

Chapter 26

Home and Community Based Services (HCBS) Elderly Waivers

Overview

The [Elderly Waiver \(EW\)](#) program funds Home and Community Based Services (HCBS) for people ages 65 and over who require the level of care provided in a nursing home but choose to reside in the community. The programs provide services and supports for people to live in their homes or a community setting and may delay or prevent nursing facility care. The purpose of these programs is to promote community living and independence with services and supports designed to address each person's individual needs and choices. In the case of EW, the additional services go beyond what is otherwise available through Medical Assistance (Medicaid).

EW Covered Services

1. 24-Hour Customized Living (CL)
2. Adult corporate foster care (monthly)
3. Adult day services
4. Adult day services bath
5. Adult family foster care (monthly)
6. Case management
7. Case management aide (paraprofessional)
8. Caregiver assessment
9. CDCS background check
10. Chore
11. Consumer-directed community supports (CDCS)
12. Companion services
13. Customized Living (CL)
14. Environmental accessibility adaptations
15. Extended personal care
16. Family caregiver training and education
17. Home care – extended services (home health aide [HHA], private duty nursing [PDN], personal care assistance [PCA])
18. Home delivered meals
19. Homemaker
20. Modification and adaptations
21. Non-medical transportation
22. Residential care
23. Respite care
24. Specialized supplies and equipment
25. Telehome-care
26. Transitional supports
27. Transportation

Long-Term Care Consultation (LTCC) Assessment

The LTCC Assessment focuses on Minnesota’s long-term care information exchange system **and** individual choice regarding community-based options as an alternative to nursing facility placement. The LTCC incorporates several components. Preadmission Screening (PAS) is one component of the LTCC and assists in identifying supports needed to maintain the member in the community or transition him/her back into the community.

The LTCC team assesses the health and social needs of a member and completes an assessment form. The team **must** conduct a face-to-face assessment for members over age 65 years. The legal representative of the member, if applicable, must be present.

The local agency must complete all face-to-face LTCC screening activities for applicable people under age 65 within 30 calendar days of enrollment.

Billing for Long-Term Care Consultation (LTCC) Assessments

Counties/tribes must submit electronic claims using the 837P claim format for completed face-to-face LTCC assessment activities for people under age 65.

1. All face-to-face assessment activities eligible for payment must be combined into one claim.
2. The date of service must match the date of an approved face-to-face assessment.
3. The maximum number of units allowed for reimbursement is 96.
4. If more than one LTCC team member is involved in the assessment process, combine the units of time into **one** claim.

Face-to-face assessment activities are eligible for payment, including time spent by LTCC team member(s) for the following:

1. Arranging assessment(s)
2. Preparing screening document(s) before assessment
3. Travel time to and from assessment (not including mileage costs)
4. Time actually spent conducting the assessment
5. Time spent in approval of the screening document

For **each** activity in the member’s file, the LTCC team member must document the following:

1. Specify activity completed
2. Date the activity was completed
3. Name and role of the team member completing the activity
4. Amount of time spent on the activity

If more than one LTCC team member is involved in the assessment process, the units of time should be combined into **one** claim.

Any member may request an assessment by making a referral to the local lead agency. The lead agency will determine program eligibility.

Member Eligibility

All applicants must meet the service eligibility criteria for the specific HCBS program in which they anticipate receiving services. Refer to Chapter 2, Health Care Programs and Services, for more information about Medical Assistance (Medicaid) and eligibility.

The county provides LTCC services including a community assessment of the needs of the member, assistance with the application process, and development of a community support plan. A member approved for an HCBS waiver program will receive service coordination from a public health nurse (PHN) or social worker who implements and monitors the community support plan. The local agency must ensure that the health and safety needs of all members are reasonably met under its community support plans. In addition, the local agency also authorizes the funds for all the HCBS services provided to an eligible member.

Roles

County Financial Worker

County financial workers determine financial eligibility for payment of EW services. Financial workers will also conduct asset assessments as needed for determination of EW financial eligibility.

Local Agency

Local agencies can be county public health agencies, county human services agencies, tribes, counties, or health plans. Lead agencies are responsible for the following:

1. LTCC

The LTCC focuses on Minnesota's long-term care information exchange system **and** individual choice regarding community-based options as an alternative to NF placement. The LTCC incorporates several components. Preadmission Screening (PAS) is one component of the LTCC and assists in identifying supports needed to maintain the member in the community or transition him/her back into the community.

The LTCC team assesses the health and social needs of a member and completes an assessment form. The team **must** conduct a face-to-face assessment for members under age 65 years. The legal representative of the member, if applicable, must be present.

The local agency must complete all face-to-face LTCC screening activities for applicable people under age 65 within 30 calendar days of enrollment.

