

Chapter 24A

Home Care Services

Definitions

Activities of Daily Living (ADL): Routine self-care functions such as eating, toileting, grooming, dressing, bathing, transferring, mobility, and positioning.

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

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

Fiscal Agent Option: See Personal Care Assistant (PCA) Choice Provider Option.

Flexible Use Service Option: Planned and approved use of authorized PCA service hours/units in a six-month flexible schedule to more effectively meet the needs of the person. IMCare follows Minnesota Health Care Programs (MHCP) guidelines in establishing two six-month periods for the PCA Flexible Use Option. The Flexible Use Option allows authorized PCA units to vary from day to day to meet the needs and schedules as specified in the PCA assessment. Flexible Use does not increase the total amount of authorized PCA units. Units may not be transferred from one six-month period to another.

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

Home Care Nursing Agency: An agency holding a Comprehensive Home Care license enrolled with IMCare to provide HCN services.

Home Care Nursing Services: Nursing services ordered by a physician for a member whose illness, injury, or physical or mental condition requires more individual and continuous care by a registered nurse (RN) or LPN than can be provided in a single or twice daily SNV and requires greater skill than a HHA or PCA can provide.

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

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

Home Health 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.

1. Basic licensure: Each application for a home care provider license must include information sufficient to show that the applicant meets the requirements of licensure, including the following:
 - a. The applicant's name, email address, physical address, and mailing address, including the name of the county in which the applicant resides and has a principal place of business
 - b. The initial license fee in the amount specified in subdivision 7
 - c. The email address, physical address, mailing address, and telephone number of the principal administrative office
 - d. The email address, physical address, mailing address, and telephone number of each branch office, if any
 - e. The names, email and mailing addresses, and telephone numbers of all owners and managerial officials
 - f. Documentation of compliance with the background study requirements of section [144A.476](#) for all people involved in the management, operation, or control of the home care provider
 - g. Documentation of a background study as required by section [144.057](#) for any individual seeking employment, paid or volunteer, with the home care provider
 - h. Evidence of workers' compensation coverage as required by sections [176.181](#) and [176.182](#)
 - i. Documentation of liability coverage, if the provider has it
 - j. Identification of the license level the provider is seeking
 - k. Documentation that identifies the managerial official who is in charge of day-to-day operations and attestation that the person has reviewed and understands the home care provider regulations
 - l. Documentation that the applicant has designated one or more owners, managerial officials, or employees as an agent or agents, which shall not affect the legal responsibility of any other owner or managerial official under this chapter
 - m. The signature of the officer or managing agent on behalf of an entity, corporation, association, or unit of government
 - n. Verification that the applicant has the following policies and procedures in place so that if a license is issued, the applicant will implement the policies and procedures and keep them current:
 - i. Requirements in sections [626.556](#), reporting of maltreatment of minors, and [626.557](#), reporting of maltreatment of vulnerable adults
 - ii. Conducting and handling background studies on employees
 - iii. Orientation, training, and competency evaluations of home care staff, and a process for evaluating staff performance
 - iv. Handling complaints from clients, family members, or client representatives regarding staff or services provided by staff
 - v. Conducting initial evaluation of clients' needs and the providers' ability to provide those services
 - vi. Conducting initial and ongoing client evaluations and assessments and how changes in a client's condition are identified, managed, and communicated to staff and other healthcare providers as appropriate
 - vii. Orientation to and implementation of the home care client bill of rights
 - viii. Infection control practices
 - ix. Reminders for medications, treatments, or exercises, if provided
 - x. Conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention (CDC) standards
 - o. Other information required by the department
2. Comprehensive home care licensure: In addition to the information and fee required in subdivision 1, applicants applying for a comprehensive home care license must also provide verification that the applicant has the following policies and procedures in place so that if a license is issued, the applicant will implement the policies and procedures in this subdivision and keep them current:
 - a. Conducting initial and ongoing assessments of the client's needs by a registered nurse or appropriate licensed health professional, including how changes in the client's conditions are identified, managed,

and communicated to staff and other health care providers, as appropriate

- b. Ensuring that nurses and licensed health professionals have current and valid licenses to practice
- c. Medication and treatment management
- d. Delegation of home care tasks by registered nurses or licensed health professionals
- e. Supervision of registered nurses and licensed health professionals
- f. Supervision of unlicensed personnel performing delegated home care tasks

Home Health Agency Services: Services provided by a Medicare-certified agency including Skilled Nurse Visits (SNVs), HHA, and physical, occupational, speech, and respiratory therapy.

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

Home Health Aide (HHA) Services: Medically oriented tasks to maintain the member's health or to facilitate treatment of an illness or injury in a person's place of residence. Services must be ordered by a physician and have professional supervision provided by a Medicare-certified agency.

Home Management Services: Home management services include at least two of the following services: housekeeping, meal preparation, and shopping. Providers of home management services must register annually with MDH. ([MN Stat. sec. 144A.43, subd. 3](#);

Instrumental Activities of Daily Living (IADL): Individual activities relating to ADL that include: meal planning and preparation; managing finances; shopping for food, communication by telephone and other media; and getting around and participating in the community.

Licensed Practical Nurse (LPN): Must hold current licensure from the Minnesota State Board of Nursing, Class A Licensure from MDH, and be enrolled with the Minnesota Department of Human Services (DHS) as an independent nurse to practice practical nursing ([MN Stat. sec. 148.171, subd. 8](#)).

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](#).

PCA Choice Provider (also known as fiscal intermediary): An individual enrolled with IMCare and employed by a personal care provider organization (PCPO), a home health agency, or is jointly employed by the member and a PCA Choice provider. The PCA is trained in the skills needed to perform the member's PCA service needs. PCAs must be enrolled with MHCP and IMCare.

