

NOTE: Due to the State of Minnesota's legislation, coverage for General Assistance Medical Care (GAMC) is switching from Health Plan coverage to Fee-For-Service coverage on April 1, 2010.

Chapter 24

Home Health Care Services

This chapter relates to home health services including personal care.

Definitions

Activities of Daily Living (ADL): Eating, toileting, grooming, dressing, bathing, transferring, mobility, and positioning.

Assessment: A review and evaluation of a recipient's need for home care services.

Care Plan – PDN: A written description of professional nursing services needed by the recipient as assessed to maintain and/or restore optimal health.

Fiscal Agent Option: See PCA Choice Option.

Flexible Service Use Option: When prior authorized, PCA units may be used in varying amounts over the duration of the Service Agreement. The use of service units may differ from day to day or week to week, but must only be used for covered care needs.

Health-Related Functions: Functions that can be delegated or assigned by a licensed health care professional under state law to be performed by a personal care assistant.

Home Care Agency (or Class A Agency): An agency holding a Class "A" license from the Minnesota Department of Health (MDH), authorized to provide Private Duty Nursing only. To enroll as a home health agency, the provider must be a Medicare certified home health agency.

Home Care Rating: Cost limits that establish a rating system based on the common assessed needs of individuals.

Home Care Services: Home health agency, private duty nursing, and personal care services delivered to a recipient whose illness, injury, physical, or mental condition creates a medical need for the service.

Home Health Agency (HHA): A public or private agency or organization, or part of an agency or organization, that is Medicare certified and holds a Class A home care license from the Minnesota Department of Health (MDH).

Home Health Aide (HHA): An employee of a home health agency who is certified and is supervised by a nurse.

Home Health Aide Services: Medically oriented tasks required to maintain the recipient's health or to facilitate treatment of an illness or injury. Services must be ordered by a physician and have professional supervision provided by a Medicare Certified agency.

Home Health Agency Services: Services provided by a Medicare Certified agency including skilled nursing visits, home health aide, physical, occupational, speech, and respiratory therapy.

Instrumental Activities of Daily Living (IADL): Meal planning and preparation, managing finances, shopping for food, communication by telephone and other media, getting around and participating in the community.

Licensed Practical Nurse: Must hold current licensure from the MN State Board of Nursing; Class A Licensure from MDH; and be enrolled with the Department of Human Services as an independent nurse.

Medically Necessary or Medical Necessity: A health service that is consistent with the recipient's diagnosis or condition, is recognized as the prevailing standard or current practice by the provider's peer group, and meets one of the following:

- Is rendered in response to a life-threatening condition or pain;
- To treat an injury, illness, or infection;
- To treat a condition that could result in physical or mental disability;
- To care for the mother and child through the maternity period; or
- To achieve a level of physical or mental function consistent with prevailing community standards for the diagnosis or condition.

Private-Duty Nursing Agency: An agency holding a Class A Home Care license and is enrolled with the Department of Human Services to provide private duty nursing services

Private Duty Nursing (PDN) Services: Nursing services ordered by a physician, for a recipient whose illness, injury, physical or mental condition requires more individual and continuous care by a Registered (RN) or Licensed Practical Nurse (LPN) than can be provided in a single or twice daily skilled nurse visit and requires greater skill than a Home Health Aide or Personal Care Assistant can provide.

Qualified Professional: An RN or mental health professional that is responsible for supervision of PCA services. The mental health professional must meet credentials of a licensed psychologist, licensed psychological practitioner, licensed independent clinical social worker, psychiatrist, clinical nurse specialist (mental health), or marriage and family therapist.

Registered Nurse: Must hold current licensure from the MN State Board of Nursing and be enrolled with the Department of Human Services as an independent nurse.

Residence: The place a recipient lives. A residence does not include a hospital, nursing facility, or intermediate care facility.

Shared Care Option – PDN: An option for two recipients to share the same nurse in the same setting at the same time.

Skilled Nurse Visits (SNV): Intermittent nursing services ordered by a physician for a recipient whose illness, injury, physical, or mental condition creates a need for the service. Services under the direction of a Registered Nurse are provided in the recipient's residence by an RN, or LPN; and provided under a plan of care or service plan that specifies a level of care which the nurse is qualified to provide.

Tele-Home-Care: The use of telecommunications technology by a home health care professional to deliver home health care services within the professional's scope of practice to a recipient located at a site other than the site where the practitioner is located. Tele-Home-care is currently approved for skilled nurse visits only.

Ventilator-Dependent Recipients: A ventilator-dependent recipient, means a recipient who receives mechanical ventilation for life support at least six hours per day and is expected to be or has been dependent for at least 30 consecutive days.

Covered Services

- Home Health Aide
- Private Duty Nurse
- Rehabilitation Therapies (Occupational Therapy, Physical Therapy, Respiratory Therapy, and Speech Therapy)
- Skilled Nurse Visit
- Personal Care Assistant

For members NOT on a Waiver, a prior authorization is required for:

- All home health aide services – after the 20th visit per year
- Skilled nurse - after the 20th visit per year
- All private duty nursing services – **required for all**
- Personal Care Services – **required for all**
- All tele-homecare visits-**required for all**

For members on a Waiver, prior authorization and/or notification is required before the initial visit:

- Member enrolled in the Developmental Disabilities (DD), Community Alternatives for Disabled Individuals (CADI), Community Alternatives for Children (CAC) or Traumatic Brain Injury (TBI) waiver, home care services must be authorized by the member's county waiver case manager. The county waiver case manager must fax the *DHS SNBC MCO-Lead Agency Communication Form* to MMSI specifying amount, durative, and frequency of home care services.

- Members enrolled in the Elderly Waiver (EW), all home care services must be authorized by member's South Country Health Alliance care coordinator. The member's care coordinator must fax the Waiver Notification Form (located on the SCHA Provider Resources webpage) to inform MMSI that the member is on the Elderly Waiver and home care claims should process.

Information about the authorization requirements and process can be found in the SCHA Medical Management Chapter.

Eligible Providers

- Home Health Agency
- Private Duty Nursing Agency
- Registered Nurse
- Licensed Practical Nurse

Provider requirements: Medicare certified, Minnesota Class A Licensed Home Health Agencies contracted with South Country Health Alliance.

Qualifying Services Must Be:

- provided to an eligible member;
- medically necessary;
- physician-ordered services provided to South Country Health Alliance members in their own residence, that is other than a hospital, nursing facility (NF), or intermediate care facility (ICF);
- documented in a written service plan, which is reviewed by the member's physician at least once every 60 days for home health agency or private duty nursing services, or at least once every 365 days for personal care services.

Home Health Aide Services

Home health aide services are medically oriented tasks required to maintain the member's health or to facilitate treatment of an illness or injury. Services must be ordered by a physician and have professional supervision provided by a Medicare Certified agency.

Eligible Recipients

Recipients must be eligible for services under one of the following programs:

- Medical Assistance
- Minnesota Care: Expanded Benefit Set (pregnant women and children under age 21); Basic; Basic Plus; Basic Plus One; and Basic Plus Two
- Medicare/Medicaid dual-eligible members (SeniorCare Complete or AbilityCare)
- Waivered service programs, including Elderly Waiver (EW), Developmentally Disabled (DD), Community Alternative Care (CAC), Community Alternatives for Disabled Individuals (CADI), and Traumatic Brain Injury (TBI).

NOTE: GAMC recipients are not eligible for home health aide services.