2. Case Management

Case management for a member approved for an EW program will be provided by a PHN or social worker who implements and monitors the community support plan and is also responsible for reassessment of the individual's level of care and the review of the community support plan. The lead agency must ensure that the health and safety needs of all members are reasonably met under their community support plans. Members may refuse case management services at any time after enrollment. Members must inform the county case manager or IMCare care coordinator of their refusal. Such refusal can be a verbal or written notification. The county case manager implements and monitors the comprehensive plan of care and is also responsible for reassessment of the individual's level of care and the review of the comprehensive plan of care. The lead agency must ensure that the health and safety needs of all members are reasonably met under their comprehensive plan of care.

3. Program Access and Administration

Lead agencies are responsible for providing program access and administration, which includes the following:

- a. Working in partnership with the Minnesota Department of Human Services (DHS) and other organizations to provide information, services, and assistance to people who request and wish to gain HCBS access
- b. Providing member case management or care coordination services, which includes the following:
 - i. Assessing program eligibility
 - ii. Developing a service plan
 - iii. Assisting members access, coordinate, and evaluate available services
- c. Generating additional copies of provider Service Agreement letters, if needed
- d. Inputting member enrollment data (e.g., screening document) and Service Authorization, as required, into the DHS Medicaid Management Information System (MMIS)
- e. Authorizing and monitoring services to reasonably ensure health and safety
- f. Monitoring the ongoing provision of individual services for efficiency, consumer satisfaction, and continued eligibility, and adjusting these provisions as necessary
- g. Managing the contract(s) and systematic monitoring of provider performance
- h. Ensuring that all providers meet State standards relevant to their area of service and have fully negotiated provider agreements
- i. Authorizing funds for all HCBS services provided to the eligible member

Notice of Action

By law, the lead agency/State is required to notify the member any time services are denied, terminated, reduced, or suspended. Notification must be in writing and sent at least 10 days before the action is taken. Lead agencies must use the [Notice of Action \(DHS-2828\)](#) to notify the member of impending changes to the waiver services.

Informed Choice

Individuals seeking waiver services will be provided, by the county local agency as required by IMCare, with the necessary information to make an informed choice among the services for which they are eligible, and the county agency will document the information given. Ensuring that a member is given informed choices is an important responsibility of the case manager.

When a member is likely to require the level of care provided in an institution such as a hospital or nursing home, the case manager must inform the member and his/her legal representative of home and community based services and supports as an alternative. The local agency will do the following:

1. Provide individuals seeking EW services the necessary information to make informed choices among the services for which they are eligible
2. Inform the member and legal representative when a member is likely to require the level of care provided in an institution, such as a hospital or nursing home, of home and community based services and supports as an alternative
3. Document that the above information was given
4. Take reasonable steps to provide the information in a format the member can understand and with a choice of service providers for all services
5. Inform a member nearing age 65 of the other community support options so that the member can choose which alternative will best meet his/her needs. A member receiving waiver services before age 65 remains eligible for the respective waiver after his/her 65th birthday if all other eligibility criteria are met. Other

options may include EW, remaining on the member's current HCBS waiver, or other alternatives that may meet the needs and preferences of the member.

Provider Information

There are many advantages for both providers and local agencies to coordinate efforts to ensure that a member receives necessary services and that providers receive timely payments for services rendered. Providers who contract with IMCare to provide services will receive instructions from IMCare on how to ensure timely payment.

Enrollment/Licensure/Certification

Certain HCBS providers, known as Tier 1 providers, must enroll with Minnesota Health Care Programs (MHCP) and IMCare and must meet specific standards in order to bill and receive payment for waiver services. More information about provider enrollment can be found on the IMCare website. For other providers, known as Tier 2 or Tier 3 providers, enrollment with MHCP and IMCare is optional. For a complete list of service components by tier and the requirements applicable to each, please refer to DHS Bulletin # 13-56-03 and [#13-56-04](#).

Providers must also determine which program services they are qualified to provide utilizing an Applicant Assurance Statement. Specific provider qualifications are found in this manual within each service description. Complete information is found in the [HCBS Waiver Services](#) section of the DHS *Provider Manual*. Some waiver services require proof of one or more of the following:

1. License(s) and or registrations from DHS or the Minnesota Department of Health (MDH)
2. Medicare certification
3. Other certification or registration as applicable
 - a. Training
 - b. Criminal background checks

For more information, please refer to one or more of the following:

1. [Community Based Support Manual \(CBSM\)](#)
2. The lead agency that serves the county(ies) in which you will be providing services
3. [DHS Licensing](#) at **1-651-431-6500**
5. [Minnesota Department of Health](#) at **1-651-201-5000** for general information

Authorization of Services (Prior Authorizations)

EW services require prior authorization from an IMCare case manager in the form of a completed Service Agreement. The Service Agreement allows the provider to bill IMCare and receive payment **after** services are provided. Only those services specified on the Service Agreement can be paid; however, an approved Service Agreement is not a guarantee of payment. The case manager is ultimately responsible to make sure that the Service Agreement is accurate.

