# Chapter 24

# Home Health Care Services/Hospice Services

**NOTE:** *Please review the following detail for specific processes and expectations with South Country Health Alliance (South Country). South Country may vary from the MHCP Manual and Minnesota Department of Human Services Guidelines. For additional detail on this chapter, please go to the Minnesota Health Care Programs Provider Manual at* MHCP Provider Manual.

**Billing Information** – Please review the South Country Provider Manual Chapter 4 Provider Billing for general billing processes and procedures.

This chapter relates to home health care services.

## Definitions

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

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

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

**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 Home Care Nursing only. To enroll as a home health agency, the provider must be a Medicare certified home health agency.

**Home Care Agency:** A home health agency delivers health services specified in MN Rules part 9505.0295 and MN Stat. sec. 256B.0651 and MN Stat. sec. 256B.0653. These services are delivered at home to recovering, disabled, and chronically or terminally ill members. They may have medical, nursing, social, therapeutic, and treatment needs and/or assistance with the essential ADL. Home health care may be provided in a place or residence including, but not limited to, the following: single family home, apartment, assisted living, adult foster home, adult day care, a relative's home, or congregate housing residence. Home health care is not usually provided in an institutional setting such as a long-term care facility (LTCF) or hospital, unless an arrangement has been made for HCN (see Home Care Nursing [HCN] section) by the member or family. Home health care providers in the State of Minnesota must be licensed by the Minnesota Department of Health (MDH) as at least one of the following in order to provide services. Only those providing home management tasks (driving, shopping) are registered rather than licensed.

A home care agency may have a basic or comprehensive Home Care license.

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

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

Home Care Nursing (HCN): HCN are nursing services that a physician orders for a member whose illness, injury, physical or mental condition requires more individual and continuous care by a registered nurse (RN) or licensed practical nurse (LPN) than can be provided in a single or twice-daily skilled nurse visit and that requires greater skill than a Home Health Aide (HHA) or Personal Care Assistant (PCA) can provide.

**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 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.

**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 (LPN):** 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 member's diagnosis or condition and is:

1. Recognized as the prevailing medical community standard or current practice by the provider's peer group; and
2. Rendered in response to a life-threatening condition or pain; or to treat an injury, illness, or infection; or to treat a condition that could result in physical or mental disability; or to care for the mother and child through the maternity period; or to achieve community standards for diagnosis or condition; or
3. Is a preventive health service as defined in MN Rules part 9505.0355.

**Home Care Nursing (HCN) Services:** Nursing services ordered by a physician, advance practice RN or physician assistant for a member 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 (SNV) and requires greater skill than a Home Health Aide or Personal Care Assistant can provide.

**Qualified Professional:** A professional providing training, supervision, and evaluation of PCA services and staff. A QP must be one of the following:

1. RN as defined in MN Stat. secs. 148.171 – 148.285
2. Licensed social worker as defined in MN Stat. sec. 148E.055
3. Mental health professional as defined in MN Stat. sec. 245.462, subd. 18, or MN Stat. sec. 245.4871, subd. 27
4. Qualified developmental disability (DD) specialist under MN Stat. sec. 245B.07, subd. 4

**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 where a member lives/resides. A residence does not include a hospital, nursing facility, or intermediate care facility (ICF-DD).

**Shared Care Option – HCN:** An option for two members 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 member 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 member'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 member located at a site other than the site where the practitioner is located. Tele-Home-care is currently approved for skilled nurse visits (SNV) only.

**Ventilator-Dependent Members:** A member who receives mechanical ventilation for life support at least six (6) hours per day and is expected to be or has been dependent for at least thirty (30) consecutive days.

## Home Care Services:

### *Covered Services:*

- Home Health Aide (HHA)
- Home Care Nursing (HCN)
- Home Care Therapies (Occupational Therapy, Physical Therapy, Respiratory Therapy, and Speech Therapy)
- Skilled Nurse Visit (SNV)

For a member to be eligible to receive home health services covered under the Medicare benefit, the law requires that a health care provider certify in all cases that the member is confined to his/her home. A member shall be considered "confined to the home" (homebound) if *one criterion from Criteria Group One is met and both criteria from Criteria Group Two are met.*

Criteria Group One

The member must either:

1.) Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave his/her place of residence; ***or***

2.) Have a condition such that leaving his/her home is medically contraindicated.

If the member meets one of the Criteria One conditions, the member must ***also*** meet ***both*** requirements defined in Criteria Group Two below.