Description of Home Health Aide Services

- Assisting with personal cares such as bathing, dressing, grooming, feeding, toileting, routine catheter and colostomy care, ambulating, transfers or positioning;
- Simple dressing changes that do not require the skills of a licensed nurse;
- Assisting with medications that are ordinarily self-administered and do not require the skill of a licensed nurse to be provided safely and effectively;
- Assisting with activities that are directly supportive of skilled therapy services but do not require the skill of a therapist to be safely and effectively performed, such as routine maintenance exercises;
- Routine care of prosthetic and orthotic devices;
- Incidental household services necessary to the provision of one of the above health related services.

Home health aide visits for the sole purpose of providing household tasks, transportation, companionship, or socialization are **not covered**.

Home health aide services are normally paid on a per visit basis at a maximum of one home health aide visit per day. Medicare qualified days are paid based on the HH PPS.

Private Duty Nursing (PDN) Services

Definition

Professional nursing care based on an assessment of the recipient's medical/health care needs. This service includes ongoing professional nursing observation, monitoring, intervention, and evaluation providing the continuity, intensity, and length of time required maintaining or restoring optimal health. Professional nursing is defined in the MN Nurse Practice Act. Private Duty Nursing Services have been designated as either "Regular" or "Complex".

Complex Private Duty Nursing Care is care provided to recipients who are either ventilator- dependent **or** who require an "intensive level of care."

- **Ventilator Dependent**
A recipient is considered ventilator dependent when mechanical ventilation for life support is needed for at least six hours per day and the person is expected to be or has been dependent for at least 30 consecutive days.
- **Intensive Level of Care**
A recipient has medical needs that meet intensive level of care when the doctor's orders require complex nursing assessments and interventions that are in response to life-threatening episodes of instability. The interventions would be needed immediately based on either anticipated or unanticipated changes in the recipient's health status.

Regular Private Duty Nursing Care is nursing provided to a recipient who is not ventilator dependent and does not require an intensive level of care.

- Regular PDN assessments and interventions are needed for a recipient who is considered stable but has episodes of instability that are not immediately life threatening. Nursing observation, monitoring and assessment is needed to determine appropriate interventions that maintain or improve the recipient's health status.

Other Information

- PDN services are for recipients who need more individual and continuous skilled nursing care than can be provided in a skilled nurse visit and the care is outside the scope of services that can be provided by a home health aide or PCA.
- PDN services are provided under a plan of care or service plan approved by the physician that specifies the level of care that the nurse is qualified to provide.
- PDN services are ordered by the recipient's physician with updates as required.
- Recipients authorized to receive PDN services in their home may use approved hours outside of their home during hours when normal life activities take them outside of their home.
- Total hours of service and payment for services outside the home cannot exceed that which is otherwise allowed in an in-home setting.
- PDN services must be provided by an RN or LPN who is not the recipient's legal guardian, or related to the recipient as the spouse, parent, or foster care provider of a recipient who is under age 18 unless a hardship waiver is approved.

Eligible Recipients

- Medical Assistance recipients;
- Minnesota Care recipients who are under age 21 or pregnant women;
- Medicare/Medicaid dual-eligible members (SeniorCare Complete or AbilityCare)
- Waiver program recipients including CAC, CADI, TBI and EW.

NOTE: GAMC recipients and non-pregnant adult MinnesotaCare recipients are not eligible for PDN services. Members on AbilityCare receive Private Duty Nursing Service through the State of Minnesota Fee for Service.

Eligible Providers of PDN Services

- Enrolled home health agency;
- Enrolled PDN Class A licensed agency;
- Enrolled independent RN;
- Enrolled independent LPN with a Class A license from MDH.

Assessment for Private Duty Nursing: Complete a data collection tool such as OASIS or your agency tool and with the information collected complete the MA Private Duty Nursing Assessment (DHS 4071A). Instructions to complete the Nursing Assessment form is the MA Private Duty Nursing Assessment Instructions (DHS 4071B).

Authorization Requirements

To request authorization for PDN services, use the process described above and the DHS PDN Decision Tree (DHS 4071C). The Provider must submit the following before services are initiated:

- 1) MA Private Duty Nursing Assessment (DHS 4071A)
- 2) Physician Orders
- 3) Plan of Care (CMS 485 or DHS 4633)

The Private Duty Nursing forms listed above must be faxed to SCHA/Health Services at 1-888-889-7822.

SCHA/MMSI will fax an authorization notice to the Provider with the approved units of services and service agreement date span dates.

Ongoing Requirements for PDN authorization and documentation:

- All PDN services require prior authorization;
- PDN services require a physician order prior to initiating service;
- Review/approval of the service plan by the recipient's physician every 60 days;
- Signed orders must be on file in the recipient's chart at the provider agency's office.
- The orders or plan of care must:
 - Specify the disciplines providing care;
 - Specify the frequency and duration of all services;
 - Demonstrate the need for the services and be supported by all pertinent diagnoses;
 - Include recipient's functional level, medications, treatments, and clinical summary;
 - Be individualized based on recipient needs;
 - Have realistic goals;
 - Subsequent plans of care must show recipient response to services and progress since the previous plan was developed; and
 - Changes to the plan of care are expected if the recipient is not achieving expected care outcomes.

Long-Term Care Change: When a change in medical status exists, the provider must submit:

- Home Care Fax Form (DHS-4074)
- Completed MA Private Duty Nursing (PDN) Assessment (DHS-4071A-ENG)
- Concise current clinical update (CMS 485, CMS 486 or DHS-4633)

PDN Hardship Waiver: The PDN Hardship Waivers allows certain relatives to receive reimbursement for providing services to his/her relative who is an MA recipient. The provider agency is responsible for:

- Receiving the request from the recipient/responsible party;

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- Obtaining the relative's signature;
- Completing the request form, ensuring the accuracy of the information; and
- Submitting the form to SCHA/MMSI 1-888-889-7822.

PDN Authorization criteria: A relative hardship waiver is now available for certain persons to provide PDN services. In order to qualify for a relative hardship waiver for a PDN Hardship Waiver, at least **one** of the following criteria must be met:

- The relative resigns from a full-time or part-time job to provide personal care for the recipient;
- The relative goes from a full-time to a part-time job with less compensation to provide personal care for the recipient;
- The relative takes a leave of absence without pay to provide personal care for the recipient;
- The relative incurs substantial expenses by providing personal care for the recipient; or
- Because of labor conditions, intermittent hours of care needed, or special language needs, the relative is needed in order to provide an adequate number of qualified PCA's or PDN's to meet the needs of the recipient.

In addition, all of the following must be met:

- Services must be necessary to prevent the hospitalization of the recipient;
- The recipient is eligible for private duty nursing under one of South Country Health Alliance programs;
- In order to provide nursing care to the recipient, the parent, spouse, or guardian must meet at least one of the authorization Hardship Waiver criteria listed above.

Requesting a PDN Hardship Waiver: The PCPO/Home Health Agency provider must follow these steps:

- Complete the Hardship Waiver Request Form;
- Obtain the relative's signature; and
- Submit the hardship waiver request form along with the supporting documentation to SCHA/MMSI 1-888-889-7822.

Review of hardship waiver requests: SCHA/MMSI will review and issue a response within 30 days of receipt of the request. A relative hardship waiver can be approved for no earlier than the date that the request is received by SCHA/MMSI. Written notice of the approval or denial will be mailed to the recipient and provider. If the request is denied, the notice will contain the recipient's appeal rights and the rationale for the denial. The provider must keep this notice in the recipient's file. Approvals will be lifetime, unless SCHA/MMSI is notified that qualifying conditions have changed.