The Service Agreement for EW may include the following:

1. Medical Assistance (Medicaid) extended home care services or Skilled Nursing Visits (SNVs), HHA, Private Duty Nursing (PDN), and PCA
2. EW services consistent with the county contract

The Service Agreement also lists the following:

1. IMCare-enrolled provider who is authorized to provide the needed services
2. National Provider Identifier (NPI) of the IMCare enrolled provider
3. Rate of payment for the service
4. Number of units approved or total amount
5. Date or date span of service
6. Approved procedure code(s)
7. Diagnosis code to be used when billing the claim
8. Medical Assistance (Medicaid) State plan home care services (SNV, HHA, PDN, and PCA) that must be utilized before EW extended services can be accessed

The EW Service Agreement displays units, duration, and rates. All authorized services must stay within the DHS published case mix budget caps and DHS published State maximum rates for services.

Billing

Payer Determination

All providers and local agencies are responsible to bill available payers for services. The order of payers is as follows:

1. Third party payers (e.g., large and small group health plans, private health plans, group health plans covering the member 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 and Medicare Advantage Plans (Medicare must always be billed unless the item is a Medicare non-covered service)
3. Minnesota Health Care Programs (IMCare)
4. Waiver Programs

EW services must be billed using the 837P Professional claim transaction. Refer to Chapter 4, Billing Policy, for more information. Under no circumstances may a provider initiate and bill for service delivery prior to the full execution of a contract for waiver services. Before submitting a claim to IMCare for EW services, the provider should verify that the Service Agreement is current. Providers of EW services should contact the county agency if they do not have a current Service Agreement.

It is recommended that providers verify the program eligibility of a member on a monthly basis.

Diagnosis Codes

IMCare requires providers to enter the most current and most specific primary diagnosis code when submitting claims for EW services

Service Authorization/Agreement letters to the provider will display the diagnosis code of the member if the diagnosis **is required for billing**. The diagnosis is captured from the primary diagnosis field on the last approved screening document.

Authorized Services vs. Non-Authorized Services

Services that require a Service Authorization cannot be billed on the same claim as services that do not require a Service Authorization. For example, services for Medical Assistance (Medicaid)-eligible members and home care therapy services (physical, occupational, respiratory, and speech therapy) do not require a Service Authorization and cannot be billed on the same claim form as a waiver service, such as adult day services.

IMCare requires providers to obtain Service Agreements or Service Authorization forms for EW services prior to the start of service in order to ensure prompt and accurate provider payment. There are many advantages for providers to coordinate their efforts with IMCare in order to ensure that a member receives his/her necessary services and providers receive timely payments for services rendered.

Payment Rates

IMCare pays DHS Fee for Service rates. DHS establishes upper rate limits for EW services. Service rates authorized and claimed may not exceed the DHS published maximum allowable service rates, and, for some market rate services must be determined based on the lowest cost effective bid within the limits.

Information about service rate changes and limits for EW services are first made available through publication of [Bulletins](#). Review the DHS [Continuing Care Provider Rate and Grant Changes](#) web page for the most up-to-date information about the current rate limits.

Members Leaving Nursing Facilities (Conversion Rates)

People receiving EW services may access a higher monthly budget if the person is a resident of a certified nursing facility and has lived there for 30 consecutive days. Refer to DHS Bulletin #12-25-01 [EW Conversion Rates and Maintenance Needs Allowance Changes](#) (PDF).

EW Obligation

Eligibility for EW is based on two income limits:

1. People with incomes equal to or less than the Special Income Standard (SIS) are eligible for EW without a Medical Assistance (Medicaid) spenddown. They must contribute any income over the maintenance needs allowance and other applicable deductions to the cost of services received under EW. This is known as the waiver obligation.
2. People with incomes greater than the SIS may still be eligible for EW but they may have a waiver obligation. The lead agency's financial assistance unit is responsible for determining the financial obligation of the EW member. The member is informed if he/she has a waiver obligation.

The waiver obligation is deducted from the cost of services received under EW, and the full amount of the waiver obligation does not have to be met each month. The member is responsible to pay the amount of the obligation toward the services that were utilized that month. This may be a portion of the waiver obligation or the entire waiver obligation.

Claims that are reduced due to the EW obligation will show claim adjustment reason code PR 142 on the remittance advice. IMCare also receives reports on members who have waiver obligations.

Members who receive waiver services through IMCare cannot use the designated provider option.

Home Care Services Provided for Medical Assistance (Medicaid)-Eligible Members Receiving EW Services

All member receiving EW services must first access State plan Medical Assistance (Medicaid) home care services to the highest extent before adding EW services to the community support plan.