Qualified Professional (QP): 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.010](#) and [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 [Minn. Stat. §245D.081, Subd 2\(b\)](#).

Registered Nurse (RN): Must hold current licensure from the Minnesota State Board of Nursing and be enrolled with DHS as an independent nurse.

Residence: The place a member lives. A residence does not include a hospital, nursing facility (NF), or intermediate care facility (ICF).

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

Skilled Nurse Visits (SNVs): 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 an RN 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 that the nurse is qualified to provide.

Telehome-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 (currently approved for SNVs only).

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

Covered Services

1. HHA
2. HC Rehabilitation therapies
 - a. Occupational therapy with a registered occupational therapist (OT) or Certified Occupational Therapy Assistant (COTA)
 - b. Physical therapy with a physical therapist (PT) or physical therapy assistant (PTA)
 - c. Respiratory therapy
 - d. Speech therapy
3. SNV

Prior authorization is required for the following:

1. All HHA services – Except MSC+ and MSHO when billed with Medicare-covered G codes
2. All HCN services - Except MSC+ and MSHO when billed with Medicare-covered G codes
3. SNVs above nine visits per member, per calendar year
4. All telehome-care visits

Information about the authorization requirements and process can be found in the *Information for All Itasca Medical Care (IMCare) Home Care Providers* section.

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

1. Medicare-certified home health agencies with a comprehensive homecare license
2. Comprehensive homecare licensed home care nursing agency
3. Independent registered nurse (RN)
4. Independent licensed practical nurse (LPN) with a comprehensive homecare license
5. 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: Provider is limited to services that are allowed under the licensure or certification of the agency and agency practitioners.

Qualifying Services

Qualifying services must be all of the following:

1. Provided to an eligible members, whom have homecare covered in their benefit set
2. Medically necessary
3. Physician-ordered services provided to IMCare members in their own residence, that is other than a hospital, SNF, or ICF
4. Documented in a written care plan, which is reviewed by the member's physician at least once every 60 days for home health agency or HCN services, or at least once every 365 days for personal care services

Face-to-Face Encounter Requirements

IMCare requires a face-to-face encounter with a physician, NP or PA, related to the primary reason home health services are required, within 90 days before or 30 days after the home health services were initiated. Home care agencies must submit a copy of this visit to IMCare upon request.

Plan of Care

The 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 do all of the following:

1. Specify the disciplines providing care
2. Specify the frequency and duration of all services
3. Demonstrate the need for the services and be supported by all pertinent diagnoses
4. Include member's functional level, medications, treatments, and clinical summary

5. Be individualized based on member needs
6. Have realistic goals
7. Subsequent plans of care must show member response to services and progress since the previous plan was developed
8. Changes to the plan of care are expected if the member is not achieving expected care outcomes

Home Health Aide (HHA) Services

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

Eligible Members

1. Members on Medical Assistance (Medicaid)
2. MinnesotaCare – members who are under age 19 or are pregnant women
3. Members on the Elderly Waiver (EW) programs

Covered Services

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

HHA services are normally paid on a per visit basis at a maximum of one HHA visit per day. As a waiver program service, HHA services may sometimes be authorized as approved units of service.

Non-Covered Services

1. HHA visits for the sole purpose of providing household tasks, transportation, companionship, or socialization
2. Services that are not medically necessary
3. Services provided in a hospital, NF, or ICF
4. More than one HHA visit per day

Home Care Nursing (HCN) Services (previously known as Private Duty Nursing [PDN])

Definition

Home Care Nursing (HCN) services are nursing services ordered by a physician for a member whose illness, injury, or physical or mental condition requires more individual and continuous care by an RN or LPN than can be provided in a single or twice daily SNV and requires greater skill than an HHA or PCA can provide. Provided under a plan of care approved by the physician and specify the level of care that the nurse is qualified to provide. May be used outside of the recipient's home during hours when normal life activities take them outside of their home.

HCN services:

1. Are for members who need more individual and continuous skilled nursing care than provided in an SNV
2. Are for care outside the scope of services provided by a HHA/PCA
3. Are provided under a plan of care or service plan approved by the physician
4. Specify the level of care the nurse is qualified to provide
5. Are ordered by the member's physician
6. May be used outside of the member's home during hours when normal life activities take the member outside of his/her home
7. Must be provided by an RN or LPN
8. May be provided by an RN or LPN with a hardship waiver who is one of the following: parent of a minor child, spouse, or non-corporate legal guardian

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."

Complex HCN Care is care provided to members who are either ventilator-dependent **or** who require an "intensive level of care."

1. **Ventilator-Dependent** – A member is considered ventilator-dependent when mechanical ventilation for life support is needed for at least six hours per day and the person is expected to be or has been dependent for at least 30 consecutive days.
2. **Intensive Level of Care** – A member whose medical needs require complex nursing assessments and interventions in response to life-threatening episodes of instability. The interventions must be ordered by a physician and are needed immediately based on either anticipated or unanticipated changes in the member's health status.

Regular HCN Care is nursing provided to a member who is in or outside of his/her home when normal life activities take the member outside of his/her home. This includes school when the service is based on an assessment of the medical needs of the member.

1. 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 assessment are needed to determine appropriate interventions that maintain or improve the member's health status. This does not include services to a person who is ventilator-dependent or who requires an intensive live of care.