PDN Eligible Persons: Must be currently licensed in the State of Minnesota as a Registered Nurse (RN) or Licensed Practical Nurse (LPN) and is employed by an MA Medicare-Certified Home Health Agency and is:

- The parent of a recipient;
- The spouse of a recipient; or
- A non-corporate legal guardian of a recipient.

The provision of these services is not legally required of the parent, spouse or legal guardian. Services provided by a parent, spouse or guardian cannot be used in lieu of nursing services covered and available under liable third-party payers including Medicare.

Hours of service provided by the parent, spouse or guardian must be included in the recipient's service plan. Hours authorized for the parent, spouse or guardian may not exceed 50% of the total approved nursing hours or 8 hours per day, whichever is less, up to a maximum of 40 hours per week.

Provision of paid service does not preclude the parent, spouse or guardian from his/her obligations for non-reimbursed family responsibilities of emergency backup caregiver and primary caregiver.

A parent or spouse may not be paid to provide private duty nursing if they fail to pass a criminal background check or if the home health agency, the waiver case manager or the physician, determine that the care provided by the parent, spouse or guardian is unsafe.

Waivered Service Program Recipients: Recipients on waived services programs including: CAC, CADI, EW, MR/RC and TBI follow the same process and must meet the same criteria.

Shared Private Duty Nurse

This option allows two recipients to share Private Duty Nurse (PDN) services in the same setting at the same time from the same private duty nurse. All regulations pertaining to private duty nursing services also apply to the shared care option.

A setting includes:

- The home or licensed foster care home of one of the recipients;
- Outside the home or foster care home of one of the recipients when normal life activities take the recipients outside the home;
- A child care program licensed under MS 245A, or operated by a local school district or private school; or
- An adult day care service licensed under MS 245A.

PDN's Providing Shared Care: Services cannot be provided to two individuals in separate apartments in the same building, to other non-private duty nursing recipients in the setting, or replace or supplement required staff at licensed facilities.

Authorization Requirements

A recipient, or a recipient's legal representative, may select the shared care option at **anytime** during the authorization period by contacting the PDN agency. Together with the recipient's physician and the PDN agency staff, the recipient (or the legal representative) will determine:

- Whether shared care is an appropriate option based upon the needs and preferences of the recipient; and
- The number of shared care units that will be part of the overall authorization of private duty nursing services. A shared care arrangement does not reduce the total number of service units authorized for the recipient. The use of authorized service units should be divided between the shared care option and 1:1 services.

The recipient (or the recipient's legal representative) and the PDN agency will approve:

- The other recipient who is sharing the PDN services. This decision must be based on the ages of the recipients, their compatibility and the ability to coordinate their care needs; and
- The arrangement and the setting for the shared services.

PDN Agency Responsibilities: Shared care requires prior authorization. To request authorization for shared services, the PDN agency must:

- Complete the Medical Assistance (MA) Private Duty Nursing Home Care Assessment and include the number of shared hours and the number of 1:1 hours on page 4 of the Assessment; and submit to SCHA/MMSI.
- Submit the Service to SCHA/MMSI via fax 1-888-889-7822.

Waiver Program Recipients: The county case manager follows the same criteria and process to determine whether the shared care option is an appropriate and safe alternative for a recipient on a waiver. If the recipient chooses the shared care option, document the number of shared PDN service units on the recipient's waiver service plan and calculate the cost of shared care into the overall cost of service plan. Use MA home care procedure codes for PDN services to the fullest extent possible (for all medically necessary nursing services) before using extended PDN codes on waiver service agreements.

Complex Reimbursement Rates: A complex care reimbursement rate is available only when the recipient is receiving 1:1 PDN services. A complex care rate is not available when the recipient is receiving shared (1:2) PDN services. This means that a recipient

can share PDN services if they are authorized complex care, but the agency will only receive the complex rate during the hours the recipient is receiving the 1:1 services.

Changing or Discontinuing Shared PDN

The recipient or legal representative must notify the provider in writing if the recipient chooses to make a change in their shared care. Changes include:

- The number of authorized units the recipient wishes to share;
- Discontinuing participation in shared care; and
- Changing providers.

The written revocation or change must be maintained in the recipient's file.

When services are changed or discontinued, the current provider must mail or fax the completed Home Care Fax Form to SCHA/MMSI indicating the change in the number of authorized shared care or the last date of shared PDN services, and the total number of units to be designated for shared care.

Documentation Requirements

Initial Documentation: Each recipient or legal representative must sign a consent form. A copy of the form is to be included in the recipient's chart. The form includes:

- Permission for the agency to schedule shared care up to the maximum hours chosen by the recipient;
- Use of services outside the recipient's home; and
- Permission to place the recipient's name in the chart of the other recipient.

Ongoing Documentation:

- How the needs of the recipients are being appropriately and safely met;
- The setting in which the shared services will be provided;
- Ongoing monitoring and evaluation of the shared services by the PDN;
- Emergency back up plans to respond to the recipient's illness or absence or the PDN's illness or absence;
- Additional training, if needed, for the PDN to provide care to two recipients;
- The names of each recipient receiving shared private duty nursing services;
- The starting and ending times that the recipients received shared private duty nursing care; and
- Routine nursing documentation such as changes in the recipient's condition and problems that may arise due to sharing services.

Billing Requirements

The process for billing shared PDN is the same as billing for 1:1 care with the following modification:

- Use a separate line item to bill the shared (1:2) PDN units; and
- Enter a “TT” in the Modifier field.

Rehabilitation Therapies

- Occupational Therapy (OT) Procedure Code S9129
- Certified Occupational Therapy Assistant Code S9129 TF modifier
- Physical Therapy (PT) Procedure Code S9131
- Physical Therapy Assistant (PTA) Procedure Code S9131 TF modifier
- Respiratory Therapy (RT) Procedure Code S5181 and
- Speech Therapy (ST) Procedure Code S9128

Coverage

Rehabilitation Therapy procedure codes are daily, per visit codes, with the exception of Respiratory Therapy, which may be provided more than once per day.

Eligible Recipients

- MinnesotaCare recipients, Medical Assistance recipients and Medicare/Medicaid dual-eligible (SeniorCare Complete and AbilityCare) recipients. To receive payment for rehabilitation therapy, the services must be:
 - Provided in the recipient’s home;
 - Ordered by a physician;
 - Appropriate to meet the recipient’s needs;
 - Specified in the plan of care;
 - Medically necessary;
 - Provided to the recipient whose functional status is expected to progress toward or achieve the goals specified in the recipient’s plan of care within a 60-day period. (If the service is a Medicare covered service, and is provided to a recipient who is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare.);
 - Rehabilitation services cannot be covered when the recipient can reasonably access these services outside his/her residence, excluding the assessment, counseling, and education. A recipient who leaves the home at will, or a parent who could easily transport the child, must obtain these services at the rehabilitation center, and will not be eligible for home care therapies.

NOTE: GAMC recipients are not eligible for Home Care Rehabilitation.

Authorization Requirements

For member NOT enrolled in a Waiver, prior authorization is NOT needed for rehabilitation therapies.