Medical Assistance (Medicaid) covers the following home care services:

1. HHA visits
2. Occupational therapy (OT)
3. Registered nurse (RN) PCA Supervision
4. PCA
5. Physical therapy (PT)
6. PDN
7. Respiratory therapy (RT)
8. SNVs
9. Speech therapy (ST)

Home Care and EW Waiver

1. The managed care products that serve EW members are Minnesota Senior Care Plus (MSC+) and IMCare Classic Complete (HMO SNP).
2. With the exception of therapy services, the FFS EW service case manager determines the amount of home care services and approves the Service Agreement. When the member has Medical Assistance (Medicaid) services through managed care, the case manager uses a pseudo code (X5609), which authorizes the amount of home care services that are counted toward the member's case mix budget.
3. For IMCare members receiving EW services, the designated care coordinator is responsible for approval and provision of all home care and EW services.

Extended Home Care Services – EW

Extended home care services include extended PCA, extended HHA, and extended home health nursing (RN/licensed practical nurse [LPN]).

1. A member must first access needed home care service benefits through Medical Assistance (Medicaid) home care before “extended home care” benefits may be approved.
2. Home care service needs that cannot be met within the Medical Assistance (Medicaid) home care limits may be approved and billed to EW as extended Medical Assistance (Medicaid) services within the budget limit available.

Refer to Chapter 24A, Home Care Services, for more information about Medical Assistance (Medicaid) home care services.

Service Descriptions, Billing Codes, and Provider Standards

Services and requirements listed are the minimum guidelines. IMCare may negotiate contracts with providers for higher provider standard requirements under each service category than those noted below. The only waiver services IMCare covers is EW.

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7. Case management aide (paraprofessional)
8. Caregiver assessment
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11. Consumer-directed community supports (CDCS)
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13. Customized Living (CL)
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15. Extended personal care
16. Family caregiver training and education
17. Home care – extended services (home health aide [HHA], private duty nursing [PDN], personal care assistance [PCA])
18. Home delivered meals
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Adult Day Services and Adult Day Services Bath

Service/HCPCS	EW
<p>Adult Day Service</p> <ul style="list-style-type: none"> • S5100 – Center-based services, 15 minutes • S5100 with modifier U7 – Family adult day services (FADS), 15 minutes 	<p>X</p> <p>X</p>
<p>Adult Day Service Bath</p> <ul style="list-style-type: none"> • S5100 with modifier TF, 15 minutes (limited to two units per day) 	

Adult Day Service

Adult day services are services furnished on a regularly scheduled basis, for one or more days per week, two or more hours per day in an outpatient setting. Meals that are provided as part of these services shall not constitute a “full nutritional regimen” (three meals per day). Services are designed to meet the health and social needs of the person. The individual support plan identifies the needs of the person and is directed toward the achievement of specific outcomes. The cost of transportation is not included in the rate.

Definitions

Adult Day Service

Adult day services is a program operating less than 24 hours per day that provides an individualized and coordinated set of services (including health services, social services, and nutritional services) directed to maintaining or improving a member's capabilities for self-care. This includes the following:

1. Supervision
2. Care assistance
3. Training
4. Activities based on the member's needs and directed toward the achievement of specific outcomes identified in the community support plan

Service goals include, but are not limited to, the following:

1. Optimizing health and/or cognitive functioning
2. Increasing socialization
3. Improving community integration

Services must be designed to meet both the health and social needs of a member and may not be used solely for recreational or diversional purposes.

Adult day services are licensed services that must be:

1. On a regularly scheduled basis
2. One or more days per week
3. Two or more hours per day

Meals that are provided as part of these services will not constitute a "full" nutritional regimen (that is, three meals/day) according to Title 42 Code of Federal Regulations (CFR) Part 441.310(a)(2)(ii). Adult day services may not be authorized for more than 12 hours in a continuous 24-hour period. The cost of transportation is not included in the rate.

Provider Standards and Qualifications

1. Adult day services are established under [MN Stat. secs. 245A.01 – 245A.16](#).
2. Adult day services provided in the license holder's primary residence, when the license holder is the primary provider of care, must be licensed under [MN Stat. sec. 245A.143](#) (family adult day services [FADS]). In addition, FADS participants must be age 55 or over, and cannot have a serious or persistent mental illness or developmental disabilities.
3. A family adult day service license holder may not serve more than eight adults at one time. Adult day services provided in any additional locations must be licensed under [MN Rules parts 9555.9600 – 9555.9730](#).
4. Nursing facilities, board and care facilities, and hospitals providing adult day care services to five or fewer non-residents/patients are exempt from adult day care licensure.
5. Lead agencies must authorize services in 15-minute units or use the daily rate for members.
6. Lead agencies shall negotiate the amount of time equal to a day of service with each authorized provider and may negotiate a 15-minute unit instead of the daily unit with individuals who require a longer day as documented in their care plan.