Non-Covered Services

1. HCN visits for the sole purpose of providing household tasks, transportation, companionship, or socialization
2. Services that are not medically necessary
3. Services that are not ordered by a physician
4. Services provided in a hospital, NF, or ICF

HCN Relative Hardship Waiver

The HCN Relative Hardship Waiver allows certain relatives to receive reimbursement for providing services to an IMCare member. The relative must be currently licensed in the State of Minnesota as an RN or LPN employed by a Medicare- certified HCN agency enrolled with IMCare and is:

1. The parent of a member;
2. The spouse of a member;
3. A non-corporate legal guardian of a member; or

4. A family foster parent of a minor child.

In order to qualify for a HCN Relative Hardship Waiver, at least one of the following criteria must be met:

1. The relative resigns from a full-time or part-time job to provide HCN for the member
2. The relative goes from a full-time to a part-time job with less compensation to provide HCN for the member
3. The relative takes a leave of absence without pay to provide HCN for the member
4. 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 HCN services to meet the member's needs

In the case of a HCN Relative Hardship Waiver, the provider agency is responsible for the following:

1. Receiving the request from the member/responsible party
2. Obtaining the relative's signature
3. Completing the [HCN Hardship Waiver Application](#) (DHS-4109)
4. Ensuring the accuracy of the information
5. Submitting the [HCN Hardship Waiver Application](#) (DHS-4109) along with supporting documentation to the [Disability Services Division \(DSD\)](#)
6. Completing a criminal background check

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.
5. HCN services may not be reimbursed if the nurse is the foster care provider of a person who is under the age of 18 years.

Eligible Members

1. Members on Medical Assistance (Medicaid)
2. MinnesotaCare members who are under age 19 or are pregnant women
3. Members on Minnesota Senior Healthcare Options (MHSO), or Minnesota Senior Care Plus (MSC+)

Note: Non-pregnant adult MinnesotaCare members are not eligible for HCN services.

Eligible Providers of HCN Services

1. Medicare- certified home health agency with a comprehensive homecare licensed
2. Independent registered nurse (RN)

Independent licensed practical nurse (LPN)

Provider requirements: Provider is limited to services that are allowed for under the licensure or certification of the agency and agency practitioners.

Authorization Requirements

Ongoing requirements for HCN authorization and documentation:

1. All HCN services require prior authorization.
2. HCN services require a physician order prior to initiating service and a face-to-face encounter with a physician, NP or PA, related to the primary reason home health services are required, within 90 days before or 30 days after the home health services were initiated. Home care agencies must submit a copy of this visit to IMCare upon request.
3. Review/approval of the service plan by the member's physician is required every 60 days; or less if the authorization is approved by IMCare for fewer than 60 days depending on the member's individual condition.
4. Signed orders must be on file in the member's chart at the provider agency's office and a signed HCFA 485 should be attached to the authorization request form.
5. The orders or plan of care must do all of the following:
 - a. Specify the disciplines providing care
 - b. Specify the frequency and duration of all services
 - c. Demonstrate the need for the services and be supported by all pertinent diagnoses
 - d. Include member's functional level, medications, treatments, and clinical summary
 - e. Be individualized based on member needs
 - f. Have realistic goals
 - g. Subsequent plans of care must show member response to services and progress since the previous plan was developed
 - h. Changes to the plan of care are expected if the member is not achieving expected care outcomes

Authorization information/process is in the *Information for All IMCare Home Care Providers* section.

Services cannot be provided to two individuals in separate apartments in the same building, to other non-HCN members in the setting, or replace or supplement required staff at licensed facilities.

Shared care must be arranged through IMCare. The HCN agency must contact IMCare for instructions on accessing shared care.

Shared HCN Services

This option allows two recipients to share HCN services in the same setting at the same time from the same HCN. All regulations pertaining to HCN services also apply to the shared care option.

A setting includes:

1. The home or licensed foster care home of one of the members;
2. Outside the home or foster care home of one of the members when normal life activities take the members outside the home;
3. A child care program licensed under [MN Stat. Chap. 245A](#), or operated by a local school district or private school; or
4. An adult day care service licensed under [MN Stat. Chap. 245A](#).

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 the following:

1. Whether shared care is an appropriate option based upon the needs and preferences of the member; and
2. The number of shared care units that will be part of the overall authorization of HCN 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:

1. 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
2. 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 do the following:

1. Submit the service authorization request and HCFA 485 via fax or mail to IMCare

Waiver program recipients: The county case manager follows the same criteria and process to determine whether the shared care option is an appropriate and safe alternative for a 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 care plan and calculate the cost of shared care into the overall cost of service plan.

Documentation Requirements

Include a copy of each of the following in the member's chart when service is shared HCN:

1. A signed consent form by each member/legal representative
2. Permission for the agency to schedule shared care up to the maximum hours chosen by the member
3. Any use of services outside the member's home
4. Permission to place the member's name in the chart of the other shared member
5. How the needs of both members are appropriately and safely being met
6. Where the shared services will be provided
7. Ongoing monitoring and evaluation of the shared services by the HCN
8. Emergency response backup plans to the member's illness/absence or HCN's illness/absence
9. Additional training, if needed, for the HCN to provide care to two members
10. The names of each member receiving shared HCN services
11. The starting and ending times the members received shared HCN
12. Routine nursing documentation such as changes in the member's condition/any problems due to sharing 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 his/her shared care. Changes include the following:

1. The number of authorized units the member wishes to share
2. Discontinuing participation in shared care
3. 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 notify IMCare via mail or fax.

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.

IMCare will transfer shared care authorizations on the same service agreement. IMCare reserves the right to request a copy of the HCN assessment tool from the new provider agency at the time services are transferred or requested.

Billing Requirements

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

1. Use a separate line item to bill the shared (1:2) HCN units; and
2. Enter a “52” on the Modifier 1 (MOD1) field.

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 he/she is authorized for complex care, but the agency will only receive the complex rate during the hours the member is receiving the 1:1 services.

