

# Chapter 24

## Home Health Care Services

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 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 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, 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.

**Home Care Nursing (HCN) Services:** Nursing services ordered by a physician, 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 personal care assistance services and staff. A qualified professional must be one of the following: Registered Nurse as defined in Minn. Stat. §148.171 to 148.285, Licensed Social Worker as defined in Minn. Stat. §148D.010 and Minn. Stat. §148D.055, Mental Health Professional as defined in Minn. Stat. §245.462, subd. 18 or Minn. Stat. §245.4871, subd. 27, Qualified Developmental Disabilities Specialist under Minn. Stat. §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)

### **Eligible Providers**

- Medicare Certified, Class A Licensed Home Health Agency
- Class A Licensed Home Care Nursing Agency
- Independent Registered Nurse (RN)
- Independent Licensed Practical Nurse (LPN) with a Class A License from MDH

### **Provider Requirements**

The eligible provider must be contracted with South Country Health Alliance and:

- 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)
- Waivered Service Programs

### **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-DD);
- documented in a written care plan, which is reviewed by the member's physician at least once every sixty (60) days for home health agency or Home Care Nursing services.

### **Home Health Aide 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 and have professional supervision provided by a Medicare Certified agency.

### **Place of Residence:**

The following are considered a place of residence:

- Home rented or owned or shared by person
- Rule 5 residential program for children with severe emotional disturbances
- Rule 8 group homes
- Rule 35 chemical dependency rehabilitation programs
- Rule 36 residential facilities for adults with mental illness
- Residential programs and services for persons with developmental disabilities excluding ICF/DD
- Non-certified boarding care homes eligible for Group Residential Housing room and board payments.

The following are not considered a place of residence:

- Hospital
- Intermediate care facility (ICF-DD)
- Nursing facility

**Covered Services:**

- Assist in administering medications that are ordinarily self-administered
- Assist in ambulating or exercises
- Assist with instrumental activities of daily living
- Perform simple procedures as an extension of therapy or nursing services
- Providers hands-on personal care

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**.

**Provider Standards and Qualifications:**

Medicare-certified home health agency that employs:

- Registered Nurse(s) with current Minnesota registration
- Home Health Aide(s) with current certification from the Minnesota Department of Health

**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 individualized 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 home health certification and plan of care and physician orders. South Country reviews the materials for completeness of information, need for service and number of visits needed. If approved, South Country provides either a temporary authorization (up to 45-days maximum) or long-term authorization (authorization for up to one year depending upon the needs of the person).
- Once approved, one visit per day per person is permitted.

Medicare qualified days are paid based on the HH PPS.

# Home Care Nursing (HCN) Services

## Definition

Provision of professional nursing services to a person in or outside their home when normal life activities take the person outside the home including school, with such services based on an assessment of the medical/healthcare needs of the person.  
Home Care

## Covered Services

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.

- **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

Home Care Nursing services if the nurse is the foster care provider of a person under the age of 18 years and regular home care nursing services to a person who is ventilator dependent or requires an intensive level of care.

## Provider Standards and Qualifications

- Registered Nurse (RN) or Licensed Practical Nurse (LPN) employed by a Medicare-certified agency and/or home care nursing class A licensed agency.
- Parent of a minor child, spouse, or non-corporate legal guardian who is a RN or LPN employed by an agency and meets criteria to receive a Home Care Nursing Hardship Waiver.
- Independent Registered Nurse.
- Independent Licensed Practical Nurse with a Class A license.

**Process/Procedures:**

- Access: to initiate services, anyone may make a referral directly to an approved home care nursing provider.
- Assessment: Registered Nurse, either independent or from an approved home care nursing provider, completes an assessment to determine need using “MA Home Care Nursing Assessment” (DHS edoc 4071A). Independent LPNs must arrange for the assessment to be completed by a RN (either independent or from an approved provider). Assessed, identified needs of the member determine whether regular or complex home care nursing is required to meet those needs and recommended amounts of activities.
- Authorization: The assessment information will be reviewed for need of service, number of units and type of nursing. If approved, provide authorization (temporary or long-term).

**Members on Special Needs Basic Care (SNBC) receive Home Care Nursing services through the State of Minnesota Fee for Service.**

**Effective 01/01/2019, members on Prepaid Medical Assistance Programs (PMAP) will receive Home Care Nursing services through the State of Minnesota Fee for Service. Providers should ensure that throughout 2018 they maintain a copy of the member’s assessment to assist with the transition of HCN from managed care to the State for reimbursement (again effective 01/01/2019).**

**Home Care Nursing Authorization Requirements**

To request authorization for Home Care Nursing (HCN) the Provider must submit the following to Mayo Clinic Health Solutions (FKA Mayo Clinic Health Solutions) before services are initiated:

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

The Home Care Nursing forms listed above must be faxed to South Country Health Alliance/ Mayo Clinic Health Solutions at 1-888-889-7822.