Adult Day Service Bath

A member receiving adult day services may also receive a bath provided by an adult day service provider. To receive an adult day bath, a member must be receiving adult day services. The adult day service bath and reason for not providing a bath in the member's home must be documented in the community support plan. This service is limited to two, 15-minute units of service per day.

1. Adult day bath is limited to two, 15-minute units of service (30 minutes) per day.
2. The second unit may be provided only if the member requires longer than 15 minutes to complete the bath. The code to indicate bath services may only be used if the member has a separate adult day service approved for the same time period.
3. Adult day care providers may provide a bath to a member attending adult day services if required.
4. The bath must be specified on the member's individual plan of care.

Family Caregiver Training and Education

Service/HCPCS
Family Caregiver Training and Education <ul style="list-style-type: none"> • S5115 – per 15 minutes (up to 48 units [12 hours] over a 365-day period)
Family Caregiver Coaching and Counseling/Caregiver Assessment <ul style="list-style-type: none"> • S5115 with modifier TF – per 15 minutes (up to 48 units [12 hours] over a 365-day period)
Family Memory Care <ul style="list-style-type: none"> • S5115 with modifier TG – per 15 minutes (up to 80 units[20 hours] over a 365-day period)

Definition and Covered Services

Family caregiver training and education provides training, education, coaching, and counseling services for family and informal caregivers who provide direct and ongoing services for members enrolled in EW programs.

Caregivers may include the following:

1. Spouse
2. Adult child
3. Parent
4. Other relative
5. Foster family
6. In-laws
7. Other non-relative caregiver (such as partners or friends)

The family caregiver is not paid and is not employed or a volunteer through the organization that cares for the recipient. Under EW, the family caregiver does not need to be living in the same household as the care recipient to obtain caregiver support services. All services must be documented in the member's community support plan.

Family Caregiver Training and Education

Training and education is provided to improve the health and well-being of the family caregiver, and to improve or maintain the quality of care provided for the member. It includes individual or group sessions and updates as necessary.

Examples include instructions about the following:

1. Treatment regimens
2. Disease management
3. Nutrition
4. Direct care skills
5. Use of equipment or technology to maintain the health and safety of the member
6. Caregiver roles
7. Family dynamics
8. Self-care skills
9. Dealing with difficult behaviors
10. Communicating with health care providers
11. Other areas, as specified in the care plan

Family Caregiver Coaching and Counseling/Caregiver Assessment

Caregiver coaching is an individualized person-centered service. The goal is to equip the caregiver with knowledge, skills, and tools to become a stronger caregiver capable of self-directed care.

Coaching or counseling includes the following:

1. Assessment of the caregiver's needs and strengths
2. Development of a person-centered plan with goals
3. Skills development (e.g., disease management, self-care skills such as managing stress, techniques for managing difficult behaviors)
4. Problem solving (e.g., learning assertiveness and communications skills, dealing with family dynamics, and developing an informal support network)
5. Ongoing support to reach established goals
6. Conducting family meetings and memory care consultation

Caregiver counseling offers professional consultation to assist caregivers in making decisions and solving problems related to their caregiving role. This includes the following:

1. Assessment to identify needs and preferences
2. Development of an individualized approach and plans
3. Family counseling
4. Conflict resolution
5. Problem solving or guidance directly related to providing care to an older adult

Limits or Conditions

Family caregiver training and education pays for the costs of training offered by enrolled providers or conference registration fees for family caregivers.

Non-covered costs include the following:

1. Transportation
2. Travel

3. Meals
4. Lodging

If any such costs are included in the registration fee, they must be deducted. The provider or individual requesting training must submit documentation of the need for training and an outline of the training (e.g., a course syllabus, training objectives, workshop description to the lead agency for approval.

Family caregiver coaching and counseling/caregiver assessment is limited to enrolled providers and pays for staff time spent with family caregivers.

Non-covered costs include the following:

1. Preparation time
2. Travel
3. Materials

Providers must submit a service description and plan to the lead agency for approval. Based on the information provided and the individual's needs, the care manager determines whether the service will be authorized. If the service is authorized, the lead agency maintains the submitted documentation in the member's file. The lead agency, as an enrolled Medicaid provider, will submit claims for this service to MMIS as appropriate.

Family Memory Care (FMC)

Family Memory Care (FMC) is a coaching and counseling service for caregivers living with a family member or friend with dementia. FMC is a translation of the evidence-based New York University (NYU) Caregiver Intervention developed by Dr. Mary Mittelman and colleagues at the NYU Alzheimer's Disease Center. The goal of FMC is to improve the ability of caregivers to withstand the difficulties of caregiving by improving social support and minimizing family conflict.

