers
- Skilled nursing observation, assessment, and evaluation by an RN (if a physician specifically requests that a nurse visit the client for this purpose and the physician's order reflects the medical necessity of the visit)

Determining whether a service requires the skill of an RN or LVN is based on the inherent complexity of the service, the condition of the client, and the accepted standards of medical and nursing practice.

If the service can be safely and effectively performed by an average non-clinician without the direct supervision of an RN or LVN, the service is not considered skilled nursing. A service that could be performed by an average non-clinician is not skilled nursing even if there is no competent person to perform it.

Some services are classified as skilled nursing on the basis of complexity alone (e.g., intravenous and intramuscular injections or insertion of catheters). If these services are reasonable and necessary to the treatment of the client's illness or injury, they may be covered. In some cases, the client's condition may require a service that is ordinarily considered unskilled and falls outside the scope of skilled nursing. This would occur when the client's condition necessitates an RN or LVN to perform the service safely and effectively.

A service that, by its nature, requires the skills of a nurse to be provided safely and effectively continues to be considered skilled nursing even if it is taught to the client, the client's family, or other caregivers. When the client needs the skilled nursing care and there is no one trained, able, and willing to provide it, the services of a nurse may be considered reasonable and necessary.

Skilled nursing must be reasonable and necessary to the diagnosis and treatment of the client's illness or injury within the context of the client's unique medical condition. To be considered reasonable and necessary for the diagnosis or treatment of the client's illness or injury, the services must be consistent with the nature and severity of the illness or injury, the client's particular medical needs, and within accepted standards of medical and nursing practice. A client's overall medical condition is a valid factor in deciding whether skilled nursing is needed. A client's diagnosis should never be the sole factor in deciding whether the service the client needs is skilled nursing or not.

The determination of whether the services are reasonable and necessary should be made in consideration of the physician's determination that the services ordered are reasonable and necessary. The services must, therefore, be viewed from the perspective of the condition of the client when the services were ordered, and what was, at that time, reasonably expected to be appropriate treatment for the illness or injury throughout the certification period.

21.3.3.1 Limitations for Skilled Nursing Services

Skilled nursing must be provided on a part-time or intermittent basis.

If medically necessary, SN and HHA visits are limited to a maximum of 30 units (7.5 hours) per day. SN or HHA visits may be provided on consecutive days.

SN Services will not be prior authorized when the client is receiving extended SN services.

Skilled nursing visits to obtain routine laboratory specimens may be reimbursed when the only alternative to obtain the specimen is to transport the client by ambulance. Collection of the laboratory specimen is considered part of the visit.

Skilled nursing visits requested primarily to provide the following services will not be prior authorized:

- Respite care

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- Child care
- Activities of daily living for the client
- Housekeeping services
- Individualized, comprehensive case management beyond the service coordination required by the *Texas Nursing Practice Act*

A parent, guardian, primary caregiver, or alternate caregiver may not be reimbursed for skilled nursing, even if he or she is employed by an enrolled provider.

Total parenteral nutrition (TPN) is not a benefit through home health services.

Refer to: Section 26.6, "Total Parenteral Nutrition (TPN)" in Chapter 26, "Medical Nutrition Services" for more detailed information.

21.3.3.2 Extended Skilled Nursing Services

Extended SN services may be a benefit of the CSHCN Services Program for medically fragile clients who meet the medical necessity criteria. Clients must require ongoing skilled nursing services provided by an RN or LVN.

Medically fragile clients are those who have a serious, chronic condition that requires extended and complex skilled nursing interventions and monitoring. Their care requires the routine use of a medical device or assistive technology to compensate for the loss of a body function needed to participate in activities of daily living. These individuals live with an ongoing threat to their continued well-being, deterioration of their condition, and risk of death.

Providers must bill procedure codes S9123 and S9124 for medically fragile clients requiring extended and complex skilled nursing care.

Medically fragile conditions include, but are not limited to:

- Cerebral palsy
- Cystic fibrosis
- Muscular dystrophy
- Other diagnoses which may be considered on a case by case basis with documentation of medical necessity

Services may include, but are not limited to:

- Skilled nursing assessment;
- Administration of medications, including IV medications and chemotherapy;
- Sterile catheter insertion;
- Medical treatments that require the skill of a licensed nurse; and
- Education of the client or parent, guardian, or caregiver.