Rehabilitation Therapies

1. Occupational Therapy Procedure Code S9129
2. Certified Occupational Therapy Assistant (COTA) Code S9129 TF modifier
3. Physical Therapy Procedure Code S9131
4. PTA Procedure Code S9131 TF modifier
5. Respiratory Therapy Procedure Code S5181
6. Speech Therapy Procedure Code S9128

Coverage

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

Eligible Members

1. MinnesotaCare members and Medical Assistance (Medicaid) members. To receive payment for rehabilitation therapy, the services must be all of the following:
 - a. Provided in the member’s home
 - b. Ordered by a physician
 - c. Appropriate to meet the member’s needs
 - d. Specified in the plan of care
 - e. Medically necessary
2. Provided to the member whose functional status is expected to progress toward or achieve the goals specified in the member’s plan of care within a 60-day period or less time if the authorization is granted for less than 60 days depending on the member’s individual condition (if the service is a Medicare-covered service and is provided to a member who is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare).
3. Rehabilitation services cannot be covered when the member can reasonably access these services outside his/her residence, excluding the assessment, counseling, and education. A member who leaves the home at will, or a parent who could easily transport the child, must obtain these services at the rehabilitation center and will not be eligible for home care therapies.

Eligible Providers

Therapists must be employed by a Medicare-certified home health agency enrolled with IMCare. Services may be provided by the following:

1. Licensed PT
2. Registered Occupational Therapist (OT)
3. Certified Occupational Therapy Assistant (COTA)*

4. PTA*
5. Respiratory Therapist (RT)
6. Speech Therapist (ST)

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

Covered Services

Rehabilitation therapy services are daily, per visit codes, with the exception of respiratory therapy, which may be provided more than once per day for services provided in the member's home. All therapies must be specified in the member's plan of care.

The following home care therapy services are not subject to the outpatient rehabilitative service thresholds:

Code	Type of Therapy
S9129 TF	Certified Occupational Therapy Assistant (COTA) services
S9129	Occupational Therapy
S9131	Physical Therapy
S9131 TF	PTA services
S5181	Respiratory Therapy
S9128	Speech Therapy

If the service is a Medicare-covered service and is provided to a member who is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare.

Therapy Classifications

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

Restorative therapy is a health service that is:

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

Specialized maintenance therapy is a health service that:

1. Is specified in the member's plan of care;
2. Is ordered by a physician;
3. Is necessary for maintaining a member's functional status at a level consistent with the member's physical or mental limitations; and
4. May include treatments in addition to rehabilitative nursing services.

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

1. When services are provided by an assistant and the licensed or registered therapist is not on the premises, the services are billed with a modifier, and the payment will be at 65 percent of the therapist's rate. The licensed PT or registered OT must provide in-person direction to the assistant at least every sixth visit.
2. When a home visit is made jointly by the therapist and assistant, the provider may bill only for the therapist's visit. Providers may not bill for both the PT and PTA (or the OT and COTA) when a joint home visit is made.
3. When billing for specialized maintenance therapies, use the XC modifier on your claim form to differentiate these services. Home care therapy services are not subject to the one-time rehabilitative service thresholds.

Skilled Nurse Visits (SNVs)

Eligible Members

1. Medical Assistance (Medicaid) members
2. MinnesotaCare Expanded Benefit Set (children under age 191, and pregnant women)
3. Minnesota Senior Healthcare Options members
4. Minnesota Senior Care Plus

Eligible Providers

Medicare-certified, home health agencies enrolled with IMCare.

Prior Authorization Requirements

Two visits per day can be authorized. If the necessary medical services are more complex and require more time than can be performed in a single or twice daily SNV, HCN services are an appropriate option.

1. SNVs above nine visits per member, per calendar year require prior authorization.
2. Waiver recipients require prior authorization from the county case manager if the service is to be covered under the waiver.

Prior authorization cannot be granted prior to the date IMCare receives the completed Service Agreement request with all corresponding documentation.

Covered Skilled Nursing Services

1. A SNV is delivered according to the member's written plan of care or service plan, ordered by the physician, and is an accepted standard of medical and nursing practice in accordance with the Minnesota Nurse Practice Act ([MN Stat. sec. 148.171, subd. 1](#)). Equipment and supplies that are usual and customary (U&C) to completing an SNV are not billable (e.g., stethoscope, nail clippers, sphygmomanometer, alcohol wipes, etc.).
2. Intermittent home visits to initiate and complete professional nursing tasks based on a member's need for service as assessed to maintain or restore optimal health. Visits are made by an RN or 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 SNV, HCN services are an appropriate option.

3. Observation, assessment, and evaluation of a person's physical or mental health status. These may be covered when the likelihood of a change in condition requires skilled nursing personnel to identify and evaluate the need for possible modification of treatment or initiation of additional medical procedures until the member's treatment regimen is stabilized.
4. A procedure that requires substantial and specialized nursing skill such as administration of intravenous therapy, intra-muscular injections, and procedures, such as sterile catheter insertion or sterile wound cares.
5. Teaching and training that requires the skills of a nurse. Examples could include: teaching self-administration of injectable medications or a complex range of medications, teaching a newly diagnosed diabetic person or caregiver on all aspects of diabetic management, teaching self-catheterization or bowel and/or bladder training.
6. 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 Cesarean section. Post-delivery 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.
7. Community health nursing visits provided by a public health agency or home health agency for the sole purpose of maternal, child, and adult health promotion are covered when an authorized skilled nursing service is provided at the same visit.
8. Two visits per day can be authorized when necessary.
9. Telehome-care visits. Coverage of telehome-care is limited to two visits per day, and all of the visits must be prior authorized.
10. Venipuncture from a peripheral site. The home health provider can submit a request for prior authorization if he/she has determined and documented the following:
 - a. That there is not an available lab service that can visit the member's home to obtain the venipuncture from the peripheral site
 - b. That there is not a service reasonably available to the member outside of his/her place of residence
 - c. The member no longer qualifies for Medicare Part A skilled Medicare services (this may include physical therapy without SNVs)