FMC outcomes to be achieved include the following:

1. Reduced negative impact of caregiving behaviors
2. Decreased symptoms of depression
3. Enhanced support network composition and effectiveness
4. Delay or prevent institutionalization of the person with Alzheimer's disease

FMC components include the following:

1. Two individual sessions with the primary caregiver
2. Four family sessions
3. Ad hoc counseling to offer support and resources for at least 12 months following family sessions
4. Follow-up assessments every six months following the family sessions

To participate in FMC, family or friend caregivers must meet the following:

1. The primary caregiver lives with the person with dementia
2. At least one family member or friend participates in each of the family meetings
3. The primary caregiver reports a physician's diagnosis of Alzheimer's disease or a related dementia, such as vascular dementia, dementia with Lewy bodies, frontotemporal dementia, Parkinson's related dementia, or other related disorder
4. The primary caregiver has no physical or mental conditions that would prevent participation.

The person with dementia must have a Global Deterioration Score (GDS) of 4 or higher as assessed by an FMC consultant.

Provider Standards and Qualifications

Staff Qualifications

Acceptable providers for family caregiver training and education include the following professionals:

1. Public health nurses
1. RNs
2. LPNs
3. Physicians
4. Social workers
5. Rehabilitation therapists
6. Gerontologists
7. Pharmacists
8. Caregiver consultants
9. Memory care consultants
10. Health educators
11. Nutritionists
12. Vocational and technical colleges offering home health aide and certified nursing assistant training
13. Independent living specialists
14. Medical equipment suppliers

Acceptable providers for family caregiver coaching and counseling include these professionals:

1. Public health nurses
2. RNs
3. LPNs
4. Physicians
5. Social workers
6. Rehabilitation therapists
7. Gerontologists
8. Pharmacists
9. Caregiver consultants
10. Memory care consultants
11. Health educators
12. Nutritionists

Acceptable provider agencies for family caregiver coaching and counseling include home care agencies and care- or support-related organizations (non-profit social service organizations, voluntary or faith-based agencies, and state and local chapters of chronic disease organizations, such as the Alzheimer's Association).

In addition, enrolled providers will have one of the following:

1. At least one year of experience in providing home care or long-term care service to older adults
2. At least one year of experience providing training, education, or counseling to caregivers of older adults

Physical cares requiring a specific technique for the safety of both the caregiver and the older adult must be taught by a professional specializing in such techniques. Such professionals include the following:

1. Public health nurse
2. RN
3. LPN

Training and education of caregivers may also be provided by vocational and technical schools offering courses such as the following:

1. Home health aide and certified nursing assistant training
2. Disease-specific training provided by care- or support-related organizations (e.g., Alzheimer’s Association) when it is determined by the case manager that the content of the training or conference directly applies to the care and wellbeing of the EW or AC member needing care.

Caregiver consultants will have completed the Minnesota Board on Aging (MBA) caregiver coaching basic training curriculum and continuing education offered by the MBA or Area Agencies on Aging.

Documentation and Reimbursement

The following must be documented for family caregiver training and education this service to be reimbursed:

1. Requested areas of training and education, or coaching or counseling
2. Potential sources of training and education, or coaching or counseling
3. Identified methods by which the family caregiver will receive information about training and educational or coaching or counseling opportunities

Documentation of the training, education, coaching, or counseling course (such as the course syllabus, workshop description, or training objectives) and receipts for any fees and expenses **must** be submitted to the lead agency prior to payment.

The lead agency, as an enrolled Medical Assistance (Medicaid) provider, may pay the family caregiver directly and then submit claims to IMCare for reimbursement of the service.

All family caregiver training, education, coaching, or counseling must be included in the written plan of care.

Adult Foster Care Services

Service/HCPCS

Foster Care – Corporate

For dates of service *before July 1, 2016*: S5141 with modifier HQ – monthly, adult

For dates of service *on and after July 1, 2016*: S5140 with modifier U9 – daily

- Monthly codes may not be used after July 1, 2016.

Foster Care – Corporate

For dates of service *before July 1, 2016*: S5141 – monthly, adult

For dates of service *on and after July 1, 2016*: S5140 – daily

- Monthly codes may not be used after July 1, 2016.

Definition

Foster care services are ongoing residential care and supportive services provided to a member living in a home licensed as a foster care.

Adult foster care is provided to members who receive these services while residing in the home. Foster care services are based on the individual needs of the member, and service rates must be determined accordingly.

When placing an adult into a licensed foster care setting, all Federal, State, county, and licensing agency rules and regulations **must** be followed. Requirements for services and supports are identified in the community support plan of the member.