Criteria Group Two

1.) The member must have a normal inability to leave home; and

2.) Leaving home must require a considerable and taxing effort. If the member does, in fact, leave the home, the member may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive health care treatment. Absences attributable to the need to receive health care treatment include, but are not limited to, the following:

a,) Attendance at adult day centers to receive medical care

b.) Ongoing receipt of outpatient kidney dialysis

c.) The receipt of outpatient chemotherapy or radiation therapy

### *Eligible Providers*

Eligible providers must be enrolled with MHCP and categorized as one or more of the following:

- Medicare-certified home health agencies with a comprehensive homecare license
- Comprehensive homecare licensed home care nursing agency
- Independent registered nurse (RN)
- Independent licensed practical nurse (LPN) with a comprehensive homecare license
- Independent LPN who can attest to all statements on the Home Care Nurse – Individual LPN or RN Applicant Assurance Statement (DHS-7099) (PDF)

### *Provider Requirements*

The eligible provider must:

- Verify South Country Health Alliance enrollment/eligibility for each member each month.
- Maintain qualifying documentation in the member's file (health service record) at the provider's office of a face-to-face encounter as specified in Minnesota Statute § 256B.0653, subd. 7. This includes: an encounter with a physician, advanced practice nurse, or physician assistant; the visit must be related to the primary reason the member requires home health services and must occur within the ninety (90) days before or the thirty (30) days after the start of home care services. The encounter/visit may occur through telemedicine. The provider must submit the qualifying documentation to South Country upon request.
- Maintain signed physician's orders in each member's file at the provider's office.
- Follow additional provider requirements outlined under each covered service.

### *Multiple Providers of Services*

Service authorization can be issued to more than one provider agency at the same time. Each provider agency receives a separate service authorization. Each provider agency may be able to bill for the same type of service on the same day. Each agency must have an approved line item on the Service Agreement and:

- Services must only be billed in consecutive date spans to avoid duplicate billing.
- 15-minute codes may be billed by more than one provider, per date of service.

### *Eligible Members (verify through MN-ITs)*

- Medical Assistance/Prepaid Medical Assistance Program (PMAP)
- MinnesotaCare (Benefit Sets differ depending on the service)

### *Alternative Care Program or Waiver Programs Qualifying Services Must Be:*

- provided to an eligible member;
- medically necessary;
- physician-ordered services. Advance practice registered nurse (APRN) or physician assistant (PA) are allowed to order home care services.

- provided to South Country Health Alliance members in their own residence or in the community where normal life activities take the member
- documented in a written care plan

## Face-to-Face Visits

All home health services require a start of service face-to-face visit, regardless of the need for prior authorization. This applies to fee-for-service, MA waivers, Alternative Care (AC) and the nine skilled nursing visits per year that do not require prior authorization.

Services include home health aide visits and home care therapies. Home care therapies are occupational, physical, respiratory and speech languages therapies.

Exception: Skilled nurse visits provided for a onetime perinatal visit do not require the face-to-face visit.

A face-to-face visit can occur through telehealth.

At the start of home health services, a face-to-face visit must:

- Be for the primary reason the person requires home health services
- Occur within 90 days before or 30 days after the start of services
- Be completed by a qualified provider

If a qualified provider other than the physician completes the start of service face-to-face visit, he or she must send or transmit their documentation to the physician including clinical findings.

**The practitioner ordering the home health services must document the following:**

- All clinical findings of the face-to-face visit are included in the person's medical record
- The correlation between the face-to-face visit and the associated home health services
- The face-to-face visit occurred within the required timelines
- The practitioner who completed the face-to-face visit and the date of the visit

**Home health agencies must do the following:**

- Retain the required documentation as part of the person's medical record
- Bill only when the required documentation is part of the person's medical record
- Submit the required documentation to South Country or designee upon request

## Home Care and Individualized Educational Program (IEP)

Covered Individualized Education Program (IEP) services include nursing services, personal care assistance (PCA), physical therapy, occupational therapy, speech language pathology, mental health services, specialized transportation, and assistive technology devices.

The child may also be receiving these services through Medical Assistance (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 program 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; and
- The IEP services do not count against the prior authorization cap for home care services and are not counted against service limitations of thresholds for therapies; and
- The IEP team and home care program are responsible to coordinate and not duplicate services.

### *Non-Covered Home Care Services:*

- Services that are not ordered by the member's physician, APRN or PA.
- Services that are not specified in the member's service plan or care plan.
- Services provided without authorization when required.
- Services that have already been paid by Medicare, other health plans, health insurance policies, or any other liable third party at more than the Medical Assistance allowable amount.
- HCN or PCA services provided to MinnesotaCare non-pregnant recipients or Minnesota Care Members over age 18.
- Services to other persons of the member'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.

HCN and PCA services provided when the number of foster care residents is greater than six, unless conditions are met for granting a variance for a sibling group

Home health agency services without the required documentation of a face-to-face visitThere may be additional non-covered services outlined under each provider-type specific covered services page.

## Plan of Care

The Home Care Nurse (HCN) Care Plan is a written description of professional nursing services needed by the member as assessed to maintain and/or restore optimal health.

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 member's functional level, medications, treatments, and clinical summary
- Be individualized based on member's needs
- Have realistic goals
- Subsequent plans of care must show member response to services and progress since the previous plan was developed; and
- Changes to the plan of care are expected if the member is not achieving expected care outcomes.