Non-Covered SNVs

Home Visits

1. U&C equipment and supplies that are necessary to complete an SNV (e.g., stethoscope, nail clippers, sphygmomanometer, alcohol wipes, etc.).
2. Home visits made for the sole purpose of supervising an HHA or PCA. However, supervision may be done during an SNV that qualified for payment.
3. Home visits made for the sole purpose of monitoring medication compliance with an established medication program for a member.
4. Home visits made for the sole purpose of monitoring a member's overall physical status, when the member's physical status has not changed and the person is considered stable.
5. Home visits made to set up or administer oral medications; pre-fill injections, such as insulin syringes for an adult member when the need can be met by an available pharmacy; or the member is physically and mentally able to self-administer or pre-fill a medication; or if the activity can be delegated to a family member or HHA.
6. Home visits when the sole purpose of the visit is to train other home health agency workers.

7. Home visits when the visit is performed in a place other than the member's residence.
8. Home visits made for Medicare evaluation or administrative nursing visits required by Medicare but not qualifying as an SNV (these visits are an administrative expense for the Medicare-certified agency and cannot be billed to IMCare.)
9. Home visits by a licensed RN who makes an SNV but is employed by a PCPO or non-Medicare HCN agency.
10. A communication between the home care nurse and member that consists solely of a telephone conversation, facsimile, or electronic mail or a consultation between two health care practitioners is not considered a telehome-care visit.

Discontinuing Care to a Member

If a home care provider determines it is unable to continue providing care to a member, the provider must notify the member, responsible party, and IMCare at least 30 days before terminating services and assist the member in transitioning to another home care provider. If the termination is a result of sanctions on the provider, the provider must give each member a copy of the Home Care Bill of Rights at least 30 days before terminating services ([Minnesota 2010 Session Law, Chapter 352, article 1, section 8](#)).

Intermediate Care Facility for the Developmentally Disabled (ICF/DD) Skilled Nurse Visits (SNVs)

IMCare may authorize SNVs for fewer than 90 days for a member residing in an ICF/DD to prevent admission to a hospital or NF, if the ICF/DD is not required to provide the nursing services. The home health agency must obtain prior authorization.

A skilled nurse may be authorized for venipuncture if none of the above conditions can be met. Authorization requests must include full documentation in a clinical update on a [CMS-485](#) or CMS-486. See also [Chapter 6 of the Medicare Program Integrity Manual](#).

Telehome-Care

1. A telehome-care visit is an 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 technology, 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 telehome-care visit.
2. T 1030-GT is the code for home telehealth face-to-face "live" (SNV).
3. A communication between the home care nurse and member that consists solely of a telephone conversation, facsimile, or electronic mail or a consultation between two health care practitioners is not considered a telehome-care visit.
4. Coverage of telehome-care is limited to one visit per week no more than four times per month, and authorization is required for all visits.
5. Home health for peripheral only (weight, pulse, oximetry, etc.), use the code 99091 (the code 99091 can be billed four times within the month [i.e., once per week]).
6. Bill using code E1399-52 for equipment used for peripheral telehome-care visit.

Skilled nursing services are covered when such skilled nursing services are necessary to maintain the member's current condition or prevent or slow further deterioration so long as the member requires skilled care for the services to be safely and effectively provided.

Skilled therapy services are covered when an individualized assessment of the member's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist ("skilled care") are necessary for the performance of a safe and effective maintenance program. Such a maintenance program to maintain the member's current condition or to prevent or slow further deterioration is covered so long as the member requires skilled care for the safe and effective performance of the program.

Combination PCA and Other Home Care Services

PCA combinations are Service Authorizations that include one or more of the following IMCare fee-for-services: SNV, HHA, and/or HCN along with PCA services. Home care services must be medically necessary and cost effective. The home care rating determines the maximum dollar amount that can be authorized for all home care services. See [Home Care Nursing Service Decision Tree \(DHS-4071C\)](#) and [PCA Decision Tree \(DHS-4201\)](#) for further information.

PCA Hardship Waiver

The need to apply for the PCA Hardship Waiver to provide PCA services has been repealed. Parents of adult recipients and adult children or siblings of a recipient may now provide PCA services to a family member without applying for a PCA Hardship Waiver, if they meet the criteria to work as a PCA.

The following family members may **not** serve as the PCA:

1. Spouse
2. Parent of a minor child
3. The responsible party

Home Care and Hospice Election

The hospice benefit:

1. Is a comprehensive package of services offering palliative care support to terminally ill individuals and their families
2. Is designed to supplement the care provided by primary care givers such as family (as the patient defines family), friends, and neighbors
3. Is **not** intended to replace the supportive services provided by primary caregivers
4. Is **not** intended to duplicate health services or supports that relate to a pre-existing condition
 - a. Example: A home care service or supply is required for a condition **unrelated** to the terminal condition (e.g., quadriplegia, schizophrenia, cerebral palsy) and does not supplant or duplicate the covered hospice benefit
5. Is **not** intended to cover medical needs that arise during the period of the hospice benefit that are unrelated to the terminal illness

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

For further information and details about the hospice benefit, see [Chapter 28, Hospice Services](#).

Individualized Educational Plan (IEP)

Refer to [Chapter 9, Children's Services](#), for additional information regarding IEP services. Covered IEP services include nursing services, PCA services, physical therapy, occupational therapy, speech-language pathology (SLP), mental health services, special transportation, and assistive technology devices.

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

Coordination of IEP services and home care services are assessed on a 24-hour non-school day.

