Home Health Care

Purpose

In this class participants will learn how Medica covers different home health care services, prior authorization and claim submission requirements.

Objectives

Upon completion of this class you will be able to:

• Explain coverage differences, limitations and prior authorization requirements for home health care services.
• Describe claim submission requirements
• Locate documents on medica.com

Topics

This course is divided into the following topics:

• Skilled Services
• Personal Care Assistance (PCA) Services
• Medica DUAL Solution®, MSC+, and Elderly Waiver Services
• Home Infusion Therapy (HIT) Services

Reference Tools on medica.com

The following reference tools are on medica.com:

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<th>Location on medica.com</th>
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<td>County Partners Care Systems and Agencies – Phone and Fax Numbers</td>
<td>Providers&gt;Reference Tools and Forms&gt;Tools and Forms&gt;Claims Tools and Forms&gt;under Referral Processes heading</td>
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<tr>
<td>Coverage Policies</td>
<td>Providers&gt;Medical Policies</td>
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<tr>
<td>Elderly Waiver Fee Schedule</td>
<td>Providers&gt;Reference Tools and Forms&gt;Tools and Forms&gt;Coding Tools and Forms</td>
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<tr>
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<td>Providers&gt;Reference Tools and Forms&gt;Tools and Forms&gt;General Tools and Forms under Electronic Commerce</td>
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<tr>
<td>Hennepin County Contracted Agencies – Referral Phone and Fax Numbers</td>
<td>Providers&gt;Reference Tools and Forms&gt;Tools and Forms&gt;Claims Tools and Forms&gt;under Referral Processes heading</td>
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<tr>
<td>Home Health Request Form</td>
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<tr>
<td>Home Health Services Requiring Prior Authorization</td>
<td>Providers&gt;Reference Tools and Forms&gt;Tools and Forms&gt;Claims Tools and Forms under Specialty Guidelines</td>
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<td>PCA Administrative Requirements</td>
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<tr>
<td>Points of Contact for Providers</td>
<td>Providers&gt;About Medica&gt;Contacts</td>
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<tr>
<td>Prior Authorizations</td>
<td>Providers&gt;Reference Tools and Forms&gt;Tools and Forms&gt;Claims Tools and Forms&gt;Referral Guidelines&gt; MSHO/DUAL Solutions &amp; MSC+</td>
</tr>
<tr>
<td>Procedure Codes for Home Health Care Services</td>
<td>Providers&gt;Reference Tools and Forms&gt;Tools and Forms&gt;Coding Tools and Forms</td>
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<td>Procedure Codes for Personal Care Assistant Services</td>
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<td>Product Grid – Medicare, Minnesota</td>
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<tr>
<td>Referral Guidelines – MSHO/MSC+</td>
<td>Providers&gt;Reference Tools and Forms&gt;Tools and Forms&gt;Claims Tools and Forms</td>
</tr>
<tr>
<td>SNP &amp; MSC+ Group Numbers</td>
<td>Providers&gt;Reference Tools and Forms&gt;Tools and Forms&gt;Product Information under Overview of Products</td>
</tr>
<tr>
<td>Utilization Management Policies</td>
<td>Providers&gt;Medical Policies&gt;Utilization Management Policies&gt; under the Home Care heading</td>
</tr>
</tbody>
</table>
A provider is considered “participating” if they have a signed Medica contract.

**Home Health Care Contract** – Can provide Home Health Care (HHC), Personal Care Assistance (PCA must have a separate contract), and Elderly Waiver Services if the providing PCA completes a form and requests a number (see PCA section).

**PCA Contract** – can only provide personal care assistance. Must have completed form and request PCA numbers (see PCA section). Elderly Waiver is provided on a non-participating basis. If there is an Elderly Waiver network, as in Hennepin County, the PCA providers may not provide Elderly Waiver services without a contract.

**Elderly Waiver** – Medica does not contract with Elderly Waiver Providers, except in Hennepin County.
1. Skilled Services

Introduction

This course separates home health care benefits into the following categories:

- Skilled Services/Home Health Aides
- Personal Care Assistance (PCA) Services
- Elderly Waiver Services
- Home Infusion Therapy (HIT) Services

Skilled Services/Home Health Aide

Skilled services are nursing or rehabilitation services requiring the skills of technical or professional clinical personnel to develop a care plan, provide the care, as well as assess the patient’s changing condition. Skilled services must be provided by an RN, an LPN under the supervision of an RN, or a physical/occupational/speech therapist. Personal Care Assistants (PCAs) cannot provide skilled services. PCA services will be covered in the following section.

Skilled treatments include, but are not limited to:

- Administering medications that cannot be self-administered
- Wound care
- Rehabilitation services
- Catheter insertion
- Teaching and training – teaching about the administration of injectable medications or medication regimens, training in wound care, etc. Teaching and training are no longer appropriate if, after a reasonable amount of time, the individual will not or is not able to be trained.

- What Services do Home Health Aides provide?

Home Health Aides provide hands-on personal care in conjunction with medical services that are needed to maintain the member’s health or to facilitate treatment of the member’s illness or injury. Services from a Home Health Aide require prior authorization. For details go to medica.com at Providers>Medical Policies>Utilization Management Policies>Medicaid Home Health Aide (under the Home Care heading)

Home Health Aides can also be used as “custodial” care through state plan benefits.
Criteria for Skilled Services

In order for a Medica enrollee to qualify for coverage of skilled services, all of the following criteria must be met for Medicare and Commercial members:

1. **To receive services the patient must be homebound**

Medica considers a patient to be homebound when it is medically contraindicated for the patient to leave the home, or when leaving the home will directly and negatively impact the patient’s physical health. Patients do not have to be bedridden to be considered confined to their home.

2. **An assessment visit is made prior to the development of a treatment plan**

An assessment visit is a personal contact visit made to the patient’s home by a home care agency’s Licensed Registered Nurse or licensed physical/occupational/speech therapist. The purpose of the visit is to identify the problems, needs and strengths of the patient and the services the patient’s family or support system can provide. Examples of issues commonly addressed during an assessment visit are:

- Patient’s diagnosis – medical condition
- Functional limitations
- Physician’s orders (i.e. medications, treatments, therapy, lab, etc.)
- Psycho-social history
- Physical assessment
- Availability of family/support system caregivers
- Home environment/equipment needs
- Safety issues/concerns
Criteria for Skilled Services (continued)

3. **A physician orders services**

The orders by the physician should be part of the “written plan of care.” Recertification must be obtained at least every two months as to the continued medical necessity of the services provided. The following items must be documented:

- An estimated length of treatment
- Frequency and duration of the services
- Description of the skilled service(s) to be received

Generally, the definition of “medical necessity” is the diagnostic testing, preventive services and medical treatment consistent with the diagnosis of a prescribed course of treatment for the patient’s condition which Medica determines on a case-by-case basis.

The services must be consistent with medical standards and accepted practice parameters of community standards determined by health care providers in the same or similar specialty. This typically will manage the condition, procedure or treatment issue, and is considered appropriate for the member’s condition.