Adult Foster Home Size

The total number of people (including waiver recipients) living in the home cannot exceed four when all residents meet the following criteria:

1. Are diagnosed with a serious and persistent mental illness (SPMI) or a developmental disability
2. Are not related to the principal care provider

The total number of people (including waiver recipients) living in the home cannot exceed five when all residents meet the following criteria:

1. Do not have a diagnosis of SPMI or developmental disability
2. Are not related to the principal care provider

Size and Location

Adult foster care providers may be licensed for up to five adults per home if none of the foster care members age 55 or over have an SPMI or any developmental disability. **Exceptions** to the size and location requirements are as follows:

1. Residence was developed before May 1, 2001, and has continuously provided waiver services
2. Temporary exception to size of setting

Covered Services

Adult foster care homes provide the following services:

1. Food preparation
2. Protection
3. Household services
4. Homemaking
5. Chore services
6. Medication assistance (as permitted under state law)
7. Assistance safeguarding cash resources
8. Personal care assistance
9. Homemaking
10. Oversight and supervision
11. Transportation

Non-Covered Services

Payment for EW foster care service does not include the following:

1. Room and board
2. Duplication of services paid by other sources
3. Items of comfort or convenience
4. Costs of facility maintenance, upkeep, and improvement
5. Payment for foster services when the member is not in the foster setting
6. Separate payment for homemaker or chore services
7. Payment for foster care services when a member is a resident of a different foster care setting

Provider Standards and Qualifications

Payments will be made only to those entities or recipients that meet current legal foster care licensure requirements found in [MN Rules part 9555.5050 – 9555.6265](#) and [2960.3000 – 2960.3230](#) and [MN Stat. sec. 245A.03](#)

Case Management/Service Coordination

Service/HCPCS
EW Case Management <ul style="list-style-type: none"> • Face-to-face T1016 with modifier UC – 15 minutes
Case Management Conversion <ul style="list-style-type: none"> • T1016 – 15 minutes
Screenings LTCC S0250 <ul style="list-style-type: none"> • Health Risk Assessment (HRA) S5190 (face-to-face) • HRA S5190-52 telephonic • Skilled Nursing Facility (SNF) assessment S0250 • Annual reassessment S0250-TS
Telephonic T1016 U4-UC – 15-minute units <ul style="list-style-type: none"> • Indirect case management T1016-54-UC – 15-minute units • Paraprofessional CM T1016-TF-UC – 15-minute units
Non-EW or SNF Case Management <ul style="list-style-type: none"> • Face-to-face case management T1016 – 15-minute units • Telephonic case management T1016 U4 – 15-minute units • Indirect case management T1016-52 – 15-minute units • Paraprofessional case management T1016-TF – 15-minute units

Definition

This service will help members gain access to needed waiver and State plan services, as well as needed medical, social, educational, and other services, regardless of the funding source. It covers case management for IMCare Classic and MSC+ members receiving EW services from different health and social service professionals and across settings of care and includes, but is not limited to, needs assessment, prior approval, care communication, coordination, and risk assessments.

Covered Services

The following case management service activities are covered under the waiver programs:

1. Development of a service plan
2. Informing the member or the member's legal guardian or conservator, or parent if the member is a minor, of service options
3. Assisting the member in the identification and choice of potential providers
4. Assisting the member access services
5. Coordinating services
6. Evaluating and monitoring of the services identified in the plan
7. Conducting annual reviews of service plans

8. Conducting assessment and reassessment of the individual's level of care and review of the plan at least annually

Case Management Administrative Activities

Case management administrative activities are not billable under any HCBS program. Case management administrative activities include the following:

1. Diagnosis
2. Intake
3. Responding to requests for conciliation conferences and appeals
4. Review of eligibility for services
5. Screening activity
6. Service authorization
7. Transportation

Non-Covered Services

Case management service activities **cannot** be duplicated with other Minnesota State plan-covered services.

Additional Information

All case management services billed under the EW program must be based on a service actually provided to the member. Services must be planned and delivered based on individual need and may not be billed based on averages of the number of billable units provided to a member, nor across program populations.

Some members receiving case management services may also be determined to be eligible for other forms of case management (such as hospice or mental health). In these situations, DHS recommends the following:

1. Designating one of the case managers as the primary contact
2. Ensuring services are not duplicated by active coordination among the case managers
3. Clearly defining roles and responsibilities of each case manager so efforts are not duplicated

Members eligible for and receiving case management under EW are not concurrently eligible for the following forms of case management services:

1. Targeted Case Management for Vulnerable Adults and Adults with Developmental Disabilities (VA/DD-TCM)
2. Relocation Service Coordination (RSC)

Provider Standards and Qualifications

Members receiving services under HCBS programs may choose to receive case management services from qualified and approved vendors that have provider agreements with the agency or State. Providers are responsible for monitoring the terms of their contract. Tier 1 providers must be enrolled with DHS as well as with IMCare. DHS Enrollment for tier 2 and tier 3 providers is optional but encouraged. If the provider is a Federally recognized tribal/local government, the case management contract may be between the tribal/local government and DHS. Based on the standards contained in the waiver plans, only county agencies are qualified to provide or contract for case management services. However, members' choice cannot be limited to the county of financial responsibility. This means the member may choose to receive case management services from another county or lead agency. Please note this applies to case management service activities only. Case management administrative activities are not directly billable under any waiver.