A parent/guardian may choose to use authorized home care or waiver services in the school rather than have the school bill for the education plan service.

1. Services must be listed in the child's IEP/individualized family service plan (IFSP)/individual interagency intervention plan (IIIP); and
2. Permission must be given by the parent/guardian in the care plan and retained by the provider in his/her records.

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

Non-Covered Services

1. Services that are not ordered by the member's physician
2. Services that are not specified in the member's service plan or care plan
3. Services provided without authorization from DHS when required
4. Services that have already been paid by Medicare, health plans, health insurance policies, or any other liable third party at more than the MHCP allowable amount
5. HCN or PCA services provided to non-pregnant MinnesotaCare members
6. Services to other members of the member's household
7. Home care services included in the daily rate of a community-based residential facility where the member is residing
8. Services that are the responsibility of the foster care provider under the terms of the foster care placement agreement and administrative rules
9. 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)

Information for All IMCare Home Care Providers – Service Agreement Quick Reference Guide

Use this Quick Reference Guide to obtain Service Authorizations in a timely and productive manner.

Getting Started

1. Obtain all health insurance coverage information.
2. Verify member eligibility; see [Chapter 4, Billing Policy](#).
3. If the member is eligible for a waiver, contact the member's county case manager or lead agency.
4. If the member is IMCare -eligible without a waiver, follow the process outlined in the Quick Reference section.

Bill Medicare and other insurance before billing IMCare.

Authorization Guidelines

Request prior authorization for all of the following:

1. All HHA services
2. All HCN services
3. SNVs visits above nine visits per recipient, per calendar year.

4. All telehome-care visits
5. More than two face-to-face PCA assessment visits conducted by the county public health nurse (PHN), per member, per calendar year
6. More than one service update assessment visit by the county PHN per member, per calendar year
7. All PCA services and supervision of PCA services

Prior authorization requests for SNV, HHA, and HCN are submitted directly to IMCare by the provider agency. The county PHN under contract with the county must submit the prior authorization requests for PCA services to IMCare at:

Fax: **1-218-327-5545**
Mail: IMCare
1219 SE 2nd Ave Grand Rapids, MN 55744

Review the Service Authorization immediately for content and comments. Line item dates may differ from header dates. If you are unclear about comments or have questions about the authorization, call the IMCare Member Services at 1-800-843-9536 (toll free).

Face-to-Face Assessments

The county PHN may conduct up to two face-to-face assessments per member per calendar year without prior authorization when:

1. A member is requesting PCA services for the first time;
2. A member's condition changes significantly;
3. PCA services change(s) is needed; or
4. A member is using the PCA Choice option.

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

1. Complete the assessment within 30 days of request
2. Conduct all assessments for PCA services
3. Conduct service updates and temporary service increase requests for PCA services
4. Provide information about options available in the PCA program
5. Develop a service plan appropriate to the member's needs
6. Recommend and provide referral information about other services as appropriate
7. Assist the member in identifying the most appropriate professional (if selected) to supervise the PCA
8. Recommend the necessary amount of PCA services and supervision of PCA services (if selected) to IMCare, including requests for temporary Service Authorizations and temporary service increases from IMCare
9. Provide the member or responsible party with a list of enrolled PCPOs and PCA Choice providers, if requested

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

1. Another PHN agency; or
2. An independent certified PHN:
 - a. Not employed by or under contract with the county agency; or
 - b. Not under contract with an enrolled PCPO to conduct the assessment and reassessments.

An assessment must include the [Personal Care Assistance \(PCA\) Assessment and Service Plan \(DHS-3244\)](#) or MNChoices Assessment and any additional documentation as necessary to substantiate services. See the [PCA Assessment and Service Plan Instructions and Guidelines \(DHS-3244A\)](#) for instructions on completing

the form.

Temporary or Long-Term Initial Authorization

Temporary requests are for services up to 45 days in length. Long-term initial authorization requests are for services that are expected to be provided for more than 45 days.

SNV, HHA, Rehabilitation Therapy, and HCN

To request initial authorization for HHA or HCN, complete and fax the [IMCare Homecare Request Form](#) along with supporting documentation (treatment plan, clinical summary, etc.) to IMCare before the first home visit. For initial authorization requests for SNV, complete the form and mail or fax it along with supporting documentation (treatment plan, clinical summary, etc.) to IMCare by the ninth visit for the calendar year for each service.

Fax: **1-218-327-5545**

Call: **1-800-843-9536** (toll free)

Mail: IMCare

1219 SE 2nd Ave

Grand Rapids, MN 55744

Home Care Continuing Authorization

For temporary or long-term home care, if more services are needed than approved in the initial authorization, provide updated clinical information, goals, and treatment plan before the end of the authorization period or before the end of the visits approved, whichever runs out first. Fax updates to IMCare at **1-218-327-5545**.

Changes in Medical Status or Primary Caregiver Availability

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

1. Change in health
2. Change in level of care
3. Addition of service(s)
4. Change in physician orders
5. Change in living arrangement (i.e., recent facility placement)
6. Change in primary caregiver's availability

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

When a change in medical status exists, the provider must fax the following to IMCare at **1-218-327-5545**:

1. **MA Home Care Technical Change Request** (DHS-4074) or IMCare Service Authorization form
2. Updated Plan of Treatment ([CMS 485](#) or [Home Health Certification and Plan of Care \[DHS-4633\]](#) or any available)
3. Concise current clinical update ([CMS 485](#), CMS 486 [see [Chapter 6 of the Medicare Program Integrity Manual](#)] or [Home Health Certification and Plan of Care \[DHS-4633\]](#) or any form available)
4. Completed [MA Home Care Nursing Assessment](#) (DHS-4071A)

PCA combinations are Service Authorizations that include PCA and one or more of the following:

1. SNV
2. HHA
3. HCN

Home care services must be medically necessary and cost effective. The home care rating determines the maximum dollar amount that can be authorized for all home care services.