The services should be rendered to:

- Help restore or maintain the member’s health to prevent deterioration of the member’s condition
- Prevent reasonable likelihood of an onset of a health problem or to detect an incipient problem

Plan of Care

4. **A Plan of Care**

The plan of care is developed to identify and address the individual needs of the patient. The purpose of the plan is to meet those needs and to stabilize and/or improve the patient’s clinical status. An established treatment plan should include the following:

- Verification of the patient’s homebound status
- Determination of need for skilled nursing care or physical/occupational/speech therapy
- Physician order for the care
- Written and measurable goals of care
- Summary of progress towards goals achieved and summary of goals yet to be reached.
5. **Skilled services are needed**

“Skilled services” are when the use of nursing or rehabilitation services requiring the use of technical or professional medical personnel are needed. These individuals develop, provide and evaluate the care, as well as assess the patient’s changing condition.

The following criteria for care must be met to designate that the services are needed:

- Ordered by and certified, if applicable, as well as being included in the treatment plan by a physician.
- Required on an “intermittent basis.” Intermittent basis is defined as a maximum of 56 hours per week. This includes a combination of all disciplines (i.e. 14 hours per discipline per week); a visit is considered up to 2 hours of care.
- Service is performed by or under the direction of a licensed RN, physical therapist, speech therapist or occupational therapist.
- Care is reasonable and necessary for the treatment of illness or injury
- Service is provided at a frequency that is considered to be community standard.

6. **Services must be performed in the patient’s place of residence**

A patient’s residence is where he or she makes his/her home. This may be the patient’s own dwelling, an apartment, a relative’s home, an apartment complex which provides assisted living services or another type of institution. However, an institution may not be considered a patient’s residence if it:

- Meets the definition of a hospital in accordance with the member’s contract; or
- Meets the definition of a skilled nursing facility in accordance with the member’s contract

**REMINDER:** The preceding criteria are specifically for skilled services provided to adults. This criterion is not followed for Personal Care Assistants (PCA), Elderly Waiver (EW), or Home Infusion Therapy (HIT) services. Additionally, Medicare products must follow Medicare guidelines.
**Prior Authorization**

**Prior Authorization Requirements**
Medica maintains a prior authorization list to evaluate the appropriateness of a medical service based on criteria, medical necessity, and benefit coverage. This list is available on medica.com at Providers>Reference Tools and Forms>Tools and Forms>Claims Tools and Forms>Referral Guidelines.

It is important to remember that this list is not applicable to all Medica members – individual groups can choose to utilize other prior authorization requirements. Coverage requirements should always be verified.

Medica requires prior authorization for the following: (This is not applicable to Conversion plans.)

- All home health aide services
- Extended hours skilled nursing home care (more than 2 hours per day)
- Any home health service from non-network providers

Medica does not require prior authorization for the following:

- Initial assessment visits
- Skilled nursing visits for adult members
- Physical therapy visits
- Occupational therapy visits
- Speech therapy visits
- Respiratory therapy services
- Medical social worker
- Registered dietitian

*Dietitian Consultation coverage policy applies (Coverage policies are on medica.com at Providers>Medical Policies>Coverage Policies)*

**Utilization Management Policies**

Medica maintains Utilization Management (UM) policies, relating to home health care services requiring prior authorization that outline the criteria that must be met in order for prior authorization to be granted. The Medica Medicare products will need to meet Medicare guidelines. These policies are available on medica.com at Providers> Medical Policies>Utilization Management Policies

- Extended Hours Home Care (Skilled Nursing Services) for Patients with Medically Complex or Medically Fragile Conditions  UM Policy III-HOM.01
- Home Health Care (III-HOM.02)
- Personal Care Assistant (PCA) (III-HOM.03)
- Medicaid Home Health Aide (III-HOM-04)

See the Referral Guidelines on medica.com at this location:
Providers>Reference Tools and Forms>Tools and Forms>Claims Tools and Forms> then see the header “Referral Processes”
Codes Requiring Prior Authorization

Codes requiring prior authorization are:

**Home Care:** S9123, S9124, T1004, T1021, T1002TG, T1003TG

**PCA:** T1019 with any modifier

**EW:** S5130, S5131

Obtaining Prior Authorization

Prior authorization can be obtained (for products other than Medica DUAL Solution and MSC+) by submitting a prior authorization request to Medica. Prior authorization can be requested by contacting Medica Care Management Department at 800-458-5512 option 4; online at medica.com (at Providers>Reference Tools and Forms>Tools and Forms>Claims Tools and Forms under Specialty Guidelines), by faxing a request to the Medica Care Management Department at 952-992-3556 or 952-992-3554; or by mailing a request to:

Medica
PO Box 9310
Minneapolis, MN 55440

The updated Home Health Care Request Form is located on medica.com at Providers>Reference Tools and Forms>Tools and Forms>General Tools and Forms under Miscellaneous
Obtaining Prior Authorization – Medica DUAL Solution and MSC+

Medica DUAL Solution and MSC+ members’ care should be arranged through the designated Care Coordinator. Provider should contact the Care Coordinator to authorize services. Providers can determine the Care Coordinator by contacting the member’s designated Care System. The Care System can be determined by the member’s group number.

To assist you in determining the Care Coordinator for DUAL Solution members, see:

- **Care System Contacts**
  
  On medica.com at Providers>Reference Tools and Forms>Tools and Forms>Claims Tools and Forms>under the Referral Processes heading, click on “County Partners Care Systems and Agencies – Phone and Fax Numbers”

- **County Contacts**
  
  On medica.com at Providers>Reference Tools and Forms>Tools and Forms>Claims Tools and Forms>under the Referral Processes heading, click on “Hennepin County Contracted Agencies – Referral Phone and Fax Numbers”

### County Partners Care Systems and Agencies

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<thead>
<tr>
<th>County</th>
<th>Phone</th>
<th>Fax</th>
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</thead>
<tbody>
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<td>Anoka</td>
<td>763-422-6970</td>
<td>763-422-6988</td>
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<td>Benton</td>
<td>320-968-5098</td>
<td>320-968-5330</td>
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<tr>
<td>Becker</td>
<td>218-847-5628</td>
<td>218-847-6738</td>
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<tr>
<td>Carlton</td>
<td>218-879-4511</td>
<td>218-878-2845</td>
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<tr>
<td>Carver</td>
<td>952-442-7671</td>
<td>952-442-7665</td>
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<tr>
<td>Cass</td>
<td>218-547-1340</td>
<td>218-547-1448</td>
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<td>Chisago</td>
<td>651-213-5231</td>
<td>651-213-5685</td>
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<td>Clay</td>
<td>318-294-7166</td>
<td>218-294-7205</td>
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<td>Crow Wing</td>
<td>218-824-1145</td>
<td>218-824-1305</td>
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<td>Dakota</td>
<td>651-554-6115</td>
<td>651-554-6130</td>
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<td>Hennepin</td>
<td>612-240-4500</td>
<td>763-569-3660</td>
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<td>Koochiching (MSC+ Only)</td>
<td>218-282-7800</td>
<td>218-282-7703</td>
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<tr>
<td>Nornan</td>
<td>218-784-5400</td>
<td>218-784-7142</td>
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<td>Mankato</td>
<td>218-956-2588</td>
<td>218-956-5459</td>
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<td>Morrison</td>
<td>320-652-0374</td>
<td>320-652-0392</td>
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<td>Otter Tail</td>
<td>218-998-8150</td>
<td>218-998-8213</td>
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<td>Polk</td>
<td>218-773-5527</td>
<td>218-773-3902</td>
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<td>Ramsey</td>
<td>651-296-4892</td>
<td>651-296-3703</td>
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<td>St. Louis</td>
<td>218-726-2063</td>
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<td>Scott</td>
<td>952-406-8556</td>
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<td>Sherburne</td>
<td>763-241-2672</td>
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<td>Sherwood</td>
<td>763-656-6800</td>
<td>763-656-6116</td>
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<td>Todd</td>
<td>320-732-4440</td>
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<td>Wadena</td>
<td>218-631-7605</td>
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<td>Washington</td>
<td>651-430-6719</td>
<td>651-430-8340</td>
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<td>Wilkin</td>
<td>218-843-7122</td>
<td>218-843-7166</td>
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<td>Wright</td>
<td>763-682-7407</td>
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### Care System