## Home Health Aide (HHA) Services

Home Health Aide services are medically oriented tasks to maintain the member's health or to facilitate treatment of an illness or injury provided in a person's/member's place of residence. Services must be ordered by a physician, APRN, or PA and have professional supervision provided by a Medicare Certified agency.

### *Eligible Members:*

Members must be eligible under one of the following programs:

- Medical Assistance
- MinnesotaCare: Expanded benefit set (pregnant women and children under age 21)
- MinnesotaCare: Basic Plus; Basic Plus One; and Basic Plus Two
- Emergency Medical Assistance (EMA) if being treated for chronic diagnosis
- Waivered Service Programs

### *Covered Services:*

- A home health aide will help 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
- Help with medications that are ordinarily self-administered and do not require the skill of a licensed nurse for safe and effective provision
- Help 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

A home health aide follows a care plan developed by the agency Registered Nurse and is supervised. Home Health Aide supervision is completed by:

- Registered Nurse
- Appropriate therapist (physical, occupational, speech-language pathology) when receiving one of the named skilled services.

South Country Health Alliance pays for Home Health Aide visits when other funding resources are exhausted.

### *Non-covered Services:*

- Home Health Aide visits for the sole purpose of providing household tasks, transportation, companionship, socialization, education, not prescribed by a physician are not reimbursed by South Country.
- Services that are not medically necessary
- Services provided in a hospital, nursing facility (NF), or intermediate care facility (ICF)
- More than one (1) HHA visit per day

### *Eligible Providers:*

Eligible providers include Medicare-certified home health agencies with a comprehensive homecare license

### *Process/Procedure for Home Health Aide Services:*

- Access: Anyone may make a referral directly to a Medicare-certified home health agency.
- Assessment: Registered Nurse of the Medicare-certified home health agency completes an assessment to determine need for service. An assessment:
    - Identifies the needs of the person/member
    - Determines outcome for visit(s)
    - Is documented in the record of the person/member
    - Includes an individuated plan of care or service plan
- Authorization: Medicare-certified home health agency submits to South Country after the 9th visit in a calendar year the medical services request form and plan of care . South Country reviews the materials for medical necessity and requested units.
- Waiver supported members require prior authorization from the county care coordinator.
- HHA services are normally paid on a per visit basis at a maximum of one HHA visit per day.

## Home Care Nursing (HCN) Services

### *Covered Services*:

Professional nursing care is based on an assessment of the member'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 Minnesota Nurse Practice Act (MN Stat. sec. 148.171, subd. 1). HCN services have been designated as either "Regular" or "Complex."

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

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

Complex Home Care Nursing Care is provided to a member who is either ventilator- dependent or who requires an "intensive level of care" as ordered of the physician, APRN or PA.

- Ventilator Dependent Member
  A member is considered ventilator dependent when mechanical ventilation for life support is needed for at least six (6) hours per day and the person is expected to be or has been dependent for at least thirty (30) consecutive days.
- Intensive Level of Care
  A member has medical needs that meet intensive level of care when the physician's orders require complex nursing assessments and interventions in response to life-threatening episodes of instability. The interventions would be needed immediately

based on either anticipated or unanticipated changes in the member's health status and ordered by a physician.

### *Non-covered Services:*

The following are not covered under HCN:

- Visits for the sole purpose of providing household tasks, transportation, companionship, or socialization
- Services that are not medically necessary
- Services that are not ordered by a physician, APRN or PA
- Services provided in a hospital, nursing facility (NF), or intermediate care facility (ICF)

Eligible Providers

- Medicare-certified home health agency with a comprehensive homecare licensed
- Independent registered nurse (RN)
- Independent licensed practical nurse (LPN)

Individual RN's and LPN's must have an active nursing license. If an enrolling individual LPN cannot attest to all statements on the Home Care Nurse – Individual LPN or RN Applicant Assurance Statement (DHS-7099) (PDF), the LPN must obtain a comprehensive homecare license.

Eligible Members:

- **SeniorCare Complete (MSHO) and Minnesota Senior Care Plus (MSC+)**
- Minnesota Department of Human Services (DHS) fee-for-service (FFS) authorizes and pays for HCN services for Families and Children (PMAP), MinnesotaCare, and Special Needs BasicCare (SNBC) members.

### *Process/Procedures:*

- Authorization: for MSC+ members and Senior Care Complete members is not required unless provider is non-contracted (outside the state of MN).
- Waiver supported members require prior authorization from the county care coordinator.