South Country Health Alliance/ Mayo Clinic Health Solutions will fax an authorization notice to the Provider with the approved units of services and service agreement date span dates.

Ongoing Requirements for Home Care Nursing (HCN) authorization and documentation:

- All HCN services require prior authorization;
- HCN services require a physician order prior to initiating service;

- Review/approval of the orders and service plan by the member's physician every sixty (60) days;
- Signed orders must be on file in the member'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 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.

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

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

**Home Care Nursing Hardship Waiver:** The HCN Hardship Waivers allows certain relatives to receive reimbursement for providing services to his/her relative who is a Medical Assistance (MA) member. The provider agency is responsible for:

- Receiving the request from the member/responsible party;
- Obtaining the relative's signature;
- Completing the HCN Hardship Waiver Application request form (DHS edoc 4109), ensuring the accuracy of the information; and
- Submitting the form and any supporting documentation to South Country Health Alliance/ Mayo Clinic Health Solutions at 1-888-889-7822.

**Eligibility:**

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:

- Has 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.
- Has 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/ Mayo Clinic Health Solutions 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/ Mayo Clinic Health Solutions. 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/ Mayo Clinic Health Solutions 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.

### **Authorization Requirements**

A member, or a member's legal representative, may select the Shared Care option at **any time** during the authorization period by contacting the HCN agency. Together with the member's physician and the HCN agency staff, the member (or the legal representative) will determine:

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

The member (or the member's legal representative) and the HCN agency will approve:

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

**HCN Agency Responsibilities:** Shared Care requires prior authorization. To request authorization for shared services, the HCN agency must:

- Complete the Medical Assistance (MA) Home Care 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 South Country Health Alliance/ Mayo Clinic Health Solutions.
- Submit the Assessment to South Country Health Alliance/ Mayo Clinic Health Solutions via fax 1-888-889-7822.

**Waiver Program Members:** 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 member on a waiver. If the member chooses the Shared Care option, document the number of shared HCN service units on the member'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 HCN services to the fullest extent possible (for all medically necessary nursing services) before using extended HCN codes on waiver service agreements.

**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/ Mayo Clinic Health Solutions 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 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.

### **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

Home Care therapies are classified as one of the following:

- Restorative therapy: health service ordered by a physician 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:**

Therapies provided in other settings such as a clinic, day program or as in an in-patient.

The physician or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law must expect the person's/member's functional status to progress toward, achieve or maintain the objectives in a person's/member's care plan within a 60-day period.

**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. All therapies must be specified in the member's plan of care.

**Authorization Requirements:**

Prior authorization is NOT needed for rehabilitation therapies.

**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)
- Licensed Occupational Therapist (OT)
- Licensed Occupational Therapy Assistant (OTA)
- Physical Therapy Assistant (PTA)
- Registered Respiratory Therapist (RT)
- Licensed speech-language pathologist (SLP)

South Country reimburses providers for the services of a PTA or OTA 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.

**Access**

Referral to a Medicare-certified home health agency starts the process. For dual-eligible persons, South Country pays for therapies after other resources have been exhausted.

**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.

**Authorization:**

There is no requirement for prior authorization of home care therapy services.

## **Skilled Nurse Visits (SNV)**

**Skilled Nurse Visits (SNV)** are visits to a person's/member's place of residence, on an intermittent basis, by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) under the supervision of a RN, to initiate and complete professional nursing tasks based on the assessed need for services to maintain or restore optimal health.

**Place of Residence:**

The following are considered place of residence:

- Home rented or owned or shared
- Rule 5 residential program for children with severe emotional disturbances
- Rule 8 group home
- Rule 35 chemical dependency rehabilitation program
- Rule 36 residential treatment facility for adults with mental illness
- Residential program and service for persons with developmental disabilities, excluding ICF/DD
- Non-certified boarding care home eligible for group residential housing room and board payment

ICF/DD exception: Skilled nursing visits may be prior authorized for up to ninety (90) days to prevent admissions to acute care hospitals or nursing facilities. Home health agencies must request prior authorization.

## **Provider Standards and Qualifications**

Only Medicare-certified home health agencies may provide Skilled Nursing Visits. Medicare-certified home health agencies must employ RNs and LPNs. Visits may be conducted face-to-face or via Tele-Home-Care technology. Assessment of need determines the length of time for the skilled nursing visit.

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

- Skilled Nursing Visits after the 9th visit per year.
- All Tele-Home-Care SNVs must be prior authorized.

Waiver members require prior authorization from the county case manager or care coordinator.