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<tr>
<th>Care System</th>
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<tr>
<td>AXIS Healthcare</td>
<td>651-566-0887</td>
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<td>EverCare</td>
<td>952-931-5900</td>
<td>952-931-5901</td>
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<td>Fairview Partners</td>
<td>952-914-1720</td>
<td>952-914-1730</td>
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<td>HealthEast</td>
<td>651-252-5509</td>
<td>651-252-5503</td>
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<td>Medica Behavioral Health</td>
<td>1-800-848-8327</td>
<td>952-769-1390</td>
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<td>Medica Care System</td>
<td>1-800-458-5112</td>
<td>952-852-2002</td>
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<td>North Clinic</td>
<td>763-587-7900</td>
<td>763-587-7069</td>
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<td>St. Mary’s Duth Clinic</td>
<td>218-765-3487</td>
<td>218-765-8136</td>
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<td>St. Mary’s Innova Health</td>
<td>218-944-8363</td>
<td>218-944-9954</td>
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<tr>
<td>University MN Physicians</td>
<td>612-984-0884</td>
<td>612-984-6405</td>
</tr>
</tbody>
</table>
Notification Requirements

There are some services for which Medica requires notification. These services are listed on the Medica Prior Authorization List:

- All home care services for maternal & prenatal
- All pediatric nursing services (<18 years of age)
- Skilled nursing visits greater than 1 visit per day
- Terbutaline pump for home care
- Home uterine activity monitor (HUAM)

Notification can be provided by contacting the Provider Service Center and following the prompts on the phone for Case Management.

Provider Service Center
1-800-458-5512

Hours of Service
Monday - Thursday from 8:30 a.m. - 5 p.m.
Friday from 9 a.m. - 5 p.m.

REMINDER: Coverage requirements may vary; not all groups utilize the previously noted requirements. Make sure to verify specific coverage requirements.
Commercial Products Benefit Coverage

Coverage on the Medica commercial products for skilled services can be located in the *Home Health Care* section of the member's plan document. In order to be eligible for coverage, the services must be ordered/directed by a physician and received from a home health care agency that is authorized under the laws of the state in which the treatment is received. There are two applicable subdivisions of the Home Health Care section that we will discuss in reference to skilled care:

- Intermittent skilled care when you are homebound, provided by or supervised by a registered nurse
- Skilled physical, speech or occupational therapy when you are homebound

Eligible services include:

- Skilled Nursing Visits
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Medical Social Worker
- Respiratory Therapist
- Registered Dietitian

Excluded Services

The following services are specifically **excluded** from coverage:

- Companion, homemaker and personal care services
- Services provided by a member of your family
- Custodial care or other nonskilled services
- Physical, speech or occupational therapy provided in your home for convenience
- Services provided in your home when you are not homebound
- Services primarily educational in nature
- Vocational and job rehabilitation
- Self-care and self-help training (non-medical)
- Health clubs
Excluded Services continued

- Correction of speech impediments (stuttering or lisps) and assistance in the development of verbal clarity
- Voice training and voice therapy
- Outpatient rehabilitation services when no medical diagnosis is present

Criteria for Coverage

In order to receive coverage for skilled services, the member must meet the criteria discussed earlier:

- Services must be medically necessary and appropriate for treatment of illness or injury
- The patient must be homebound
- The patient must have a skilled nursing or rehabilitation need that requires the skills of a medical professional to develop, provide and assess the patient’s changing condition
- Care is required on an intermittent basis

The home health care agency must do an assessment to determine what home health care services are necessary and request prior authorization, if applicable.
Medicare Products Benefit Coverage

Medica currently offers the following Medicare products:

- Medica Prime Solution®
- Medica Select Solution®
- Medica Advantage SolutionSM

A member enrolled on one of the above plans must meet Medicare guidelines in order to receive coverage for skilled services under the home health care benefit. Members on Medica DUAL Solution must also meet Medicaid guidelines.

Medicaid & Dual Eligibles

Special Needs Plans & Minnesota Senior Care Plus (MSC+)

- MSHO: Medica DUAL Solution®
- SNBC: Medica AccessAbility Solution®
- Chronic: Medica Complete Solution®
- Minnesota Senior Care Plus (MSC+)  

Medicare Guidelines

According to the Centers for Medicare and Medicaid Services (CMS) guidelines, a Medicare beneficiary must meet the following requirements in order to be eligible for home health care coverage:

- Be confined to the home (not for special needs plans);
- Under the care of a physician;
- Receiving services under a plan of care established and periodically reviewed by a physician;
- Be in need of skilled nursing care on an intermittent basis or physical therapy or speech language pathology; or
- Have a continuing need for occupational therapy.
Additionally, CMS has made some National Coverage Determinations (NCD) regarding several home health services:

- Home Health Nurse Visits to Patients Requiring Heparin Injections
- Home Health Visits to a Blind Diabetic
- Home Prothrombin Time INR Monitoring for Anticoagulation Management
  
  (INR = International Normalized Ratio is the ratio of the patient's prothrombin time compared to the mean prothrombin time for a group of normal individuals. Prothrombin = a plasma protein involved in blood coagulation that on activation by factors in the plasma is converted to thrombin.)

- Home Use of Oxygen
- Home Use of Oxygen in Clinical Trials


**Medica Prime Solution®, Group Number 70XXX**
Open access Cost Plan, Medicare is primary for all home health care claims
Skilled services covered if member meets Medicare criteria

**Medica Select Solution®, Group Number 71XXX**
Medicare supplement policy, Medicare is primary for all services
Skilled services covered if member meets Medicare criteria

**Medica Advantage SolutionSM, Group Number 79XXX**
Medicare Advantage Private Fee-for-Service plan
Skilled services covered if member meets Medicare criteria
May have Medicaid benefit in addition to Medicare benefit

**Medica DUAL Solution®, Group Number 07XXX**
Minnesota Senior Health Options (MSHO) product
Follow Medicare or Medicaid guidelines.