### *Home Care Nursing Requirements*

Ongoing Requirements for Home Care Nursing (HCN) documentation:

- HCN services are ordered by a member's physician

Must be provided by a RN or LPN

- Signed orders must be on file in the member's chart at the provider agency's office.
- The 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 member's functional level, medications, treatments, and clinical summary;

- Be individualized based on member needs;
- Have realistic goals;
- Subsequent plans of care must show member response to services and progress since the previous plan was developed; and
- Changes to the plan of care are expected if the member is not achieving expected care outcomes; and
- Orders must be signed within thirty (30) days of the start of care or ninety (90) days prior to the start of care.

**Home Care Nursing Hardship Waiver:**

The HCN Relative Hardship Waiver allows certain relatives to receive reimbursement for providing services to an MA member. The relative must be currently licensed in the State of Minnesota as an RN or LPN and must be one of the following:

- The parent of a member
- The spouse of a member
- Legal guardian or conservator
- Family foster parent of a minor child

To qualify for a HCN Relative 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 HCN for the member
- The relative goes from a full-time to a part-time job with less compensation to provide HCN for the member
- The relative takes a leave of absence without pay to provide HCN for the member
- 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 HCNs to meet the member's needs

**Please note:**

1. 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. 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.
2. Paid hours of service provided by the parent, spouse, or guardian must be included in the member's care plan. Hours authorized for the parent, spouse, or guardian may not exceed 50 percent of the total approved nursing hours or eight hours per day, whichever is less, up to a maximum of 40 hours per week.
3. A parent, spouse, or guardian may not be paid to provide HCN if he/she fails to pass a criminal background check or if the home health agency, the waiver case manager, or the physician determines that the care provided by the parent, spouse, or guardian is unsafe.
4. The review process is 30 days. Written notice will be issued upon a decision. The provider must keep this notice in the member's file. The hardship waiver will be approved from the date received forward. If the hardship waiver is denied an explanation will be provided.

### *Eligibility for Hardship Waiver*

The person who provides home care nursing must meet certain criteria to ensure he or she is eligible to receive reimbursement for these services. To be eligible to apply for the Hardship Waiver, the parent/family foster parent of minor children, legal guardian or spouse must:

- Be a Registered Nurse or Licensed Practical Nurse currently licensed in Minnesota
- Be employed by a HCN agency
- Expect to continue as the primary and/or emergency back-up caregiver without any reimbursement for those services
- Pass a criminal background check.

The person who applies for this position must meet at least one of the following criteria:

- Changed from a full-time employment status to a part-time position with less compensation to provide HCN.
- Is needed to provide an adequate number of qualified nurses to meet the needs of the member because of labor conditions, intermittent hours of care needed or special language needs.
- Resigned from a full-time or part-time employment to provide HCN.
- Has taken a leave of absence without pay to provide HCN.

South Country will not reimburse HCN services authorized and provided under the HCN Hardship Waiver if the case manager, physician, or the HCN agency determine:

- HCN is not following the physician orders
- HCN services provided by the nurse could potentially jeopardize the member's health and safety.

Home Care Nursing services are authorized and provided by the parent/family foster parent or minor children, legal guardian or spouse:

- Are not legally required services
- Cannot be provided in lieu of nursing services covered and available through other third-party payers including Medicare
- May not exceed 50 percent (50%) of the total authorized nursing hours that are billed to South Country or eight (8) hours per day, whichever is less, up to the maximum of forty (40) hours a week (7 consecutive days) regardless of the number of children or adults who receive services at the same residence
- Must be included in the plan of care
- Must be necessary to prevent hospitalization of the person.

The nurse must be employed by one of the following:

- Medicare-certified home health agency
- Home care nursing agency with Class A licensure

The RN must conduct a face-to-face assessment with the person to determine the member's HCN needs. The HCN agency is responsible to submit the HCN Hardship Waiver Application (DHS edoc 4109) to South Country Health Alliance for authorization as stated above.

**HCN Review of hardship waiver requests:** South Country Health Alliance will review and issue a response within thirty (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 South Country Health Alliance. Written notice of the approval or denial will be mailed to the member and provider. If the request is denied, the notice will contain the member's appeal rights and the rationale for the denial. The provider must keep this notice in the member's file. Approvals will be lifetime, unless South Country Health Alliance is notified that qualifying conditions have changed.

**HCN Shared Home Care Nurse Option:** This option allows two members to share HCN services in the same setting at the same time from the same Home Care nurse. All regulations pertaining to Home Care nursing services also apply to the Shared Care option.

**HCN's Providing Shared Care Option:** Services cannot be provided to two individuals/members in separate apartments in the same building, to other non-Home Care nursing members in the setting or replace or supplement required staff at licensed facilities.

**Complex Reimbursement Rates:** A complex care reimbursement rate is available only when the member is receiving 1:1 HCN services. A complex care rate is not available when the member is receiving shared (1:2) HCN services. This means that a member can share HCN services if they are authorized complex care, but the agency will only receive the complex rate during the hours the member is receiving the 1:1 services.

**Changing or Discontinuing Shared HCN**

The member or legal representative must notify the provider in writing if the member chooses to make a change in their Shared Care arrangement. Changes include:

- The number of authorized units the member wishes to share;
- Discontinuing participation in Shared Care; and
- Changing providers.