For members on a Waiver, prior authorization and/or notification is required before the initial visit:

- Member enrolled in the Developmental Disabilities (DD), Community Alternatives for Disabled Individuals (CADI), Community Alternatives for Children (CAC) or Traumatic Brain Injury (TBI) waiver, home care services must be authorized by the member's county waiver case manager. The county waiver case manager must fax the *DHS SNBC MCO-Lead Agency Communication Form* to MMSI specifying amount, durative, and frequency of home care services.
- Members enrolled in the Elderly Waiver (EW), all home care services must be authorized by member's South Country Health Alliance care coordinator. The member's care coordinator must fax the Waiver Notification Form (located on the SCHA Provider Resources webpage) to inform MMSI that the member is on the Elderly Waiver and home care claims should process.

Eligible Providers

Therapists must be employed by a Medicare-Certified Home Health Agency enrolled with South Country Health Alliance. Services may be provided by:

- Licensed Physical Therapist;
- Registered Occupational Therapist;
- Certified Occupational Therapy Assistant;* or
- Physical Therapy Assistant.*

When services are provided by an assistant and the licensed or registered therapist is not on the premises (the recipient's home), the services are billed with a TF modifier, and the payment will be at 65% of the therapist's rate. The licensed PT or registered OT must provide in-person direction to the assistant at least every sixth visit. When a home visit is made jointly by the therapist and assistant, the provider may bill only for the therapist's visit. Providers may not bill for both the PT and PTA (or the OT and COTA) when a joint home visit is made.

Therapy Classifications

Therapies must be classified as to whether they are restorative or specialized maintenance.

Restorative therapy is a health service that is:

- Specified in the recipient's plan of care;
- Ordered by a physician; and
- Designed to restore the recipient's functional status to a level consistent with the recipient's physical or mental limitations.

Specialized Maintenance Therapy is a health service that is:

- Specified in the recipient's plan of care;

- Ordered by a physician;
- Necessary for maintaining a recipient's functional status at a level consistent with the recipient's physical or mental limitations; and
- May include treatments in addition to rehabilitative nursing services.

When billing for specialized maintenance therapies, use the XC modifier on your claim form, to differentiate these services. Home care therapy services are **not** subject to the one-time rehabilitative service thresholds.

Skilled Nurse Visits (SNV)

Definition

Skilled nurse visits: Intermittent home visits to initiate and complete professional nursing tasks based on a recipient's need for service as assessed to maintain or restore optimal health. Visits are made by a registered nurse (RN) or licensed practical nurse (LPN), employed by a Medicare certified home health agency, under the supervision of an RN.

Two visits per day can be authorized. If the necessary medical services are more complex and require more time than can be performed in a single or twice daily skilled nurse visit, private duty nursing services is an appropriate option.

Eligible Recipients

Medical Assistance recipients, Minnesota Care Expanded Benefit Set (children under age 21, and pregnant women) and Minnesota Care Basic, Basic Plus, Basic Plus One or Basic Plus Two coverage, Medicare dual eligible recipients – SeniorCare Complete and AbilityCare.

NOTE: GAMC recipients are not eligible for Home Care Services.

Eligible Providers

Medicare certified, Class A Licensed home health agencies, enrolled with South Country Health Alliance.

For member NOT enrolled in Waivered Programs, prior authorization requirements include:

- Skilled nurse services after the 20th visit per year.
- All Tele-Home-Care SNVs must be prior authorized.
- Waiver recipients require prior authorization from the county case manager.

For members on a Waiver, prior authorization and/or notification is required before the initial visit:

- Member enrolled in the Developmental Disabilities (DD), Community Alternatives for Disabled Individuals (CADI), Community Alternatives for Children (CAC) or Traumatic Brain Injury (TBI) waiver, home care services must be authorized by the member's county waiver case manager. The county waiver case manager must fax the *DHS SNBC MCO-Lead Agency Communication Form* to MMSI specifying amount, durative, and frequency of home care services.
- Members enrolled in the Elderly Waiver (EW), all home care services must be authorized by member's South Country Health Alliance care coordinator. The member's care coordinator must fax the Waiver Notification Form (located on the SCHA Provider Resources webpage) to inform MMSI that the member is on the Elderly Waiver and home care claims should process.

Covered Skilled Nursing Services

- A Skilled Nurse Visit is made according to the recipient's written plan of care or service plan, ordered by the physician, and is an accepted standard of medical and nursing practice in accordance with the Minnesota Nurse Practice Act. Equipment and supplies that are usual and customary to completing a SNV are not billable (i.e., stethoscope, nail clippers, sphygmomanometer, alcohol wipes, etc.).
- Observation, assessment, and evaluation of a person's physical or mental health status. These may be covered when the likelihood of a change in condition requires skilled nursing personnel to identify and evaluate the need for possible modification of treatment or initiation of additional medical procedures until the recipient's treatment regiment is stabilized.
- A procedure that requires substantial and specialized nursing skill such as administration of intravenous therapy, intra-muscular injections, and procedures, such as sterile catheter insertion or sterile wound cares.
- Teaching and training that requires the skills of a nurse. Examples could include: teaching self-administration of injectable medications or a complex range of medications; teaching a newly diagnosed diabetic person or caregiver on all aspects of diabetic management; teaching self-catheterization or bowel and/or bladder training.
- Postpartum visits to new mothers and their newborn infants if the mother and her newborn are discharged early from the hospital. Early discharge means less than 48 hours following a vaginal delivery or less than 96 hours following a caesarian section. Post delivery care includes a minimum of one home visits by a licensed RN. The RN must provide parent education, assistance and training in breast and bottle-feeding and conduct any necessary and appropriate clinical tests. The licensed RN must make the home visit within four days following hospital discharge. A separate plan of care is needed for the mother and newborn.
- Community health nursing visits provided by a public health agency or home health agency for the sole purpose of maternal, child, and adult health promotion

are covered when an authorized skilled nursing service is provided at the same visit.

Non-Covered Skilled Nurse Visits

Home visits made:

- For the sole purpose of supervising a home health aide or PCA. However, supervision may be done during a SNV that qualified for payment.
- For the sole purpose of monitoring medication compliance, with an established medication program for a recipient.
- For the sole purpose of monitoring a recipient's overall physical status, when the recipient's physical status has not changed and the person is considered stable.
- To set up or administer oral medications; pre-fill injections, such as insulin syringes for an adult recipient when the need can be met by an available pharmacy; or the recipient is physically and mentally able to self-administer or pre-fill a medication; or if the activity can be delegated to a family member or HHA.
- When the sole purpose of the visit is to train other home health agency workers.
- When the visit is performed in a place other than the recipient's residence.
- For Medicare evaluation or administrative nursing visits required by Medicare but not qualifying as a SNV. (These visits are an administrative expense for the Medicare certified agency and cannot be billed to South Country Health Alliance).
- By a licensed RN who makes a SNV but is employed by a Personal Care Provider Organization or non-Medicare private duty nursing agency.

ICF/MR Skilled Nurse Visits

South Country Health Alliance may authorize skilled nurse visits for fewer than 90 days for a recipient residing in an ICF/MR to prevent admission to a hospital or nursing facility, if the ICF/MR is not required to provide the nursing services. The home health agency must obtain prior authorization.

A skilled nurse may be authorized for venipuncture, if none of the above conditions can be met. Authorization requests must include full documentation in a clinical update on a CMS 485, or CMS 486.