Services must be delivered according to the following criteria:

- Services must be medically necessary and appropriate;
- Services must be prescribed by a physician, APRN, or PA;
- Services must be provided according to an established Plan of Care (POC) which is reviewed, signed, at minimum by the ordering practitioner every 60 days.

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Up to 400 hours of extended SN services may be approved per client per calendar year with documented justification of need and cost effectiveness.

Note: *Extended SN services may not exceed 400 hours per client per calendar year.*

21.3.4 Occupational Therapy (OT), Physical Therapy (PT), and Speech-Language Pathology (SLP) Services

OT (procedure code G0152), PT (procedure code G0151), and SLP (procedure code G0153) services are benefits of the CSHCN Services Program for clients with acute or chronic medical conditions when documentation from the prescribing physician and the treating therapist indicates there is or will be progress made toward goals.

21.3.4.1 Prior Authorization for Occupational Therapy (OT), Physical Therapy (PT), and Speech-Language Pathology (SLP) Services

Evaluations or re-evaluations do not require prior authorization. Therapy treatment services require prior authorization.

Prior authorization for therapy services will be considered when all of the following criteria are met:

- The client has acute or chronic medical conditions resulting in a significant decrease in functional ability that will benefit from therapy services in an office, home, or outpatient setting.
- Documentation must support treatment goals and outcomes for the specific therapy disciplines requested.
- Services do not duplicate those provided concurrently by any other therapy.
- Services are provided within the provider's scope of practice as defined by state law.

Documentation supporting the medical need for therapy services includes:

- A completed CSHCN Services Program Prior Authorization Request form:
  - Initial Outpatient Therapy (TP1) Form for initial therapy treatment services, or
  - Extension of Outpatient Therapy (TP2) Form for extension of on-going therapy treatment services.

  Note: *The request form must be signed and dated by the ordering physician, APRN, or PA and therapy provider(s). A request form that is missing required information is considered incomplete.*
- A current evaluation or re-evaluation for each therapy service requested and comprehensive treatment plan with the following:
  - Date of the evaluation
  - Diagnosis(es)
  - Client's medical history and background
  - Client's current and prior functional level, to include current standardized assessment scores or criterion-referenced scores as appropriate for the client's condition
  - Date of onset of the illness, injury, or exacerbation requiring the therapy services
  - Short- and long-term treatment goals, including prior treatment goals, for the therapy discipline and associated disciplines requested, related to the client's individual needs
  - A description of the specific treatment modalities being prescribed and the recommended amount, frequency and duration of services
  - Prognosis for improvement

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- Requested dates of service
- Date and signature of the licensed therapist

21.3.4.2 Limitations for Occupational Therapy (OT) and Physical Therapy (PT)

The following outpatient OT or PT treatment procedure codes will be denied if billed on the same date of service as procedure codes G0152 or G0151 respectively, by any provider:

Procedure Codes									
97012	97016	97018	97022	97024	97026	97028	97032	97033	97034
97035	97036	97110	97112	97113	97116	97124	97140	97150	97530
97535	97537	97542	97750	97755	97760	97761	97763	97999	

Therapy evaluations or re-evaluations are limited to four per 180 days, any provider for procedure codes G0151 and G0152.

21.3.4.3 Limitations for Speech-Language Pathology (SLP)

Outpatient speech therapy treatments (procedure codes 92507, 92521, 92522, 92523, 92524, 92526, 92610, and S9152) will deny if billed on the same date of service as procedure code G0153 by any provider.

Therapy evaluations or re-evaluations are limited to four per 180 days, any provider for procedure code G0153.

21.3.5 Medical Nutritional Counseling Services

Medical nutritional counseling services (procedure codes 97802, 97803, and S9470) are a benefit of the CSHCN Services Program when provided in the home by a licensed dietician. If either procedure code 97802 or 97803 is billed with procedure code S9470 for the same date of service, then either procedure code 97802 or 97803 is reimbursed, and procedure code S9470 is denied.