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

When services are changed or discontinued, the current provider must mail or fax the completed Home Care Fax Form to South Country Health Alliance/ indicating the change in the number of authorized Shared Care or the last date of shared HCN services, and the total number of units to be designated for Shared Care.

### *Documentation Requirements*

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

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

**Ongoing Documentation:**

- How the needs of the members 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 HCN;
- Emergency back up plans to respond to the member's illness or absence or the HCN's illness or absence;
- Additional training, if needed, for the HCN to provide care to two members;
- The names of each member receiving shared Home Care nursing services;

- The starting and ending times that the members received shared Home Care nursing care; and
- Routine nursing documentation such as changes in the member's condition and problems that may arise due to sharing services.

### *Billing Requirements*

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

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

## Home Care Rehabilitation Therapies

Home Care therapies are provided in the home to improve or maintain a person's/member's functioning. Home care therapies include physical, occupational, speech-language pathology and respiratory.

### *Eligible Providers:*

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

- Licensed Physical Therapist (PT)
- Registered Occupational Therapist (OT)
- Certified Occupational Therapy Assistant (COTA)
- Physical Therapy Assistant (PTA)
- Registered Respiratory Therapist (RT)
- Licensed speech-language pathologist (SLP)

South Country reimburses providers for the services of a PTA or COTA when services are provided under the direction of a PT or OT. The therapist must provide on-site observation of the treatment and documentation of its appropriateness at least every sixth treatment and documentation of its appropriateness at least every sixth treatment session when the therapist assistant provides services. Therapists will not be reimbursed for assistant providing evaluations or reevaluations.

### *Required Documentation:*

Providers must document all evaluations, services provided, member progress, attendance records and discharge plans. Documentation must be kept in the person's/member's record. The record of therapy services must contain the following:

- The date, type, length, and scope of each service provided
- The name and title of the person(s) providing each service
- A statement, every thirty (30) days, by the therapist providing or supervising the services, that the nature, scope, duration, and intensity of the therapy are appropriate to the medical condition of the person in accordance with Minnesota Statute.

### *Eligibility:*

The following groups of people are eligible for the home care therapies:

- Medical Assistance/Prepaid Medical Assistance Program (PMAP)
- MinnesotaCare Recipients

If a person can obtain the needed services at a rehabilitation center, they are not eligible for payment through home care services.

### *Covered Services:*

Home Care therapies include:

- Occupational Therapy (OT)
- Physical Therapy (PT)
- Respiratory Therapy (RT)
- Speech-language pathology (ST)

Home Care therapies are classified as one of the following:

- Restorative therapy: health service ordered by a physician, APRN or PA specified in the person's/member's care plan and designed to restore a person's/member's functional status to a level consistent with the person's/member's physical or mental limitations.
- Specialized maintenance therapy: health service ordered by a physician, specified in a person's/member's care plan and necessary for maintain a person's/member's functional status at a level consistent with the person's/member's physical or mental limitations.

### *Non-covered Services:*

1. Rehabilitation services in the home when the member can reasonably access these services outside his/her residence, or to a member who can leave at will
2. Rehabilitation provided to a child who could easily be transported by a parent/guardian to a rehabilitation center
3. Therapies provided in other settings, such as a clinic or day program, or as an inpatient

### *Billing:*

Rehabilitation Therapy procedure codes are daily, per visit codes, with the exception of Respiratory Therapy, which may be provided more than once per day. All therapies must be specified in the member's plan of care.

These home care therapy services are not subject to the one-time rehabilitative service thresholds:

| Code | Type of Therapy |
|---|---|
| S9129 TF | Certified Occupational Therapy Assistant (COTA) services |
| S9129 | Occupational Therapy (OT) |
| S9131 | Physical Therapy (PT) |
| S9131 TF | Physical Therapy Assistant (PTA) services |
| S5181 | Respiratory Therapy (RT) |
| S9128 | Speech Therapy (ST) |

### *Authorization Requirements:*

Prior authorization is needed for rehabilitation therapies when more than nine visits are needed in a calendar year. Respiratory therapy always requires authorization.

Providers are required to submit Medical Services Request form along with detailed member plan of care.

Waiver supported members require prior authorization from the county care coordinator.

## Skilled Nurse Visits (SNV)

Eligible Providers:

Medicare-certified home health agencies with a comprehensive home care license.

Eligible Members:

PMAP

MNCare Basic Plus, Basic Plus One or Basic Plus Two

SNBC (Single Care, Shared Care, Ability Care)

MSC+

Senior Care Complete

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

- Skilled Nursing Visits after the 9th visit per year (No authorization is required for AbilityCare, MSC+ and Senior Care Complete members unless provider is out of the state of MN)
- All Tele-Home-Care SNVs must be prior authorized.