Venipuncture as a Skilled Nurse Visit

If a SNV is needed for the purpose of performing a venipuncture from a peripheral site, the home health provider can submit a request for prior authorization if they have determined and documented:

- That there is not an available lab service that can visit the recipient's home to obtain the venipuncture from the peripheral site;
- That there is not a service reasonably available to the recipient outside of his/her place of residence; and

- The recipient no longer qualifies for Medicare Part A skilled nurse services

Tele-Home-Care

- A tele-home-care visit is a SNV that is made via live, interactive audiovisual technology between the home care nurse and the recipient. It can also be augmented by utilizing store- and-forward technologies, which is a technology that does not occur in real time via synchronous transmission and does not require a face-to-face encounter with the recipient for all, or part of any such tele-home-care visit.
- T 1030-GT is the code for home tele-health face-to-face “live” (SNV)
- A communication between the home care nurse and recipient that consists solely of a telephone conversation, facsimile, electronic mail or a consultation between two health care practitioners **is not** considered a tele-home-care visit.
- Coverage of tele-home-care is limited to one visit per week no more than 4 times per month and authorization is required for all visits.
- Home health for peripheral only (wt., pulse, oximetry, etc.) use the code 99091 (the code 99091 can be billed 4 times within the month-once per week)
Bill using Code E1399-52 for equipment used for peripheral tele-home care visit.

Personal Care Assistant Services

Definition: The assistance and support to eligible persons with disabilities and special health care needs including the elderly, who live independently in the community. Services are provided by a qualified personal care assistant (PCA) and may be provided in the person’s own home or in the community where a person may go in a typical day and included on the PCA Care Plan.

Eligibility: PCA services are available to persons covered by:

- PMAP
- MinnesotaCare Expanded Benefit - pregnant women and children under age 21
- Minnesota Senior Care Plus (MSC+)
- SeniorCare Complete

Note: PCA services are not covered for General Assistance Medical Care (GAMC) recipients or non-pregnant adults enrolled in MinnesotaCare. Members on AbilityCare receive PCA and PCA RN Supervision through the State of Minnesota Fee for Service.

Persons eligible for one of the above programs must meet the following criteria to qualify for PCA services:

- Have a stable medical condition and do not have any acute health care needs that require inpatient hospitalization but need PCA services to live in the community

- Live in their own home which is NOT a hospital, nursing facility, intermediate care facility, health facility licensed by the Minnesota Department of Health (MDH) or foster care setting where there are more than four residents
- Be able to identify their needs, direct and evaluate PCA task accomplishment and provide for their health and safety or have a responsible party that is able to do so
- Have a service plan developed with the county public health nurse (PHN) that specifies the PCA services needed

In addition, PCA services may only be provided when:

- Medically necessary
- There is a Physician Statement of Need
- Provided under the supervision of a qualified professional, the person or the Responsible Party.

Covered Services: PCA services and supports that are eligible for payment are divided into the following four broad categories:

- **Activities of daily living (ADLs):** ADLs include assistance with dressing, grooming, bathing, eating, toileting, transferring, positioning and mobility.
- **Instrumental activities of daily living (IADLs):** If the PCA assessment determines that a person has a need for assistance with ADLs, PCA services may be used for assistance with IADLs. IADLs include meal planning and preparation, managing finances, shopping for food, clothing and other essential items, completing necessary homemaking tasks, communicating by telephone and/or other media, getting around in the community and participating in community activities.
- **Health-related functions:** Through hands-on assistance, supervision and cueing that can be delegated or assigned under state law by licensed health care professionals to be performed by a PCA (health-related functions must be under the direction of a qualified professional or physician).
- **Redirection and intervention for behavior:** Redirection and intervention for behavior Includes observation and monitoring.

Required individual PCA standards

- SCHA will pay up to a maximum of 16 hours per day up to the 275 hours per month allowed for services provided by an individual PCA. (Member may have more hours, but must use a second PCA).
- Core training and training on complex needs
- Must pass a criminal background check. May be disqualified or disenrolled from frau/abusive activities and cannot work with another agency for five years.
- Supervision of individual PCAs ages 16-17 is required by the agency's qualified professional every 60 days.
- PCAs ages 16 or 17 must be employed by only one PCA provider agency.

Secondary Information: The PCA program has two methods of using PCA Service hours/units:

- **Standard PCA:** PCA service hours/units are authorized to be used on a daily average allocation with flexibility only **within** each month. PCA hours **do not** transfer from month to month.
 - Two line item date spans are required for Service Agreements that exceed six months in length. The consumer or responsible party and the PCA provider are required to monitor use of PCA service hours/units.
- **Flexible use of PCA hours:** PCA service hours/units are authorized to be used flexibly within two six-month date spans.

Provider Standards and Qualifications:

- Providers who own or control the living arrangements of a PCA recipient whether licensed or unlicensed and are not related by blood, marriage or adoption cannot receive payment to provide the PCA service for the recipient.
- Agencies cannot receive payment for PCA services if the services are provided by the paid legal guardian, stepparent of a minor, staff of a residential setting or licensed family foster care holders, except as defined in statute.
- All newly enrolled PCA provider agencies will need to submit prescribed documentation with their enrollment application and agreement, (bond of \$50,000, fidelity bond coverage, Worker's Compensation insurance coverage, policy and procedures, tic.)
- Information must be submitted on an annual basis.

There are three types of providers that can provide PCA services.

- **Personal care provider organization (PCPO):** Provides the traditional services of recruiting and hiring staff, training and orientation, scheduling, collecting time cards, financial management and termination of staff, if needed.
- **Medicare-certified home health agency (HHA):** A private or public organization that provides skilled nurse visits, home health aide visits, therapies and medical supplies. A home health agency is required to meet all federal and state conditions of participation and sign an agreement with Medicare and Medicaid to furnish home health services according to a plan of care for a person.
- **PCA Choice provider:** Serves in a fiscal intermediary role with the person and their staff and for financial management tasks.

Request an Assessment/Reassessment: Contact the county PHN to request an assessment before providing service.

- Provide a care plan indicating an immediate need for service, if needed.
- Use the MA Health Status Assessment Referral for PCA Services [DHS-3244P](#) for your PCA assessment request form.

Face-to-Face Assessment: The county PHN may conduct up to two face-to-face assessments per recipient per calendar year without prior authorization when one of the following situations is present:

- A recipient is requesting PCA services for the first time;
- A recipient's condition changes significantly;
- PCA services change(s) is needed; or
- A recipient is using PCA Choice

The county PHN or certified PHN under contract with the county must:

- Complete the assessment within 30 days of request;
- Conduct all assessments for PCA services;
- Conduct service updates, and temporary service increase requests for PCA services;
- Provide information about options available in the PCA program;
- Develop a service plan appropriate to the recipient's needs;
- Recommend and provide referral information about other services as appropriate;
- Assist the recipient in identifying the most appropriate professional (if selected) to supervise the PCA;
- Recommend the necessary amount of PCA services and supervision of PCA services (if selected) to MCO, including requests for temporary service authorizations and temporary service increases;
- Provide the recipient or responsible party with a list of enrolled PCPOs and PCA Choice providers, if requested.

A county PHN agency that is also a provider of PCA services cannot conduct assessments for its own PCA recipients. These county agencies must contract with one of the following:

- Another PHN agency
- An independent certified PHN either:
 - Not employed by or under contract with the county agency
 - Not under contract with an enrolled PCPO to conduct the assessment and reassessment

An assessment must include the MA Health Status Assessment and Service Plan (DHS-3244) and any additional documentation as necessary to substantiate services.

Authorization Requirements: The County Public Health Nurse (PHN) submits the recommendation for PCA units and service agreement span dates to SCHA/MMSI Health Services within 30 days after receiving the referral for PCA services.