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 Service Authorization. Each provider agency can bill for the same type of service on the same day. Each agency must have an approved line item on the Service Agreement.

1. Daily codes (i.e., HCN and rehabilitation therapies) must be billed in consecutive date spans only, to avoid duplicative billing.
2. 15-minute codes may be billed by more than one provider, per date of service (DOS).

Each provider must submit the [MA Home Care Technical Change Request \(DHS-4074\)](#) or the Itasca Medical Care (IMCare) Authorization Request, indicating all of the following:

1. All provider names and numbers
2. DOS for each provider
3. The number of units to be used by each provider

Members using the PCA Choice option cannot use more than one PCA Choice provider or use a PCPO along with a PCA Choice provider.

Change in Provider

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

Discontinuing Provider

To discontinue using a provider, fax the [MA Home Care Technical Change Request \(DHS-4074\)](#) or the Itasca Medical Care (IMCare) Authorization Request to **1-218-327-5545**, with all of the following information:

1. Member identification (ID) number
2. Service Agreement number being adjusted
3. Provider ID number of agency discontinuing services, last DOS with agency discontinuing services
4. Last DOS with agency discontinuing services
5. Total units to be transferred to the new agency

Initiating New Provider

To begin using a new provider, fax the [MA Home Care Technical Change Request \(DHS-4074\)](#) or the Itasca Medical Care (IMCare) Authorization Request to **1-218-327-5545** with all of the following information:

1. Member ID number
2. Service Agreement number being adjusted (if available)
3. Provider ID number of agency beginning services
4. Date services will begin with the new agency

In the event the discontinuing provider does not submit the [MA Home Care Technical Change Request \(DHS- 4074\)](#)

release, the member, responsible party, or legal guardian must provide a signed written statement indicating the last DOS 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 [MA Home Care Technical Change Request \(DHS-4074\)](#) or the Itasca Medical Care (IMCare) Authorization Request to 1-218-327-5545, indicating the following:

1. The last date service was provided
2. 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 [MA Home Care Technical Change Request \(DHS-4074\)](#) or the Itasca Medical Care (IMCare) Authorization Request to 1-218-327-5545 indicating:

1. The first date service will be reinstated
2. The total number of units requested

Change in Member Identification (ID)/ Personal Member Identifier (PMI) Number

When a member's ID/PMI number changes, the provider must submit the completed [MA Home Care Technical Change Request \(DHS-4074\)](#) to 1-218-327-5545, indicating all of the following:

1. Previous PMI number
2. Previous name
3. New PMI number
4. New name
5. Date of birth (DOB)
6. Date of change to the new PMI number

Temporary Prepaid Medical Assistance Program (PMAP) Disenrollment

When a member is disenrolled from IMCare, PCA providers must contact DHS directly within 30 calendar days to request authorization so that services for the member can continue, and fee-for-service payment is made to the PCA provider.

If providers do not contact DHS within 30 calendar days, DHS will adjust the start date of the new Service Agreement to the date the [MA Home Care Technical Change Request \(DHS-4074\)](#) was received by DHS.

If the member is not re-enrolled in IMCare within 60 days of the disenrollment, immediately request a PCA assessment from the county PHN.

Technical Change/Correction

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

1. Provider name/ID number
2. Member name/DOB
3. Healthcare Common Procedure Coding System (HCPCS) code/units/rate
4. *International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)* codes

Submit the correct information on the [MA Home Care Technical Change Request \(DHS-4074\)](#) and use the

“Comments” section to explain why the correction is being requested.

Skilled Nursing Visit (SNV), Home Health Aide (HHA), Rehabilitation Therapy, and Home Care Nursing (HCN)

When a change or correction is need for SNV, HHA, rehabilitation therapy, and HCN services, the provider must submit the completed [MA Home Care Technical Change Request \(DHS-4074\)](#) or the Itasca Medical Care (IMCare) Authorization Request to **1-218-327-5545**. The submitted form must do the following:

1. State the correct information
2. Contain documentation in the “Comments” section stating the reason the correction is being requested

Non-Waiver Home Care to Waiver Home Care

The county case manager must do the following:

1. Provide a Service Request Form to the provider

Recovery of Excessive Payments

IMCare 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.

Non-Covered Home Care Services

1. HCN or PCA services provided to MinnesotaCare members over the age of 18.
2. Services provided to a person who is not an eligible IMCare member
3. Services provided by a provider that is not enrolled or does not have a valid provider agreement with IMCare
4. Services that are not ordered by the member’s physician
5. Services that are not specified in the member’s service plan or care plan
6. Services provided without authorization from IMCare when required
7. Services that have already been paid by Medicare, health plans, health insurance policies, or any other liable third party at more than the IMCare allowable amount
8. Services to other members of the member’s household
9. Home care services included in the daily rate of a community-based residential facility where the member is residing
10. Services that are the responsibility of the foster care provider under the terms of the foster care placement agreement and administrative rules
11. 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)

Billing IMCare – Order of Payers

IMCare pays for services after the member has used all other sources of payment. IMCare is the payer of last resort. The order of payers for an IMCare member is as follows:

1. Third party payers or primary payers to Medicare (e.g., large and small group health plans, private health plans, group health plans covering the beneficiary with End Stage Renal Disease [ESRD] for the first 18 months, Workers’ Compensation law or plan, no-fault or liability insurance policy or plan)
2. Medicare
3. IMCare Medical Assistance (Medicaid) or MinnesotaCare

Providers must bill all third party payers, including Medicare, and receive payment to the fullest extent possible before billing. IMCare becomes the payer only after all other pay options (other than a Medical Assistance [Medicaid] waiver program) have been exhausted. Services that could have been paid by Medicare, a health maintenance organization (HMO), or insurance plan, if applicable rules were followed, are not covered by IMCare.