Waiver supported members require prior authorization from the county care coordinator.

### *Covered Services:*

- Services provided according to the recipient's written plan of care or service plan.
- 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. 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.
- Observation, assessment, and evaluation of a person's physical or mental health status. This 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 regimen is stabilized.
- A procedure that requires substantial and specialized nursing skill, such as administration of intravenous therapy, intramuscular injections, or procedures such as sterile catheter insertion or sterile wound cares.
- Teaching and training that requires the skills of a nurse. Examples 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 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. Postdelivery care includes a minimum of one home visit 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 only when an authorized skilled nursing service is provided at the same visit.
- Telehomecare visits. Coverage of telehomecare is limited to two visits per day and all of the visits must be prior authorized.
- Skilled nurse visits for fewer than 90 days for a recipient residing in an ICF/DD to prevent admission to a hospital or nursing facility, if the ICF/DD is not required to provide the nursing services. The home health agency must obtain prior authorization.
- Venipuncture from a peripheral site. The home health provider can submit a request for prior authorization if they have determined and documented:
    a. That no lab service is available that can visit the recipient's home to obtain the venipuncture from the peripheral site
    b. That no service is reasonably available to the recipient outside of his or her place of residence
    c. The recipient no longer qualifies for Medicare Part A skilled nurse services

### *Non-Covered Services:*

- Usual and customary equipment and supplies that are necessary to complete a SNV (that is, stethoscope, nail clippers, sphygmomanometer, alcohol wipes)
- SNV for the sole purpose of supervising a home health aide or PCA. However, supervision may be done during a SNV that qualified for payment
- SNV for the sole purpose of monitoring medication compliance with an established medication program for a recipient
- SNV 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
- SNV 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; when 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
- 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 MA.)

- SNV provided by an RN that is employed by a Personal Care Provider Organization (PCPO) or non-Medicare certified private duty nursing agency
- 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 telehomecare visit.

### *Access:*

To initiate service, anyone may make a referral directly to a Medicare-certified home health agency.

**Assessment:** Registered Nurse or appropriate therapist of the Medicare-certified home health agency completes an assessment that:

- Determines outcome for visit(s)
- Identifies the needs of the person/member
- Includes an individualized plan of care or service plan
- Is documented in the record of the person/member

**Authorization:**

Medicare-certified home health agency submits to South Country:

- Home Health Certification and Plan of Care

Medical Services Request Form South Country will review the materials submitted for medical necessity.

**Beginning 1/1/2020 authorization requests for SNV's must indicate by procedure code if an RN or LPN will perform the visit.**

**Limitations**

No more than two (2) visits per day per person is permitted. Up to nine (9) visits per calendar year per person/member are allowed without requiring prior authorization. All Tele-Home-Care visits must receive prior authorization.

### *Tele-Home-Care Services*

- A Tele-Home-Care visit is a SNV that is made via live, interactive audiovisual technology between the home care nurse and the member. 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 member 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 member 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.
- Home health for peripheral only (wt., pulse, oximetry, etc.) use the code 99091 (the code 99091 can be billed four (4) times within the month-once per week).
- Bill using Code E1399-52 for equipment used for peripheral tele-home care visit.

## Summary of Authorization Requirements

### *Getting Started:*

- Obtain all health insurance coverage information.
- Verify member enrollment/eligibility online through MN-ITs.
- If the member is eligible for a waiver, contact the member's county case manager or care coordinator.
- If the member is South Country Health Alliance eligible without a waiver, home health agencies are responsible for obtaining prior authorization through Medical Services at South Country Health Alliance.

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

- Home Health Aide services – after the 9th visit per calendar year for SNBC (Single Care, SharedCare) PMAP and MNCare
- Skilled Nurse Visit - after the 9th visit per calendar year for SNBC (Single Care, SharedCare) PMAP and MNCare
- Home Care Nursing services – not required **for MSC+ and SCC (MSHO) - DHS FFS authorizes and pays PMAP/MNCare and SNBC**
- Rehabilitation Therapies - after the 9th visit per calendar year for SNBC (Single Care, SharedCare) PMAP and MNCare

Tele-Home-Care visits – required for all ***For members on a Waiver, prior authorization and/or notification is required before the initial visit:***

Service Agreements (SA) may be either temporary (45 days), or long-term (up to 365 days or 366 days in a leap year). Approved home care authorizations requests can begin the date the request is received unless the request meets an exception. South Country must receive all the required information before authorization can be approved.

South Country Health Alliance cannot authorize waiver services requested by a home care provider (refer to Home and Community Based Services (HCBS) Elderly Waiver).