The PHN must fax the following documents to SCHA/MMSI Health Services at 1-888-889-7822:

- MA Health Status Assessment and Service Plan (DHS-3244)

- Any additional documentation as necessary to substantiate services (i.e. Level 1 behavior documentation).

SCHA/MMSI will fax an authorization notice to the Provider with the approved units of service and service agreement date span dates.

Request Long-Term Care Authorization/Reassessment: To request long-term authorization (a re-assessment), the PCA Organization completes and sends the MA Health Status Assessment Referral for PCA Services form (DHS-3244P) to the recipient's County Public Health Department or Case Manager **60 days** before the end of the current Service Agreement.

Temporary Change: When a change in medical status exists, the PHN conducts the temporary service increase by telephone with the provider's qualified professional (QP), the recipient, responsible party, or other health care professional.

The PHN recommends to SCHA/MMSI Health Services the increased units of PCA and/or QP units using the PCA Request Form (DHS 4292) and may bill for the temporary service increase assessment for PCA. The temporary service increase remains in effect for 45 days. If a recipient requests services to continue beyond 45 days, the county PHN must conduct a new face-to-face assessment for a permanent increase in service.

To request authorization for the temporary service increase the PHN must fax the PCA Request Form (DHS 4292) to SCHA/MMSI Health Services at 1-888-889-7822. SCHA/MMSI will fax a service authorization notice to the Provider with the temporary increase in units and authorized date span.

Long-Term Change in Services: When a change in medical status exists, the PCA organization must contact the county PHN for a new face to face assessment. The PHN will use the PCA Request Fax Form to submit new assessment information to SCHA/MMSI Health Services. SCHA/MMSI Health Services will prorate the PCA service hours/units based on the amount of the increase and the amount of the PCA service hours/units already used under the flexible use plan if the same home care rating applies.

- If the consumer has exhausted the previously authorized amount of PCA service hours/units, only the approved increase in PCA service hours/units will be added to the SA
- If there is a change in the home care rating, SCHA/MMSI Health Services will prorate PCA service hours/units as appropriate for the new SA

Prior to the end of the existing SA, the PHN may either conduct a second face-to-face assessment or submit a Home Care Service Update (DHS 3244B) if the person's condition is unchanged.

The PCA Provider is required to obtain a new Physician Statement of Need before they bill DHS for any increase in PCA service hours/units.

Change of Responsible Party: To notify SCHA/MMSI Health Services of a change in the recipient's responsible party, the PCA provider currently authorized to provide services can fax the MA Home Care Fax Form (DHS-4074) to SCHA/MMSI Health Services at 1-888-889-7822.

The PCA provider enters a comment in section 7 of the Home Care Fax Form - Treatment Plan/Change Request to indicate there has been a change in the responsible party and name the new responsible party.

The Responsible party currently listed or the PHN may also notify SCHA/MMSI Health Services of the change in the recipient's responsible party.

PCA Hardship Waiver: The need to apply for the PCA Hardship Waiver to provide PCA services has been repealed. Parents of adult recipients and adult children or siblings of a recipient may now provide PCA services to a family member without applying for a PCA Hardship Waiver, if they meet the criteria to work as a PCA. Family members who may **not** serve as the PCA:

- spouse,
- parent of a minor child, and
- responsible party.

Combination PCA and Other Home Care Services

PCA combinations are service authorizations that include one or more of the following South Country Health Alliance fee-for-services: Skilled Nursing (SNV), Home Health Aide (HHA), and/or Private Duty Nursing (PDN), along with Personal Care Assistant (PCA) services. Home care services must be medically necessary and cost effective. The home care rating determines the maximum dollar amount that can be authorized for all home care services. See PDN and PCA decision trees for further information.

Hospice Elected While Under an Approved Home Care Service Agreement

Covered Services

The hospice benefit includes coverage for the following services, when provided directly in response to the terminal illness:

- Physician services
- Nursing services
- Medical social services
- Counseling

- Medical supplies and equipment
- Outpatient drugs for symptom and pain control
- Dietary and other counseling
- Short-term inpatient care
- Respite care
- Home health aide and homemaker services
- Physical, occupational and speech therapy
- Volunteers
- Other items and services included in the plan of care that are otherwise covered medical services

Eligible recipients

- MSHO – SeniorCare Complete - Hospice services are paid through Fee For Service Medicare.
- SNBC – AbilityCare – for members that are dual eligible with Medicare and Medical Assistance - Hospice services are paid through Fee For Service Medicare.
- MSC+ - for members that are dual eligible with Medicare and Medical Assistance - Hospice services are paid through Fee For Service Medicare.
- For SCHA members on PMAP, MSC+ and AbilityCare and do not have Medicare and reside in the nursing home, hospice services are paid through Fee For Service Minnesota Department of Human Services.
- For SCHA members on PMAP, MSC+ and AbilityCare who do not have Medicare and reside in the community, hospice services are paid through SCHA.

The Hospice benefit is:

- A comprehensive package of services offering palliative care support to terminally ill individuals and their families.
- Is designed to supplement the care provided by primary care givers such as family (as the patient defines family), friends and neighbors.
- Is NOT intended to replace the supportive services provided by primary caregivers.
- Is NOT intended to duplicate health services or supports that relate to a pre-existing condition. Example: A home care service or supply is required for a

condition **unrelated** to the terminal condition (e.g. quadriplegia, schizophrenia, cerebral palsy) and does not supplant or duplicate the covered hospice benefit.

- Is NOT intended to cover medical needs that arise during the period of the Hospice Benefit that are unrelated to the terminal illness.

Generally, the determination about whether a service duplicates a Hospice Benefit service will be made as part of the hospice provider's general responsibility to provide care coordination. The hospice care coordinator assumes the lead responsibility for collaborating with the county case manager, home care agency, physician, or other providers providing the services that are outside of the Hospice benefit.

Individualized Educational Plan (IEP)

Covered IEP services include nursing services, personal care assistants (PCA), physical therapy, occupational therapy, speech language pathology, mental health services, special transportation, and assistive technology devices.

The child may also be receiving these services through MA and/or a home and community-based services waiver. When services are provided through the school, they are considered IEP services and billed as such. IEP services are not considered or billed as home care, therapy or waiver services.

Coordination of IEP services and home care services are assessed on a 24-hour non-school day. A parent/guardian may choose to use authorized home care or waiver services in the school rather than have the school bill for the education plan service:

- Services must be listed in the child's IEP/IFSP/IIIP; and
- Permission must be given by the parent/guardian in the care plan and retained by the provider in their records.

The education plan services do not count against the prior authorization cap for home care services, will not be counted against the waiver cap or affect the amount of services available under the waiver and are not counted against DHS service limitations or thresholds for therapies. The education plan team and the home care provider or waiver case manager are responsible to coordinate and not duplicate services.

Information for All South Country Health Alliance Home Care Providers

Getting Started

- Obtain all health insurance coverage information.
- Verify recipient eligibility online through MN-ITS or by calling the phone eligibility verification line at (651) 282-5354 or 1-800-657-3613.
- If the recipient is eligible for a waiver, contact the recipient's county case manager or lead agency.

- If the recipient is South Country Health Alliance eligible without a waiver, home health agencies are responsible for obtaining prior authorization through Medical Services at SCHA/MMSI.

Bill Medicare and other insurance before billing South Country Health Alliance.