Medical nutritional therapy procedure codes 97802, 97803, and nutritional counseling procedure code S9470 will not be reimbursed when the client is receiving PPECC services.

Refer to: Section 26.4.2, "Benefits, Limitations, and Authorization Requirements" in Chapter 26, "Medical Nutrition Services" for additional information about medical nutritional counseling services.

21.3.5.1 Prior Authorization for Medical Nutritional Counseling Services

Prior authorization is required for medical nutritional counseling services. Prior authorization must be submitted using the CSHCN Services Program Prior Authorization Request for Medical Nutritional Products Form and Instructions.

Providers are responsible for maintaining documentation to support medical necessity of nutritional counseling services in the clinical record.

21.4 Claims Information

Home health services claims must be submitted to TMHP in an approved electronic format or on a UB-04 CMS-1450 paper claim form. Providers may purchase UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a UB-04 CMS-1450 paper claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills or itemized statements are not accepted as claim supplements.

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The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the Centers for Medicare & Medicaid Services (CMS) NCCI web page for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

Refer to: Chapter 41, "TMHP Electronic Data Interchange (EDI)" for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for general information about claims filing.

Section 5.7.2.7, "Instructions for Completing the UB-04 CMS-1450 Paper Claim Form" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Services and supplies that exceed the 28-items-per-page limitation must be submitted on separate UB-04 CMS-1450 paper claim forms.

21.5 Reimbursement

Skilled nursing visits provided by home health agencies enrolled in the CSHCN Services Program must be billed in 15-minute increments.

One practicing registered nurse skilled nursing visit may be reimbursed every 30 days outside of the prior authorized visits when skilled nursing visits have been authorized for the particular client.

Skilled nursing provided in the day care or school setting will not be reimbursed.

All claims for reimbursement of procedure codes G0156 (HHA services), G0299 (RN services), and G0300 (LVN services) are based on the actual amount of billable time associated with the service. For those services in which the unit of service is 15 minutes (1 unit = 15 minutes), partial units should be rounded up or down to the nearest quarter hour.

To calculate billing units, count the total number of billable minutes for the calendar day for the client, and divide by 15 to convert to billable units of service. If the total billable minutes are not divisible by 15, the minutes are converted to one unit of service if they are greater than seven, and converted to 0 units of service if they are seven or fewer minutes.

For example: 68 total billable minutes/15 = 4 units + 8 minutes. Since the 8 minutes are more than 7 minutes, those 8 minutes are converted to one unit. Therefore, 68 total billable minutes = 5 units of service.

Time intervals for 1 through 8 units are as follows:

Units	Number of Minutes
0 units	0 minutes through 7 minutes
1 unit	8 minutes through 22 minutes
2 units	23 minutes through 37 minutes
3 units	38 minutes through 52 minutes
4 units	53 minutes through 67 minutes
5 units	68 minutes through 82 minutes

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Units	Number of Minutes
6 units	83 minutes through 97 minutes
7 units	98 minutes through 112 minutes
8 units	113 minutes through 127 minutes

Procedure codes G0156, G0299, and G0300 will be limited to 30 units per day, for any procedure, any provider. All services are reimbursed hourly.

Procedure codes S9123 and S9124 must be used when billing for extended SN services. The unit of service is hour increments.

> ***Note:*** *These codes cannot be billed in conjunction with procedure codes G0156 (Home Health Aide), G0299 (RN services), and G0300 (LVN Services) on the same day unless approved by the CSHCN Medical Director. If approved, procedure codes G0156, G0299, and G0300 will not be reimbursed on the same day.*

All claims for reimbursement of these procedure codes are based on the actual amount of billable time associated with the service. For those services in which the unit of service is 1 hour (1 unit = 1 hour), partial units should be rounded up or down to the nearest tenth of an hour.

Two medical nutritional counseling visits (procedure code S9470) may be reimbursed per rolling calendar year.

Reimbursement for mileage is not a benefit of the CSHCN Services Program.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at www.tmhp.com.

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled "Adjusted Fee" to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates/rate-changes.

> ***Note:*** *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

21.6 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

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