- For Members enrolled in the Developmental Disabilities (DD), Community Access for Disability Inclusion (CADI), Community Alternatives for Children (CAC) or Brain Injury (BI) waiver, home care services must be authorized by the member's county waiver case manager. The county waiver case manager must fax the "Recommendation for State Plan Home Care Services" (DHS edoc 5841) form to South Country Health Alliance at 1-507-431-6329 specifying the provider, amount, duration, and frequency of home care services.
- For Members enrolled in the Elderly Waiver (EW), the South Country/County Care Coordinator authorizes the services on the member's care plan and updated on the members services agreement.
- **Upon Receiving Service Authorization** Review the Service Authorization immediately for content and comments. Line item dates may differ from header dates. If you have questions about this process, contact the Provider Contact Center at 1-888-633-4055

Note: Information about the authorization requirements and process can be found in South Country Health Alliance's Provider Manual Chapter 6 Service Authorizations and Notification Standards.

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

## *Exceptions to Prior Authorization*

Authorization may be requested after a home care services is provided to a member only under the following conditions:

- Emergency Service Provision: The home care services were required to treat an emergency medical condition that, if not immediately treated, could cause a member serious or physical or mental disability, continuation of severe pain, or death. Providers must be able to substantiate the emergency by documentation such as reports, notes, and admission or discharge history.
    - Request retroactive authorization within five (5) working days from starting the initial service.
- Retroactive Eligibility: Home care services were provided on or after the date on which the member's eligibility began.
- Third Party Payer: A third party payer for home care services denied or adjusted a payment.
    - Submit authorization requests to South Country within twenty (20) working days of the notice of denial or adjustment. Include a copy of the third-party payer's notice of the request.
- Administrative Error: The local county agency, care coordinator, or South Country made an error.
    - Submit the request within twenty (20) working days and include a statement that specifies:
        - Which agency made the error
        - What the error was
        - When it occurred
        - If a county agency or care coordinator made an error, supporting documentation from that agency must be included.
- Medical Need: The professional nurse determines an immediate medical need for up to forty (40) Skilled Nursing or Home Health Aide visits per calendar year. Exceptions to prior authorization requests are evaluated according to the same criteria applied to prior authorization requests.
    - Submit the request within five (5) working days and include a statement that specifies the medical need, reason for immediacy need for forty (40) Skilled Nursing or Home Health Aide benefits.

## *SNV and HHA – Long-Term Change*

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

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

### *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 (e.g. HCN 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 edoc 4074), indicating:
    - All provider names and numbers;
    - Dates of service for each provider; and
    - The number of units to be used by each provider.

### *Change in Provider*

A member may change service delivery from one provider to another provider at any time.

### *Unable to provide continued services*

If a home care provider is unable to continue services to a member, the provider must notify the member, responsible party, and South Country Health Alliance by fax 1-888-633-4052 at least ten (10) days before terminating the service and assist the member in transitioning to another provider. If the termination is a result of sanctions on the provider, the provider must give the member a copy of the home care bill of rights at least thirty (30) days before terminating services

### *Discontinuing Provider*

To discontinue using a provider, fax the “Home Care Fax Form” (DHS edoc 4074) to 1-888-633-4052 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; 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 edoc 4074) to 1-888-633-4052 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 member, 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 member is admitted to a facility, the provider must submit the "Home Care Fax Form" (DHS edoc 4074) to 1-888-633-4052 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 member is discharged from a facility into the community, the provider must submit the "Home Care Fax Form" (DHS edoc 4074) to 1-888-633-4052 indicating:

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

### Change in Member ID/PMI Number

When a member's ID/PMI number changes, the provider must submit the completed "Home Care Fax Form" (DHS edoc 4074) to 1-888-633-4052 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 member is dis-enrolled from a PMAP health plan, providers must contact DHS directly within thirty (30) calendar days to request authorization, so that services for the member can continue and fee-for-service payment is made to the provider.

### Technical Change/Correction

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

- Provider name/ID#;
- Member name/date of birth;
- HCPCS code/units/rate; or
- ICD-10 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 HCN (HCN for MSHO or MSC+ only)

When a change or correction is need for SNV, HHA, and HCN (for MSHO or MSC+ only on or after 01/01/2019) services, the provider must submit the completed "Home Care Fax Form" (DHS edoc 4074) to : 1-888-633-4052

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

**Recovery of Excessive Payments**

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

**Changes in Medical Status or Primary Caregiver Availability**

Changes in medical status are either temporary for forty-five (45) days or less or long term for up to 365 days (366 days in a leap year). These include, but are not limited to, a change in health or level of care, service addition, a change in physician orders, recent facility placement, or a change in primary caregiver's availability. Documentation must support the requested change in service. Temporary authorizations can only be approved for forty-five (45) days or less. South Country cannot approve back-to-back temporary requests.