Authorization Guidelines for members NOT enrolled in a Waiver program:

- Home health aide services – after the 20th visit per year for members not receiving CADI, CAC, TBI or DD Waiver services.
- Private duty nursing services- authorization **required for all**
- Skilled nurse - after the 20th visit per year for members not receiving CADI, CAC, TBI or DD Waiver services.
- All tele-home-care visits-**required for all**
- More than two face-to-face PCA assessment visits conducted by the county PHN, per recipient, per calendar year;
- More than one service update assessment visit by the county PHN per recipient, per calendar year; and All PCA services and supervision of PCA services.

Prior authorization requests are submitted directly to SCHA/MMSI by the provider agency.

For members on a Waiver, prior authorization and/or notification is required before the initial visit:

- Member enrolled in the Developmental Disabilities (DD), Community Alternatives for Disabled Individuals (CADI), Community Alternatives for Children (CAC) or Traumatic Brain Injury (TBI) waiver, home care services must be authorized by the member's county waiver case manager. The county waiver case manager must fax the *DHS SNBC MCO-Lead Agency Communication Form* to MMSI specifying amount, durative, and frequency of home care services.
- Members enrolled in the Elderly Waiver (EW), all home care services must be authorized by member's South Country Health Alliance care coordinator. The member's care coordinator must fax the Waiver Notification Form (located on the SCHA Provider Resources webpage) to inform MMSI that the member is on the Elderly Waiver and home care claims should process.

Temporary Initial Authorization

Temporary requests are for services up to 45 days in length.

SNV, HHA, and PDN

To request temporary initial authorization, complete and fax the Home Care Fax Form (DHS- 4074) to SCHA/MMSI Fax: (888) 889-7822

Long-Term Initial Authorization

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Long-term initial authorization requests are for services that are expected to be provided for more than 45 days. Request long-term authorization for up to 365/366 days.

SNV and HHA

To request long-term SNV or HHA services, submit the following (see fax and address above) within 20 working days of the first home visit:

- Plan of Treatment (CMS 485 or DHS-4633);
- Current clinical summary (CMS 485, CMS 486, DHS-4633 or nurses notes);

Temporary Continuing Authorization

Temporary continuing authorizations are only for requests when a discharge is anticipated. There is **NO** grace period for continuing requests.

SNV, HHA, and PDN

To request a continuing authorization, before the current SA ends, submit the Home Care Fax form (DHS-3070) to (888) 889-7822.

Long-Term Continuing Authorization

Long-term continuing service authorizations are for recipients that require ongoing care.

SNV, HHA, and PDN

To request long-term SNV, HHA or PDN services, submit the:

- Updated Plan of Care (CMS 485 or DHS-4633);
- Concise current clinical update (CMS 485, 486 or DHS-4633);

Changes in Medical Status or Primary Caregiver Availability

Changes in medical status include, but are not limited to:

- Change in health;
- Change in level of care;
- Addition of service(s);
- Change in physician orders;
- Change in living arrangement (i.e., recent facility placement); and/or
- Change in primary caregiver's availability.

Changes are temporary (45 days or less) or long-term (up to 365/366 days). (DHS cannot approve back to back temporary requests.) Documentation **must** support the requested change in service.

SNV, HHA, and PDN – Temporary Change

When a change in medical status exists, the provider must fax the Home Care Fax Form (DHS- 4074) SCHA/MMSI at (888) 889-7822.

SNV and HHA – Long-Term Change

When a change in medical status exists, the provider must submit:

- Home Care Fax Form (DHS-4074);
- Updated Plan of Treatment (CMS 485 or DHS-4633);
- Concise current clinical update (CMS 485, CMS 486 or DHS-4633); and

Combination of Services

PCA combinations are service authorizations that include PCA and one or more of the following:

- SNV
- HHA
- PDN

Home care services must be medically necessary and cost effective. The home care rating determines the maximum dollar amount that can be authorized for all home care services. See PDN and PCA decision trees for further information.

Multiple Providers of Services

Service authorization can be issued to more than one provider agency at the same time. Each provider agency must receive its own authorization. Each provider agency can bill for the same type of service on the same day.

- Daily codes (i.e., PDN and Rehabilitation Therapies) must be billed in consecutive date spans only, to avoid duplicative billing;
- 15-minute codes may be billed by more than one provider, per date of service.
- Each provider must submit the Home Care Fax form (DHS-4074), indicating:
 - All provider names and numbers;
 - Dates of service for each provider; and
 - The number of units to be used by each provider.

Recipients using the PCA Choice Option cannot use more than one PCA Choice Provider or use a PCPO along with a PCA Choice Provider.

Change in Provider

A recipient may change services delivery from one provider to another provider.

Discontinuing Provider

To discontinue using a provider, fax the Home Care Fax Form (DHS-4074) to (888) 889-7822 with the following information:

- Member ID#;
- Service agreement number being adjusted;
- Provider ID# of agency discontinuing services, last date of service with agency discontinuing services;
- Last date of service with agency discontinuing services; and
- Total units to be transferred to the new agency.

Initiating New Provider

To begin using a new provider, fax the Home Care Fax Form (DHS-4074) to (888) 889-7822 with the following information:

- Member ID#;
- Service agreement number being adjusted (if available);
- Provider ID# of agency beginning services; and
- Date services will begin with the new agency.

In the event the discontinuing provider does not submit the Home Care Fax Form release, the recipient, responsible party or legal guardian must provide a signed written statement indicating the last date of service, and the name of the new provider agency. Provide a copy to the provider agency terminating and initiating services.

Change in Living Arrangement

Admission to a Facility

When a recipient is admitted to a facility, the provider must submit the Home Care Fax Form (DHS-4074) to (888) 889-7822 indicating:

- The last date service was provided; and
- The total number of units provided up to that date.

Discharge from a Facility to the Community

When a recipient is discharged from a facility into the community, the provider must submit the Home Care Fax Form (DHS-4074) to (888) 889-7822 indicating:

- The first date service will be reinstated; and
- The total number of units requested.

Change in Recipient ID/PMI Number

When a recipient's ID/PMI number changes, the provider must submit the completed Home Care Fax Form (DHS-4074) to (888) 889-7822 indicating the:

- Previous PMI number;
- Previous name;
- New PMI number;

- New name;
- Birth date; and
- Date of change to the new PMI number.

Temporary PMAP Disenrollment

When a recipient is dis-enrolled from a PMAP health plan, PCA providers must contact DHS directly within 30 calendar days to request authorization, so that services for the recipient can continue and fee-for-service payment is made to the PCA provider.

If the recipient is not re-enrolled in Managed Care Organization (MCO) within 60 days of the disenrollment, immediately request a PCA assessment from the county PHN.

Technical Change/Correction

Technical changes/corrections include, but are not limited to, incorrect:

- Provider name/ID#;
- Recipient name/date of birth;
- HCPCS code/units/rate; or
- ICD-9 codes.

Submit the correct information on the Home Care Fax Form and use the Comments section to explain why the correction is being requested.

SNV, HHA, and PDN

When a change or correction is need for SNV, HHA, and PDN services, the provider must submit the completed Home Care Fax Form (DHS-4074) to (888) 889-7822:

- Stating the correct information, and
- Documenting in the comments section the reason the correction is being requested.

Recovery of Excessive Payments

SCHA/MMSI will seek monetary recovery from home care providers who exceed coverage and payment limits. This does not apply to services provided to a recipient at the previously authorized level pending an appeal.