*For details, see “Product Grid – Medicare, Minnesota” on medica.com at Providers>Reference Tools and Fools>Tools and Forms>Product Information>then look for the document under the Overview of Products heading.*
Medica Special Needs Plans

*Medica AccessAbility Solution®
DHS product name is Special Needs BasicCare (SNBC). Follow Medicare or Medicaid guidelines.

*Medica Complete Solution® Chronic Care. Follow Medicare or Medicaid guidelines.

Medica Choice Care Benefit Coverage

Medica Choice Care℠ is the Medica Minnesota Health Care Programs (MHCP) product for members eligible for Medical Assistance (MA) and General Assistance Medical Care (GAMC). This product offers varying level of coverage depending on a member’s status. The criteria for coverage of skilled services are the criteria we have previously reviewed.

Medica Choice Care members are first broken-out into a senior and non-senior population. Within those two large groups, the members are further broken-out depending on their status. You can determine the member’s status by the 5-digit group number.

*MSC+
Default Medical Assistance program, formerly known as PMAP for seniors. Not a voluntary program. Has been in the Twin Cities Metro area since January 1, 2009.

* For details and group numbers, see “SNP MSC+ Group Numbers” on medica.com at Providers>Reference Tools and Fools>Tools and Forms>Products>then under the Medicare Products heading, click on SNP MSC+ Group Numbers.
**Minnesota Senior Care Plus (MSC+)**

All MSC+ members have a care coordinator responsible for home care oversight.

Please review the grid below for specific coverage.

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<thead>
<tr>
<th>HOME CARE</th>
<th>MSC without copays</th>
<th>MSC with copays</th>
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<td>Some services may require prior authorization before you receive services. Your provider must obtain prior authorization. Call Customer Service for more information.</td>
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<td>• home health aide</td>
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<td>• private duty nursing</td>
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<td>• personal care assistant (PCA) services</td>
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<tr>
<td>• rehabilitation therapies (e.g., speech, physical, occupational)</td>
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MSC+
Families and Children on Medical Assistance

Medica Choice Care Under the MN Prepaid Medical Assistance Program (PMAP) and MN Prepaid General Assistance Medical Care Program (PGAMC)

Members in this population are either on Medical Assistance (MA) or General Assistance Medical Care (GAMC).

Please review the grid below for specific coverage.

<table>
<thead>
<tr>
<th>HOME CARE</th>
<th>PGAMC</th>
<th>PMAP without copays</th>
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<td>• Skilled nursing</td>
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<td>• Personal care assistant (PCA) services</td>
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<td>• Rehabilitation therapies (e.g., speech, physical, occupational)</td>
<td>Not Covered</td>
<td>Covered. No copay.</td>
<td>Covered. No copay.</td>
</tr>
</tbody>
</table>

Home Care is not covered.
Medica MinnesotaCare is the Medica MHCP product for members eligible through MinnesotaCare. Currently, there are sets of benefits available for members enrolled on MinnesotaCare – members on the Limited Benefit have no coverage for skilled services. The criteria for coverage of skilled services are the criteria we have previously reviewed.

You can determine which benefit set applies by the member’s five-digit group number:

- Expanded
- Basic Plus Two
- Basic Plus One
- Transitional MinnesotaCare (same coverage as Basic Plus One)

Please review the grid below for specific coverage.

<table>
<thead>
<tr>
<th>HOME CARE</th>
<th>Expanded</th>
<th>Basic Plus Two</th>
<th>Basic Plus One</th>
<th>Basic Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>skilled nursing</td>
<td>Covered</td>
<td>No app</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>house health aid</td>
<td>Covered</td>
<td>No app</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>rehabilitation therapies (e.g., speech, physical, occupational)</td>
<td>Covered</td>
<td>No app</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>private duty nursing</td>
<td>Covered</td>
<td>No app</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>personal care assistant (PCA) services</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

Some services may require prior authorization before you receive services. Your provider must obtain prior authorization. Call Customer Service for more information.
Claim Submission and Reimbursement of Skilled Services

There are different requirements depending on what type of provider is providing the services.

All claims must include the referring physician information. Failure to include the referring physician will result in a claim denial for reason code 272 – referring physician name and number missing.

Due to the Health Insurance Portability and Accountability Act (HIPAA) requirements, there is no longer a grace period for ICD-9, CPT or HCPCS updates. HIPAA transaction and code set requires the use of national medical code sets that are valid at the time of service. Therefore, Medica will deny or close claims that lack current codes.

Home care contracts are 2-year contracts that begin September 1st of even numbered years. The current contract goes from September 1, 2008 through August 31, 2010. Commercial reimbursement rates remain static for the entire two-year period. PCA contracts are generally one-year contracts.

Medica reimburses all Home Care Services based upon the actual service provided as indicated by a combination of the Revenue Code and the HCPCS or CPT code submitted. Refer to the UB-04 manual (electronic transaction 837i) for third-digit position of the revenue code, if not noted below.

Medica typically reimburses the following services on a per-visit basis:

- 042X/97001 & S9131 – Physical Therapy/Visit
- 043X/97003 & S9129 – Occupational Therapy/Visit
- 044X/92506 & S9128 – Speech Pathology/Visit
- 056X/S9127 – Medical Social Services/Visit
- 041X, S5180 and S5181 – Respiratory Services

The following services may be provided as a visit or other unit of service:

- 055X – Skilled Nursing (RN or LPN)
- 057X – Aide/Home Health (includes services provided by a PCA)
Home Health Care Providers

Home Health Care Providers, UB-04 or electronic equivalent (837i)

Home health care providers bill on a UB-04 claim form or the electronic equivalent, 837i. This is a requirement for both contracted and non-contracted providers, regardless of which state the services are rendered. Claims not submitted in this format will be denied.

UB-04 Fields

Electronic Equivalent = 837i

Some of the specific field requirements are:

- **Type of Bill, Field Number 4**: In most cases, for Medica claims, bill type “331 – home health/outpatient/admit through discharge, should be used. There may be some situations involving government products where Medicare billing requirements will necessitate the use of a third-digit other than “1” and/or the use of bill type “32X.” In these cases, it will be necessary to refer to the UB-04 manual for the appropriate third-digit and other applicable details.

- **Revenue Code, Field Number 42**: The list of applicable revenue codes are listed on the previous page.

- **Treatment Authorization Code, Field Number 63**: Applicable if the service requires prior authorization.

- **E-Code, Field Number 72**: Per the *ICD-9-CM Official Guidelines for Coding and Reporting*, E-codes should only be assigned to the initial treatment of an injury, poisoning or adverse effect of drugs. A late effect E-code may be used for subsequent visits when the late effect of the initial injury of poisoning is being treated. Further information regarding E-codes can be found in *ICD-9-CM Official Guidelines for Coding and Reporting* at [www.cdc.gov/nchs](http://www.cdc.gov/nchs).

Public Health Providers

Public Health Providers

Public Health providers should bill skilled services on a CMS-1500 form or the electronic equivalent (387P).