Providers must be familiar with Medicare coverage for members receiving home care. This includes billing Medicare when Medicare is liable for the service or, if the provider is not Medicare-certified, referring the member to a Medicare-certified provider of the member’s choice and notifying members when Medicare is no longer the liable payer for home care services.

Medicare Home Health Prospective Payment System (PPS)

If the service is covered by Medicare, then Medicare guidelines must be followed. This affects all dually eligible members (those members covered under a Medicare home health plan of care and who are on Medical Assistance [Medicaid]).

Medicare requires consolidated billing of all home health services while a Medicare recipient is under a home health plan of care. All supplies and services listed under PPS are the responsibility of the home health agency whose care the member is under during the Medicare PPS episode and are not billable by other providers. During each 60-day PPS episode, the home health agency is responsible to bill Medicare for all home health services included in the PPS episode including the following:

1. Services provided by a home health agency affiliated or under common control with a hospital
2. Care for homebound patients involving equipment too cumbersome to take to the home
3. Home health aide services
4. Medical services provided by an intern or resident-in-training at a hospital, under an approved teaching program of the hospital
5. Medical social services
6. Skilled nursing care
7. Speech-language pathology
8. Occupational therapy
9. Physical therapy
10. Routine and non-routine medical supplies

Home health services are paid on a cost basis. Therefore, the PPS rate assigned to the 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.

Medical Assistance (Medicaid)/ MinnesotaCare Home Care Service	Procedure Code	Modifier	Shared Indicator	Authorization Required	Service Unit
County PHN service update for PCA services	T1001	TS		No*	Per update
County PHN temporary service increase	T1001	U6		Yes	Per update

for PCA services					
Home health aide visit	T1021			Yes	Visit
LPN – Regular Home Care Nursing	T1003			Yes	15 minutes
LPN – Shared Home Care Nursing 1:2	T1003	TT	Yes	Yes	15 minutes
LPN – Complex Home Care Nursing	T1003	TG		Yes	15 minutes
Occupational therapy visit	S9129			No	Visit
Physical therapy visit	S9131			No	Visit
Respiratory therapy visit	S5181			No	Visit
RN – Regular Home Care Nursing	T1002			Yes	15 minutes
RN – Shared Home Care Nursing 1:2	T1002	TT	Yes	Yes	15 minutes
RN – Complex	T1002	TG		Yes	15 minutes
Skilled nurse visit	T1030			No**	Visit
Speech therapy visit	S9128			No	Visit

* Authorization is required for more than one service update, per member, per calendar year.

** Authorization is required after nine skilled nurse visits per member, per calendar year, except for the EW members who always require authorization.

Information about the Waivered Services and the Alternative Care (AC) program can be found in [Chapter 26, Home and Community Based Services \(HCBS\) Elderly Waivers](#), of the *Provider Manual*.

DHS Internet Forms Available

1. [Service Agreement \(DHS-3070\)](#)
2. [Personal Care Assistance \(PCA\) Assessment and Service Plan \(DHS-3244\)](#)
3. [PCA Assessment and Service Plan Instructions and Guidelines \(DHS-3244A\)](#)
4. [MA Home Care Nursing Assessment \(DHS-4071A\)](#)

5. [MA Home Care Technical Change Request \(DHS-4074\)](#)
6. [Home Care Nursing Hardship Waiver Application \(DHS-4109\)](#)
7. [PCA Decision Tree \(DHS-4201\)](#)
8. [Home Health Certification and Plan of Care \(DHS-4633\)](#)
9. [Home Care Shared Services Agreement \(Home Care Nursing or PCA\) \(DHS-5899\)](#)

Legal References

[MN Stat. sec. 144A.43, subd. 3](#) – Definitions: Home care service
[MN Stat. Chap. 144G](#) – Assisted Living Services
[MN Stat. sec. 148.171, subd. 1](#) – Definitions; Title: Title
[MN Stat. sec. 148.171, subd. 8](#) – Definitions; Title: Licensed practical nurse
[MN Stat. secs. 148.171 – 148.285](#) – Nurses
[MN Stat. sec. 245.462, subd. 18](#) – Definitions: Mental health professional
[MN Stat. sec. 245.4871, subd. 27](#) – Definitions: Mental health professional
[MN Stat. Chap. 245A](#) – Human Services Licensing
[MN Stat. sec. 256B.0625](#) – Covered Services
[MN Stat. sec. 256B.0625, subd. 7](#) – Covered Services: Home Care Nursing
[MN Stat. sec. 256B.0625, subd. 19c](#) – Covered Services: Personal care
[MN Stat. sec. 256B.0651](#) – Home Care Services
[MN Stat. sec. 256B.0653](#) – Home Health Agency Services
[MN Rules part 9505.0290](#) – Home Health Agency Services
[MN Rules part 9505.0295](#) – Home Health Services
[MN Rules part 9505.0335](#) – Personal Care Services
[MN Rules part 9505.0355](#) – Preventive Health Services
[Title 42 Code of Federal Regulations \(CFR\) Part 440.70](#) – Home health services
[42 CFR 440.80](#) – Home Care Nursing services
[42 CFR 440.167](#) – Personal care services
[42 CFR 441.15](#) – Home health services
[42 CFR 441.302](#) – State assurances
[Minnesota 2010 Session Law, Chapter 352, article 1, section 8](#)
[Public Law 97–35: OBRA 1981](#)
[Title XIX, section 1915 of the Social Security Act](#) – Provisions Respecting Inapplicability and Waiver of Certain Requirements of this Title