Non-covered Home Care Services

- Services provided to GAMC recipients;
- PDN or PCA services provided to Minnesota Care non-pregnant recipients;
- Services provided to a person who is not an eligible SCHA recipient;
- Services provided by a provider that is not enrolled or does not have a valid provider agreement with South Country Health Alliance;
- Services that are not ordered by the recipient's physician;
- Services that are not specified in the recipient's service plan or care plan;
- Services provided without authorization from SCHA/MMSI when required;

- Services that have already been paid by Medicare, health plans, health insurance policies, or any other liable third party at more than the South Country Health Alliance allowable amount;
- Services to other members of the recipient's household;
- Home care services included in the daily rate of a community-based residential facility where the recipient is residing;
- Services that are the responsibility of the foster care provider under the terms of the foster care placement agreement and administrative rules; and
- Services provided when the number of foster care residents is greater than four (unless the county responsible for the recipient's foster placement made prior to April 1, 1992, requests that home care service be provided, and county or state case management is provided).

Billing South Country Health Alliance - Order of Payers

SCHA pays for services after the recipient has used all other sources of payment. SCHA is the payer of last resort. The order of payers for a South Country Health Alliance recipient is:

- Third party payers or primary payers to Medicare (e.g., large and small group health plans, private health plans, group health plans covering the beneficiary with End Stage Renal Disease for the first 18 months, workers compensation law or plan, no-fault or liability insurance policy or plan);
- Medicare;
- South Country Health Alliance Medical Assistance, General Assistance, MinnesotaCare; and
- Dual Eligible programs – (MSHO) SeniorCare Complete or (SNBC) AbilityCare

Providers must bill all third party payers, including Medicare, and receive payment to the fullest extent possible before billing. South Country Health Alliance becomes the payer only after all other pay options (other than an MA waiver program) have been exhausted. Services that could have been paid by Medicare, an HMO, or insurance plan, if applicable rules were followed, are not covered by South Country Health Alliance.

Providers must be familiar with Medicare coverage for home care recipient. Billing Medicare when Medicare is liable for the service or, if the provider is not Medicare certified, referring the recipient to a Medicare certified provider of the recipient's choice, and notifying recipients when Medicare is no longer the liable payer for home care services.

Billing/Claim submission

For AbilityCare and SeniorCare Complete, Medicare criteria are utilized in order to determine whether the services will be covered under the Medicare payment methodology/benefits. Services not meeting the criteria will then be evaluated per

Medicaid guidelines for possible reimbursement under the Medicaid payment guidelines/benefits.

- Home care services (SNV, HHA and therapies) require a Prior Authorization after the 20th visit per calendar year. The Prior Authorization process will be initiated via the home health agency.
- Exception: Home Care services rendered in conjunction with Elderly Waiver do not require a prior authorization. The care coordinator or county case manager must notify SCHA/MMSI when the member becomes effective for EW services.
- Nursing services and applicable DME/Medical Supplies can be submitted on a single UB-04 (837I) claim. Include the appropriate revenue code and HCPCS code for the supplies being provided.
- South Country Health Alliance contracts with MMSI for claims processing. Professional and institutional claims should be sent electronically to MMSI. Payer ID# 41154.
- For Medicare Services: Home care providers should complete the OASIS and bill on the HIPAA 837I claims transaction using Medicare guidelines, as appropriate. The following billing cycle should be used for all Medicare claims:
- Request for Anticipated Payment (RAP): Bill the RAP to open the Home Health episode. The RAP is submitted only after all four of the following conditions are met:
 - 1) After the OASIS assessment is completed.
 - 2) Once the physician's verbal orders for home care have been received and documented;
 - 3) A plan of care has been established and transmitted to the physician; and
 - 4) The first visit under the plan has been delivered.
- The RAP should be submitted with Type of Bill (TOB) 322. Begin and end dates on the claim should reflect the initial DOS. One revenue code is required; use revenue code 0023, with the HIPPS code in FL 44. The corresponding PPS rate, as determined via the OASIS, should be listed as the billed charge. Include the admit type and CBSA code in the appropriate fields.
- HH PPS claim: Bill the claim for the episode at the end of the 60-day period for the remaining split percentage payment. The HH PPS claim should be submitted with Type of Bill (TOB) 329. Begin date of service should reflect the initial DOS for the episode. The end date should reflect the last date of the episode. Use revenue code 0023 for the final episode with the HIPPS code in FL 44. Include \$0.00 in the charge field corresponding with the 0023. In addition to 0023,

itemize each service rendered during the episode, with the appropriate CPT/HCPCS, DOS and billed charge. Include the admit type and CBSA code in the appropriate fields.

- For Medicaid services: Billed charges should reflect the amount being submitted to SCHA/MMSI for PMAP and MNCare. Claims should be itemized and submitted with the appropriate CPT/HCPCS and DOS. Services must be billed on the 837I using the appropriate MA home health care qualifying HCPCS codes
- Services provided to members on dual eligible programs (SeniorCare Complete – MSHO and AbilityCare – SNBC) when the home health services does not meet criteria to be covered under the Medicare Benefit must be submitted using the MA home health care qualifying HCPCS codes, now eligible under the Medicaid benefit.
- SCHA/MMSI will use the following entities as the standard:
 - Carrier/Part B: Wisconsin Physician Services (WPS) Medicare Review System
 - DMERC, Region B, AdminaStar Federal
 - Intermediary/Part A: Noridian Administrative Services (NAS)
- Per the Medicare claims processing manual, “If a beneficiary under fee for service home care elects Medicare Advantage organization during a HH PPS episode, the episode will end and be proportionally paid according to its shortened length (a partial episode payment (PEP) adjustment). The MA organization becomes the primary payer upon the MA organization enrollment date.”
- The provider should first seek an adjustment PEP payment from Medicare. Once this has occurred, the claim should be submitted to SCHA/MMSI, along with the statement showing Medicare’s payment for service. SCHA/MMSI will then issue the remaining payment due.

PCA Claim submission

- Claims must be submitted electronically using the 837P claim format.
- SCHA will seek monetary recovery for PCA providers that exceed 275 hours per month
- Only one PCA provider per claim. Claims submitted with multiple PCA providers on the claim will be returned to provider.
- Only on service date per line. **No date spans allowed for PCA services.**

- PCA RN Supervision services are to be billed on a separate claim.
- Claims billed with HCPCS - T1019 (PCA Services) - (no modifier) require the UMPI in Box 24J or electronic equivalent.
- PCA providers must be enrolled and active with DHS. SCHA/MMSI will verify enrollment of PCA provider via MN-ITS before payment will be made if provider is not enrolled with DHS the claim will be denied.
- PCA agencies NPI is required on all PCA RN Supervision – (T1019 code and UA modifier) claims.
- Claims billed in the 837I format will be denied.

DHS Internet Forms Available

MA Health Status Assessment (DHS-3244)
 Home Care Service Plan (DHS-3244A)
 Service Agreement (DHS-3070)
 Payer Determination Form (DHS-3273)
 Home Care Service Update (DHS-3244B)
 Personal Care Decision Tree (MS-0520B)
 Private Duty Nurse Decision Tree (DHS-4071C)
 MA Private Duty Nursing (PDN) Assessment (DHS-4071A)
 Home Care Fax Form
 Hardship Waiver Form – PCN and PDN
 Shared PDN Consent Form

Forms Available from CMS or Office Supplier

Home Health Certification and Plan of Treatment (CMS-485 and 486);

Telephone Numbers

Provider Help Desk (800) 995-4543