**REMEMBER**: Medicare is primary for Medica Prime Solution. All home health claims should be billed to Medicare.

Codes for Home Health Care Providers

See the Home Health Care reference guide located on medica.com at Providers>Reference Tools and Forms>Tools and Forms>Coding Tools and Forms>Procedure Codes for HHC
2. Personal Care Assistance

PCA Overview

In this section, we will discuss Personal Care Assistance (PCA) services. Personal Care services are services that assist with activities of daily living and may assist with some independent activities of daily living. PCAs provide assistance and support to persons with disabilities living independently in the community, including the elderly and others with special health care needs. Examples of PCA services are:

- Bathing
- Dressing
- Grooming
- Mobility
- Transfers

Personal Care Assistants are employees of, or under contract with, a Personal Care Provider Organization. A Personal Care Assistant:

- Must be at least 18 years of age (16 & 17 year olds can be a PCA but must meet additional requirements), and
- Able to effectively communicate with the recipient and PCA Provider agency and be able to maintain daily written records, and
- Communicate with the member receiving services; and
- Complete DHS Personal Care Assistant Standardized Training.

Obtaining Individual Personal Care Assistant #s

- As soon as a PCA has a DHS ID#, they can provide services. The PCA provider cannot bill for those services until they have a Medica PCA ID#.
- PCA applies for an individual number with DHS
- PCA agency submits DHS provider number to Medica to obtain Medica ID number for individual PCA.
- The Medica form needs to be completed and emailed to IndividualPCANum@medica.com. All changes, including additions, terminations, corrections, etc. must be submitted on this form and sent to the email box.
- In 2010, an on-line template replaces the email process. This will be available through the provider portal on medica.com.

NOTE: Call your Contract Manager for changes to the Agency demographic information. These changes cannot be submitted on the Medica PCA form.
Prior Authorization/Criteria

PCA services require authorization (a verbal authorization from a care coordinator is acceptable for services to start). In order to be eligible for coverage, the following criteria must be met:

- The services must be medically necessary; and
- The member must require PCA services in order to live independently in the community; and
- The member must be able to identify his/her needs, direct and evaluate PCA task accomplishment and provide for his/her own health and safety; or
- Member must have responsible party who can make decisions about care for the member; and
- An independent assessment, conducted by a public health nurse from a designated third-party health agency or by a Medica or county case manager, validates above criteria; and
- A written care plan has been developed that specifies PCA needs of the patient.

Detailed criteria for coverage is included in the Medica UM Policy *Personal Care Assistance*, UM Policy III-HOM.03 on Medica.com at Providers>Medical Policies>Utilization Management Policies under the Home Care heading.
Flexible Use

Flexible use allows members to use authorized PCA hours in a flexible way to meet their needs and schedules for medically necessary covered services as specified in the assessment. PCA hours are authorized as flexible use unless specified otherwise. Hours are allocated considering the ongoing needs of the member over an entire year. Though Medica may send out PCA authorizations for a 1-year span, PCA providers are responsible for monthly monitoring of the PCA utilization to ensure appropriate use of flexible PCA. Members do not have to use their hours on the same schedule each day but the plan for use of flexible PCA must be documented in the PCA provider care plan. The use of authorized units of PCA services may vary within the length of the service authorization. Authorized hours not used within the service authorization period may not be carried over to another time period. Flexible use does not increase the total amount of authorized units available.

Example:

- Member is authorized for a total of 14 hours of PCA services per week. May use 4 hours on Monday, 1 hour on Tuesday, 2 hours Wednesday, 1 hour Thursday, and 2 hours each Thursday, Friday, Saturday and Sunday.

Most PCA authorizations will be entered as flexible use per DHS policy. The exception to this is for recipients who are in the Minnesota Restricted Recipient Program (MRRP) as determined by DHS or a Managed Care Organization (MCO). MRRP service recipients are not allowed to use PCA flexibly.

By Minnesota state statute, flexible use authorizations given for a year need to be broken down into two 6-month time frames. At the end of the 1-year authorization period, unused hours cannot be carried over into the next authorization.

The PCA agency must monitor the hours used and report any problems to Medica. Failure to appropriately monitor use of hours will result in non-authorization of additional hours to supplement an authorization exhausted prior to the end date. When a client is using flexible use hours, how those hours are to be used must be documented in the care plan. If use of those hours for personal care services exceeds the number of hours authorized (for the 6-month time period), it is the responsibility of the agency to notify the client and Medica. Example:

- Member authorized for a total of 728 hours PCA; 364 hours of PCA services to be used flexibly between January 1 to June 30. If member uses 364 hours by May 1st, no additional hours will be authorized.
Flexible Use, Con’t.

The hours do not have to be divided evenly, however no more than 75% of the total authorized units for a 12-month authorization can be used in a six-month date span. Example:

- Member receives 800 total service units in a 12-month period. Member may use 500 units in one six-month period and 300 units in the second six-months of the year.

If there is a change in situation or medical need for increased services, the PCA agency or member can request a re-evaluation, or temporary increase in PCA services. Supporting clinical documentation from primary care physician, or other sources may be required.

Benefit Coverage

Coverage

Medica only provides coverage for PCA services for:

- MSHO: Medica DUAL Solution members
- MSC+
- Medica Choice Care members (except those on GAMC)
- Medica MinnesotaCare members — only children and pregnant women

The Medica commercial products and SNBC (Special Needs Basic Care) products (AccessAbility) specifically excludes coverage for PCA services. SNBC (AccessAbility) members are eligible for PCA services through the state (fee for service). Refer to county for authorizations.

Not covered

These services, supplies and associated expenses are not covered:

1. Companion, homemaker and personal care services.

Medicare does not provide coverage for PCA services, therefore the services are not covered under Medica Prime Solution, Medica Select Solution or Medica Advantage Solution.
**Medica Choice Care Coverage**

PCA services are eligible for coverage for all enrollees on Medica Choice Care except for those on Prepaid General Assistance Medica Care (PGAMC). The criteria for coverage of skilled services are the criteria we have previously reviewed.

**Prepaid Medical Assistance Program (PMAP) and PGAMC Coverage Specifics**

<table>
<thead>
<tr>
<th>HOME CARE SERVICES</th>
<th>PGAMC</th>
<th>PMAP without copays</th>
<th>PMAP with copays</th>
</tr>
</thead>
<tbody>
<tr>
<td>• home health aide</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• private duty nursing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Personal Care Assistant (PCA) services (PCA services must be provided by a network PCA provider and ordered by a network physician—they cannot be ordered by a non-network physician.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• rehabilitation therapies (e.g., speech, physical, occupational, respiratory)</td>
<td>Not Covered</td>
<td>Covered. No copay.</td>
<td>Covered. No copay.</td>
</tr>
</tbody>
</table>

**Minnesota Senior Care Coverage Specifics**

<table>
<thead>
<tr>
<th>HOME CARE SERVICES</th>
<th>MSC Plus without copays</th>
<th>MSC Plus with copays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some services may require service authorization before you receive services. Your provider must obtain service authorization. Call Customer Service at the phone number in Section A for more information.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• home health aide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• private duty nursing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Personal Care Assistant (PCA) services (PCA services must be provided by a network PCA provider)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• rehabilitation therapies (e.g., speech, physical, occupational, respiratory)</td>
<td>Covered. No copay.</td>
<td>Covered. No copay.</td>
</tr>
</tbody>
</table>
MinnesotaCare Coverage
PCA Services are covered for members enrolled through MinnesotaCare Expanded Benefit. Please review the grid below for specific coverage.