## Billing

South Country pays for SNV, HHA, and HCN (HCN for MSHO or MSC+ only) services after the member has used all other sources of payment. South Country is the payer of last resort. The order of payers for a South Country member is:

- First: 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 ESRD for the first 18 months, workers compensation law or plan, no-fault or liability insurance policy or plan)
- Second: Medicare
    - Members enrolled in SeniorCare Complete (MSHO) and AbilityCare (SNBC-SNP) (AbilityCare is SNV and HHA only), South Country manages the member's Medicare benefit.
- Third: Medical Assistance/Prepaid Medical Assistance Program or MinnesotaCare
    - Products include PMAP, MinnesotaCare, MSC+, and SNBC – SingleCare and SharedCare
- Last: MHCP Waivered Services program or Alternative Care (AC) program.

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

Providers must be familiar with Medicare coverage for home care recipients/members, bill Medicare when Medicare is liable for the service or, if not Medicare certified, refer the member to a Medicare certified provider of the member's choice, and notify members when Medicare is no longer the liable payer for home care services.

### *SeniorCare Complete and AbilityCare – Medicare Billing/Claim submission*

For AbilityCare (SNV and HHA only) and SeniorCare Complete (MSHO), Medicare criteria are utilized 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.

- If the Medicare criteria is met, then Medicare guidelines must be followed. Medicare requires consolidated billing of all home health services while a SeniorCare Complete or AbilityCare member is under a home health plan of care. All services listed under the

PPS are the responsibility of the Home Health Agency that has the member under an episode and are not billable by other providers.

- During each 30-day episode, the home health agency is responsible to bill South Country for all home health services including:
    - A home health agency affiliated or under common control with that hospital
    - Care for homebound patients involving equipment too cumbersome to take to the home
    - Home Health Aide services
    - Medical services provided by an intern or resident-in-training at a hospital, under an approved teaching program of the hospital
    - Medical social services
    - Skilled nursing care
    - Speech-language pathology
    - Occupational therapy
    - Physical therapy

Home health services are paid on a cost basis. Therefore, the PPS rate assigned to the beneficiary/member includes all the above services. Home health agencies that do not have these services available need to hire staff and keep supplies on hand or contract services with other agencies.

- Nursing services can be submitted on a single UB-04 (837I) claim. Include the appropriate revenue code and HCPCS code for the supplies being provided.
- 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 (4) 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 30-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 South Country Health Alliance 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 do not meet criteria to be covered under the Medicare Benefit must be submitted using the Medical Assistance (MA) home health care qualifying HCPCS codes, now eligible under the Medicaid benefit.
- South Country Health Alliance will use the following entities as the standard:
    - Medicare Administrative Contractors/Part A/B: National Government Services, Inc.
    - DMERC, Region B, CGS Administrators, LLC
- 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." SeniorCare Complete and AbilityCare are considered Medicare Advantage plans.
- The provider should first seek an adjustment PEP payment from Medicare. Once this has occurred, the claim should be submitted to South Country Health Alliance, along with the statement showing Medicare's payment for service. South Country Health Alliance will then issue the remaining payment due

## Hospice Services

The hospice benefit is a comprehensive package of services offering palliative care support to terminally ill members and their families. Hospice care offers holistic support and relief from pain and other symptoms of the terminal illness.

South Country Health Alliance follows the same rules and regulations as the Medicare and DHS MHCP hospice benefit, which was designed to supplement the care that primary caregivers, such as family (as the member defines family), friends and neighbors provide. The hospice benefit is not intended to replace the supportive role of the member's informal support network of primary caregivers. As such, MA-covered services that replace the duties of primary caregivers do not duplicate the hospice team's services. Information on the Medicare and DHS MHCP Hospice benefit may be found at: CMS Manual Chapter 9 Hospice Services and DHS MHCP Provider Manual Hospice Services

Hospice benefits include coverage for the following services when provided directly in response to the terminal illness:

- Physician services
- Nursing services
- Medical social services
- Counseling (Bereavement counseling does not qualify for additional payment)
- 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 service
- Physical, occupational, and speech therapy
- Volunteers
- Other items and services included in the plan of care that are otherwise covered medical services

### *Notification/Authorization:*

Hospice providers are required to notify South Country Health Alliance (Form #4735) via fax to Utilization Management 1-888-633-4052 within 24 hours of admission to Hospice. The Hospice admission diagnosis is required on the notification for prompt and timely payment.

### *Hospice Rate:*

South Country follows MN Department of Human services provider reimbursement rates for hospice services which can be found at: https://mn.gov/dhs/partners-and-providers/policies-procedures/minnesota-health-care-programs/provider/types/

### DHS Internet Forms Available

- Service Agreement (DHS edoc 3070)
- Home Care Service Update (DHS edoc 3244B)
- Home Care Nurse Decision Tree (DHS edoc 4071C)
- MA Home Care Nursing (HCN) Assessment (DHS edoc 4071A)
- Home Care Fax Form
- Hardship Waiver Form – PCN and HCN
- Shared HCN Consent Form

### Forms Available from CMS or Office Supplier

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

### Telephone Numbers

- Provider Contact Center 1-888-633-4055

### South Country Authorization Grid

https://mnscha.org/?page_id=304