## **Covered Services**

Skilled Nursing Visits include any of the following:

- Completion of a procedure requiring substantial and specialized nursing skill such as administration of intravenous therapy; intra-muscular injections and sterile procedures
- Consumer teaching and education/training requiring the skills of a professional nurse
- Observation, assessment and evaluation of the physical and/or mental status of the person

All Skilled Nursing Visits must be:

- Made in accordance with the accepted standard of medical and nursing practice in accordance with the Minnesota Nurse Practice Act
- Made in accordance with the member's plan of care or service plan
- Ordered by a physician

## **Non-Covered Services**

Skilled Nursing Visits to the place of residence of a person not covered when made for the sole purpose of:

- Directly observing medication administration for communicable tuberculosis
- Monitoring medication compliance with an established medication program
- A Public health nursing clinic visit
- Setting up or administering oral medications, pre-filling a medication or for any other activity that can be delegated to a family member
- Supervising a home health aide
- Training other home health agency workers

Nursing visits that are required by Medicare but do not qualify as Skilled Nurse Visits are an administrative expense for agencies and cannot be billed to South Country. Examples include: Medicare evaluation or administrative nursing visits required by Medicare.

**Access:**

To initiate service, 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 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
- Physician orders

South Country will review the materials submitted for completeness, need for services, and number of visits. If approved, South Country provides temporary authorization (one-time authorization up to 45 days) or Long-term authorization (an authorization for up to one year, depending on the needs of the person).

**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.

**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 member's home to obtain the venipuncture from the peripheral site;
- That there is not a service reasonably available to the member outside of his/her place of residence; and
- The member no longer qualifies for Medicare Part A skilled nurse services.



## 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.
- Coverage of Tele-Home-Care is limited to one (1) visit per week no more than four (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 four times within the month-once per week). Bill using Code E1399-52 for equipment used for peripheral tele-home care visit.

## 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.
- 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.
- 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.
- Services provided when the number of foster care residents is greater than four (unless the county responsible for the member's foster placement made prior to April 1, 1992, requests that home care service be provided, and county or state case management is provided).

There may be additional non-covered services outlined under each provider-type specific covered services page.

## **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/ Mayo Clinic Health Solutions.

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

- All Home Health Aide services – after the 9th visit per calendar year
- Skilled Nurse Visit - after the 9th visit per calendar year
- All Home Care Nursing services – **required for all**
- All Tele-Home-Care visits-**required for all**

\*\*Authorization is required after 9 Skilled Nurse Visits per member, per calendar year, except for waiver service program recipients/members who always require authorization.

Before requesting an authorization:

- Verify a member's South Country eligibility via MN-ITs or Health Solutions (Mayo Clinic Health Solutions) Online Portal.
- Obtain all health insurance coverage information.
- Use all insurance and Medicare benefits.

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.

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

- 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 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 must complete the (DHS eDoc 5841) "Recommendation for State Plan Home Care Services" form and fax it to South Country at 507-431-6329 or securely email to [countyinfo@mnscha.org](mailto:countyinfo@mnscha.org). The document must also be resubmitted any time there is a change in the member's currently authorized service. The member's updated care plan/service plan must also accompany the request.

Note: Information about the authorization requirements and process can be found in South Country Health Alliance's Medical Management Chapter.

**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, HHA, and HCN – Temporary Change**

When a change in medical status exists, the provider must fax the "Home Care Fax Form" (DHS edoc 4074) South Country Health Alliance/ Mayo Clinic Health Solutions 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 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 at 507-431-6329 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 (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; 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 (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 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 (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 member is discharged from a facility into the community, the provider must submit the “Home Care Fax Form” (DHS edoc 4074) to (888) 889-7822 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 (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 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**

When a change or correction is need for SNV, HHA, and HCN services, the provider must submit the completed “Home Care Fax Form” (DHS edoc 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**

South Country Health Alliance/ Mayo Clinic Health Solutions 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.

### **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 Provider Help Desk at (800) 995-4543.

## **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.

## Billing

South Country pays for 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), South Country manages the member's Medicare benefit.
- Third: Medical Assistance/Prepaid Medical Assistance Program or MinnesotaCare
  - Products include PMAP, MNCare, 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 and SeniorCare Complete, 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 supplies and 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 60-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
  - Routine and non-routine medical supplies

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 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 Mayo Clinic Health Solutions (FKA Mayo Clinic Health Solutions) for claims processing. Professional and institutional claims should be sent electronically to Mayo Clinic Health Solutions using 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 (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 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 South Country Health Alliance/ Mayo Clinic Health Solutions for PMAP and MNCare. Claims should be itemized and submitted with the appropriate CPT/HCPCS and DOS. Services must be billed on the 8371 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/ Mayo Clinic Health Solutions 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/ Mayo Clinic Health Solutions, along with the statement showing Medicare’s payment for service. South Country Health Alliance/ Mayo Clinic Health Solutions will then issue the remaining payment due.

#### **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 Help Desk (800) 995-4543