<table>
<thead>
<tr>
<th>HOME CARE SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some services may require service authorization before you receive services. Your provider must obtain service authorization. Call Customer Service at the phone number in Section A for more information.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Expanded</th>
<th>Basic Plus Two</th>
<th>Basic Plus One</th>
<th>Basic Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled nursing</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Home health aide</td>
<td>No co-pay</td>
<td>No co-pay</td>
<td>No co-pay</td>
<td>No co-pay</td>
</tr>
<tr>
<td>Rehabilitation therapies (e.g., speech, physical, occupational, respiratory)</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td></td>
<td>No co-pay</td>
<td>No co-pay</td>
<td>No co-pay</td>
<td>No co-pay</td>
</tr>
<tr>
<td></td>
<td>Your provider must obtain service authorization. Call Customer Service for more information.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private duty nursing</td>
<td>Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Personal care assistant (PCA) services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Claim Submission and Reimbursement

In this section, we will discuss claim submission and reimbursement of claims for personal care assistant services. The Medica Home Health and Public Health contracts include contracted rates for PCA services. Generally, T1019 should be billed for PCA services. PCA must bill with appropriate code, including modifier which is noted on reference documents, if applicable (See “Procedure Codes for Home Health Care Services” document and/or “Procedure Codes for Personal Care Assistant Services” document at this location on medica.com: Providers>Reference Tools and Forms>Tools and Forms>Coding Tools and Forms.)

Home Health Providers

Home health providers should submit their claims on a UB-04 claim form or electronic equivalent, 837i. Code T1019 with any modifier is not payable to a 59 provider type, only to a PCA agency. Refer to the reference documents on medica.com (See “Procedure Codes for Home Health Care Services” document and/or “Personal Care Assistant Services” document at this location on medica.com: Providers>Reference Tools and Forms>Tools and Forms>Coding Tools and Forms.)

PCA Providers – PCA Providers submit on a CMS-1500 or electronic equivalent (837i or 837p) using code T1019 under the individual PCA provider. Supervision of PCA services (UA modifier) should be billed under the PCA agency, not the UMPI for the individual PCA.

Public Health Providers

Public health providers should submit claims for PCA services on a CMS-1500 claim form or electronic equivalent (837p). T1019 should be billed for PCA services.

Reimbursement

PCA services billed outside of the authorization will be denied reason code 941 – PCA Services not approved. This denial is provider liability and charges may NOT be billed to the member.
3. Medica DUAL Solution, MSC+ & Elderly Waiver Services

**Medica DUAL Solution & MSC+ Overview**

Elderly Waiver (EW) services are services that are covered under Medica DUAL Solution that would normally be considered “custodial” in nature and not covered under commercial or Medicare plans. EW Services are covered for DUAL Solution and MSC+ members. Medica DUAL Solution is the Medica product through Minnesota Senior Health Options (MSHO). The MSHO program has a unique coordination of benefits for Medicare and Medicaid.

**Eligibility**

Members enrolled on Medica DUAL Solution must:

- Be eligible for Medicaid
- Be 65 years of age or older
- Must be eligible for Medicare, must have Parts A & B
- May live in nursing home or be community based

**Care System**

The Care System is responsible for coordinating all of the member’s care. Through the Care System, the member is assigned to a Care Coordinator who is responsible for coordination of care and serves as a health care liaison, and is responsible for referrals when needed. Each Care System will have its own notification requirements. Additionally, there is a standardized list of services that require an administrative referral.

The current MSHO care systems are:

- EverCare
- Fairview Partners
- HealthEast
- Medica Care System
- North Clinic
- St. Mary’s Duluth Clinic (SMDC)
- St. Mary’s Innovis Health (SMIH)
- University MN Physicians (UMP)
Minnesota Senior Care Plus – MSC+. This product is for members who are currently enrolled in Minnesota Senior Care (formerly PMAP – Prepaid Medical Assistance Plan).

All members on the program will have an assigned care coordinator. The care coordinator, a nurse or a social worker, conducts a comprehensive assessment annually or upon change of condition, arranges for services and assists the member in navigating the healthcare system.

All Elderly Waiver providers, if not a participating home health care or PCA, are considered nonparticipating/non-contracted.

See Referral Guidelines on medica.com at Providers>Reference Tools and Forms>Tools and Forms>Claims Tools and Forms

Elderly Waiver Services

As stated earlier, Elderly Waiver services are services that would normally be considered “custodial” in nature. Elderly Waiver services are available for MSHO and MSC+ enrollees. Examples of services that are considered Elderly Waiver services are:

- Home Delivered Meals
- Adult Day Care
- Home Modifications (installation of ramp, grab bar)
- Lawn Care
- Homemaker Services

EW services are provided by EW vendors. EW vendors are a person or entity who:

- Is licensed, registered or certified in Minnesota, if required; and
- Provides goods or services that constitute EW services
There are specific codes that have been designated EW codes. Please see the EW Code list located on medica.com at Providers>Reference Tools and Forms>Tools and Forms>Coding Tools and Forms.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1004.U1 (formerly G0156)</td>
<td>Extended Home Health Aide, 15 min</td>
</tr>
<tr>
<td>H0045</td>
<td>Respite Care Services, Not In Home, per diem, daily</td>
</tr>
<tr>
<td>H0045</td>
<td>Respite Care Services, Not In Home, per diem, daily (24 hours)(Formerly Respite, Hospital)</td>
</tr>
<tr>
<td>H0045</td>
<td>Respite Care Services, Not In Home, per diem (Formerly Respite, Certified Facility)</td>
</tr>
<tr>
<td>H2032</td>
<td>Independent Living Services, 15 min</td>
</tr>
<tr>
<td>S5215</td>
<td>Transportation, non commercial, mileage</td>
</tr>
<tr>
<td>S5100</td>
<td>Day Care Services, adult, 15 min</td>
</tr>
<tr>
<td>S5100.TF</td>
<td>Adult Day Care Bath, 15 minutes</td>
</tr>
<tr>
<td>S5102</td>
<td>Day Care Services, per diem</td>
</tr>
<tr>
<td>S5116</td>
<td>Caregiver Training/Education, per session</td>
</tr>
<tr>
<td>S5120</td>
<td>Chore Services, 15 min</td>
</tr>
<tr>
<td>S5130</td>
<td>Homemaker Service, 15 min</td>
</tr>
<tr>
<td>S5131</td>
<td>Homemaker Service, per diem</td>
</tr>
<tr>
<td>S5135</td>
<td>Companion Care, adult, 15 min</td>
</tr>
<tr>
<td>S5141</td>
<td>Foster Care, Adult, per month (Formerly Foster Care, Family)</td>
</tr>
<tr>
<td>S5141.HQ</td>
<td>Foster Care, Corporate, monthly</td>
</tr>
<tr>
<td>S5150 and T1005</td>
<td>Respite Care, In Home, 15 min</td>
</tr>
<tr>
<td>S5150.UB and T1005.UB</td>
<td>Respite Care, Out of Home, 15 min</td>
</tr>
<tr>
<td>S5151</td>
<td>Respite Care, In Home, per diem</td>
</tr>
<tr>
<td>S5160</td>
<td>Emergency response system; installation and testing</td>
</tr>
<tr>
<td>S5161</td>
<td>Emergency response system; service fee, per month (excludes installation and testing)</td>
</tr>
<tr>
<td>S5165</td>
<td>Home Modifications, per item</td>
</tr>
<tr>
<td>S5170</td>
<td>Home Delivered Meals, per meal</td>
</tr>
<tr>
<td>S9992</td>
<td>Case Management Transportation costs</td>
</tr>
<tr>
<td>T1002.TGUC</td>
<td>RN Complex Extended, 15 min</td>
</tr>
<tr>
<td>T1002.TTUC</td>
<td>RN Regular Extended 1:2, 15 min</td>
</tr>
<tr>
<td>T1002.UC</td>
<td>RN Regular Extended 1:1, 15 min</td>
</tr>
<tr>
<td>T1003.TGUC</td>
<td>LPN Complex Extended, 15 min</td>
</tr>
<tr>
<td>T1003.TTUC</td>
<td>LPN Regular Extended 1:2, 15 min</td>
</tr>
<tr>
<td>T1003.UC</td>
<td>LPN Regular Extended 1:1, 15 min</td>
</tr>
<tr>
<td>T1016.UC and T1016</td>
<td>Case Management, 15 min</td>
</tr>
<tr>
<td>T1016.TFUC</td>
<td>Case Management, Paraprofessional, 15 min</td>
</tr>
<tr>
<td>T2003.UC</td>
<td>Extended Transportation, 1 way trip</td>
</tr>
<tr>
<td>T2028</td>
<td>Consumer Directed Community Supports, per session</td>
</tr>
<tr>
<td>T2029</td>
<td>Extended Home Health Med Supp/Equipment, per item</td>
</tr>
<tr>
<td>T2030</td>
<td>Assisted Living Services, monthly</td>
</tr>
<tr>
<td>T2030.TG</td>
<td>Assisted Living Plus, monthly</td>
</tr>
<tr>
<td>T2032</td>
<td>Residential Care Services, monthly</td>
</tr>
<tr>
<td>T2038</td>
<td>Transitional Services, per service</td>
</tr>
<tr>
<td>T2040</td>
<td>CDOS Background Checks, 15 min</td>
</tr>
<tr>
<td>T2041</td>
<td>CDOS Mandatory Case Management, 15 min</td>
</tr>
<tr>
<td>X5609</td>
<td>PPHP/MSD/MSC+Home Care Services</td>
</tr>
</tbody>
</table>
Administrative Referrals

There are some EW codes that will require that Medica receives an administrative referral from the Care Coordinator in order to appropriately adjudicate the claim. These services require a referral because there is no rate assigned. Medica needs instructions from the Care System on how to pay the claim. Codes that require an administrative referral are:

- X5291 Residential Living
- T2030 Customized Living
- T2030TG and T2030.TG Customized Living Plus
- X5363 Corporate Foster Care
- S5165 Modifications & Adaptations (requires description on claim)
- S5160 Emergency Response System monthly service fee
- T2028 CDCS
- T1019 Personal Care Assistant (PCA) services
- T2029 Supplies and Equipment (requires description on claim)
- S5141 and S5141.HQ Foster Care, Corporate, Monthly

Claims without an administrative referral may be paid at the incorrect rate or denied.

- 55130 Homemaker Service, 15 minutes
- 55131 Homemaker Service, per diem
**Claim Submission**

Claims for Minnesota providers are to bill according to AUC guidelines. Go to http://www.health.state.mn.us/auc for details.

Electronic commerce information can be accessed on medica.com at Providers>Reference Tools and Forms>Tools and Forms>General Tools and Forms under the Electronic Commerce heading

Contracted Home Health providers should submit claims for EW services on a UB-04 claim form (or electronic equivalent 837i); contracted PCA providers for EW on a CMS-1500 (or electronic equivalent 837p).

Other contracted providers and non-contracted EW providers should submit claims on a CMS-1500 claim form or electronic equivalent, 877p.

Because many EW providers are unfamiliar with requirements to complete the claim form, Medica has adjusted guidelines for the submission of EW services by non-contracted EW providers. A sample of the CMS-1500 claim form is available on medica.com at Providers>Reference Tools and Forms>Tools and Forms>Claims Tools and Forms>How To Complete CMS-1500 Claim Form. Correctly completing the CMS-1500 form will improve the turnaround time for payment of claims. Minnesota providers are to submit claims electronically per AUC guidelines.

Please note that if a claim is submitted with missing or invalid information in a required field, the claim will be returned to you for correction/addition of the required information.

**Elderly Waiver Obligation**

Some Medica DUAL Solution and MSC+ members may be responsible for a certain dollar amount of their EW services per month. This is called the “EW Obligation.”

The EW obligation is a monthly dollar amount for which the member is responsible. Medica tracks this dollar amount in its claims processing system. Until the EW obligation is satisfied for the month, dollar amounts will be disallowed with reason code 928 – EW obligation, and placed in the copayment field. This is member liability. EW obligation is done on a “first in – first out” basis.

Members cannot designate a provider for the EW obligation.
4. Home Infusion Therapy Services

Overview

Home Infusion Therapy (HIT) is the delivery of medications to patients in their homes that could also be given in a hospital or clinic setting. Patients and doctors find the convenience of skilled care without exposure to contagions and comfort of being at home very appealing. Patients do not have to be homebound to be eligible for HIT. Examples of HIT services are:

- Intravenous medications using infusion pumps
- Injections of medications into the muscles or tissues
- Medications given into the space around the spinal cord.

Benefit Coverage:

Commercial Products

HIT services are eligible for coverage if the plan document includes coverage for home health care services. The benefit is included in the Home Health Care section of the plan document. Medica considers this a medical benefit; it is not covered under the prescription drug benefit. Generally, a coinsurance will apply for HIT services received from in-network providers. If the infusion therapy is received in an office setting, the office visit copayment would apply.

**REMINDER:** It is important to verify coverage, not all commercial plans will have coverage.

Medicare Products

Medica provides coverage for HIT drug and equipment services if the services meet Medicare guidelines for:

- Medica Prime Solution – Medicare has primary payment responsibility for nursing services associated with HIT.
- Medica Advantage Solution
- Medica Select Solution

Members on Medica DUAL Solution have coverage for HIT if authorized by the Care System.
**Benefit Coverage continued**

**Medica Choice Care**

HIT services are eligible for coverage if skilled services are covered. GAMC members have no coverage for the nursing services associated with HIT services, however will have coverage for the drugs.

**Medica MinnesotaCare**

HIT services are eligible for coverage if skilled services are covered. Limited Benefit members have no coverage for HIT services.

**Claim Submission**

Claims for HIT services for Medica Commercial, Choice Care, MinnesotaCare, Prime Solution and DUAL Solution members should be billed on a CMS-1500 claim form (or electronic equivalent) under the provider’s 60-XXXXX provider number.

Medica Select Solution is a Medicare supplement. Therefore, claims should be billed to Medicare first. Medica will supplement with an EOMB.

Claims for HIT services for Medica Advantage Solution members should be billed identical to how the services would be billed to Medicare. Medicare National and Local Coverage Decisions will apply.

Claims for Medica Prime Solution members should be billed using codes off the Prime Solution HIT payment appendix. This payment appendix includes more specific codes required for Prime Solution billing. Medicare National and Local Coverage Decisions (NCD/LCD) will apply, even though Medica is processing the claims.

If you are submitting multiple infusions for one day, appropriate modifiers must be appended:

- SH – second procedure
- SJ – third or additional procedure
Reimbursement

HIT contracts are two-year contracts that begin September 1st of even numbered years. The current contract goes from September 1, 2008 through August 31, 2010. The contracts include the codes that should be billed and are on the following pages. Please note that there is another appendix for Prime Solution members.

HIT Codes

Home Infusion Therapy Codes – Contract Years 09/01/08-08/31/10
Non-Medicare

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99601</td>
<td>Home infusion/specialty drug administration, nursing services; per visit (up to 2 hours)</td>
</tr>
<tr>
<td>99602</td>
<td>Home infusion/specialty drug administration, nursing service, each additional hour</td>
</tr>
<tr>
<td>S9365</td>
<td>Home infusion therapy, TPN, 1 liter per day; administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment including standard TPN formula, per diem</td>
</tr>
<tr>
<td>S9366</td>
<td>Home infusion therapy, TPN, &gt;1-2 liters per day; administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment including standard TPN formula, per diem</td>
</tr>
<tr>
<td>S9367</td>
<td>Home infusion therapy, TPN, &gt;2-3 liters per day; administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment including standard TPN formula, per diem</td>
</tr>
<tr>
<td>S9368</td>
<td>Home infusion therapy, TPN, &gt;3 liters; administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment including standard TPN formula, per diem</td>
</tr>
<tr>
<td>B4185.99</td>
<td>Parenteral nutritional solution; lipids per day</td>
</tr>
<tr>
<td>B4149-B4162</td>
<td>PKU, per day</td>
</tr>
<tr>
<td>Applicable HCPCS Code</td>
<td>Drugs</td>
</tr>
<tr>
<td>S9494, S9497, S9500-S9504</td>
<td>Home infusion for antibiotics/antifungals/antivirals therapy; administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment, per diem</td>
</tr>
<tr>
<td>S9329-S9331</td>
<td>Home infusion therapy, chemotherapy infusion; administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment, per diem</td>
</tr>
<tr>
<td>S9325-S9328</td>
<td>Home infusion therapy, pain management; administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment, per diem</td>
</tr>
<tr>
<td>S9373-S9377</td>
<td>Home infusion therapy, hydration therapy; administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment, per diem</td>
</tr>
<tr>
<td>Codes</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
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</tr>
<tr>
<td>S9379 (Misc); or S9061 (aerosolized drug), S9336 (coagulation), S9355 (chelation), S9338 (immunomodulating), S9348 (inotropic), S9346 (a-1 protein inhibitor), S9359 (anti-tumor necrosis factor-a), S9357 (imiglucerase), S9347 (epoprostenol), S9351 (con't anti-emetic), S9363 (anti-spasmotic), S9361 (diuretics), S9353 (continuous insulin), S9349 (tocolytic), and S9490 (corticosteroid)</td>
<td>Home infusion therapy, of miscellaneous drugs, administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment, per diem</td>
</tr>
<tr>
<td>S9358</td>
<td>Home infusion of blood product(s); administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment, per diem</td>
</tr>
<tr>
<td>P9010 + invoice</td>
<td>Blood/Components</td>
</tr>
<tr>
<td>S5498, S5501, S5502, S5517-S5518</td>
<td>Home infusion therapy, catheter care/maintenance and supplies</td>
</tr>
<tr>
<td>S5520, S5221</td>
<td>Home infusion therapy, all supplies (including catheter) necessary for PICC/midline insertion</td>
</tr>
<tr>
<td>S5522, S5523</td>
<td>Home infusion therapy, insertion of midline or peripherally inserted central venous catheter, nursing services only (no supplies or catheter included) (Coded separately from 99601 and 99602 and any other per diem “S” code)</td>
</tr>
<tr>
<td>Applicable HCPCS with 22 modifier</td>
<td>Injectable medication –Drugs</td>
</tr>
<tr>
<td>Applicable HCPCS Code</td>
<td>Coagulation Products</td>
</tr>
</tbody>
</table>
Payment Protocols

By signing the contract with Medica, the provider has agreed to and will comply with the payment protocols of Medica. Next, we will review these payment protocols.

All Inclusive Rate: All services and/or supplies, as appropriate, to each disease or therapy are included in the payment rate or per diem payment and no separate or additional payment will be made.

Multiple Administration of Infusion Therapy: Multiple infusion therapies performed concurrently on the member by the provider will be reimbursed:

- The code with the highest payment specified, pursuant to the Home Infusion Therapy Services Payment Appendix, less any applicable copayment, coinsurance or deductible; and
- 50% of the code, using the SH modifier, with the next highest payment specified, pursuant to the Home Infusion Therapy Services Payment Appendix, less any applicable copayment, coinsurance or deductible.
- Third and additional services, using the SJ modifier, are reimbursed at 0%.

Payment for Nursing Services: The payment rate or per diem payment includes payment for the first two (2) hours of nursing services. Nursing services provided after the first 2 hours will be paid at an hourly rate, per your contract.

Unlisted Drugs: Drugs should be billed with both the appropriate HCPCS code and the National Drug Code (NDC). If J3490 or J9999 is submitted, the provider must include the NDC number and the drug name. If no NDC number is available, the provider must include the invoice. Claims without an NDC or invoice will be denied. Medica will reimburse the 80th percentile of the Average Wholesale Price (AWP) based on First Data Bank pricing.

Injectables: Medica reimburses 100% of the AWP when submitted with a 22 modifier, as there is typically no nursing/supply charge allowed for these drugs.

**Drug coverage policies can be found on medica.com at Providers>Medical Policies>Coverage Policies.**
Resources

Resources for further learning

- CMS Home Health Agency Center
  http://www.cms.hhs.gov/center/hha.asp

- Medicare Coverage Center
  http://www.cms.hhs.gov/center/coverage.asp

- AUC Guidelines at
  http://www.cms.hhs.gov/center/hha.asp

- AUC Guidelines are also on medica.com at Providers>Reference Tools and Forms>Tools and Forms>Claims Tools and Forms under the Electronic Claims Submission heading.

- Medica Coding Tools and Forms at Providers>Reference Tools and Forms>Tools and Forms>Coding Tools and Forms:

- Medica Provider Resources Tools and Forms on medica.com at Providers>Reference Tools and Forms

- Medica Provider contact information on medica.com at Providers>About Medica>Contact Medica
  http://www.medica.com/C16/ContactMedica/default.aspx

- Certificate of Coverage information on medica.com at Providers>Reference Tools and Forms>Tools and Forms>General Tools and Forms

Provider Service Center
1-800-458-5512

Hours of Service
Monday - Thursday from 8:30 a.m. - 5 p.m.
Friday from 9 a.m. - 5 p.m.