The provider of case management services must not have a financial interest in other services provided to an individual, unless it is the county or lead agency that provides the case management services.

Elderly Waiver (EW)

1. If the case manager is not a local agency employee, then the provider of services will be required to execute a contract with the agency in order to provide case management.
2. Case managers, with the exception local agency employees, may not have a financial interest in the provision of services.

Case management/service coordination may be provided by the following individuals who are employed by, or contracted with, the local agency:

1. PHN
2. RN licensed under MN Stat. secs. 148.171 – 148.285
3. Social worker graduate of an accredited four-year college with a major in social work, psychology, sociology, or a closely related field; or a graduate of an accredited four-year college with a major in any field and one year experience as a social worker in a public or private social service agency. Social workers must also pass a written exam through the Minnesota Merit System or a county civil service system in Minnesota. Standards are authorized under MN Rules parts 9575.0010 – 9575.1580. Authority to set personal standards is granted under MN Stat. sec. 256.012.

Different credentialing standards can be applied to services provided by tribal governments under MN Stat. sec. 256B.02, subd. 7.

Case Management Aide/Paraprofessional

Service/HCPCS

Case Management Aide/Paraprofessional

- T1016 with modifiers TF & UC – 15 minutes

Definition

Paraprofessional and case management aides provide assistance to the case manager in carrying out administrative activities of the case management function.

Covered Services

Case management aides must perform only those tasks delegated and supervised by the case manager that do not involve professional expertise or judgment, per MN Stat. sec. 256B.49, subd. 13

Examples of duties case aides may perform include the following:

1. Filing
2. Contacting vendors to schedule services
3. Phone contacts

Non-Covered Services

A case management aide must not do the following:

1. Assume responsibilities that require professional judgment
2. Conduct assessments

3. Conduct reassessments
4. Develop care plans

Billing

1. All case management-related tasks that are not professional in nature must be billed as case aide services and not as case management services.
2. Duplicate payments will not be made for case aide management services by more than one provider.

Provider Standards and Qualifications

The case management aide must understand, respect, and maintain confidentiality concerning all details of each case. The case aide cannot have a financial interest in the services provided to the individual. The case manager is responsible for providing oversight to the case aide.

The case management aide must:

1. Be a high school graduate
2. Have one year of experience as a case aide or in a closely related field; or one year of education beyond high school (for example, business school or college)
3. Be employed by the agency providing case management
4. Receive oversight of delegated tasks from the case manager.

Chore Services

Service/HCPCS

Chore Services

- S5120 – 15 minutes

Definition

Chore services support or assist a member or his/her primary caregiver to maintain the home of a member as a clean, sanitary, and safe environment.

Eligibility

Chore services will be covered only if **both** of the following conditions are met:

1. Neither the member nor anyone else in the household is capable of performing **or** financially providing for the chore services
2. There is no relative, caretaker, landlord, local county agency, community volunteer/agency, or third party payer capable of **or** responsible for the provision of the chore services

Covered Services

1. Heavy household chores such as washing floors, windows, and walls, and indoor/outdoor general home maintenance
2. Moving or removal of large household furnishings and heavy items to provide safe access inside the home and egress or to prevent falls
3. Shoveling snow and lawn maintenance to provide access and egress to and from the home
4. May include customary service charges made for the delivery of grocery store products when these products represent the majority of the member's needs for a minimum of a 7-day period and it is the most cost

efficient way of procurement of groceries in the community. The amount and service charge should be reasonable and customary in the member's community.

5. Extermination and pest control limited to the reasonable number of treatments required to alleviate the pest problem
6. Dumpster rental and refuse disposal

Other sources of funding, including Community Social Services Act CSSA/Title XX, or in the case of rental property, the responsibility of the landlord pursuant to the lease agreement should be explored before the county authorizes payment under EW.

Non-Covered Services

Services cannot be duplicated with other Medical Assistance (Medicaid)-covered services. In the case of rental property, the lease agreement shall be reviewed to determine if the service may be the responsibility of the landlord. If the care plan also includes homemaker services, the care plan must be efficiently specific to ensure that there is no duplication.

Provider Standards and Qualifications

Either IMCare or the county acting in a pass through capacity approves the providers of chore services and ensures the chore services are all of the following:

1. Provided by individuals who are qualified and who meet the unique needs and preferences of the member who will receive the chore services
2. Delivered in a cost-effective manner
3. Directed at the outcomes desired by the member
4. Designed to meet the health and safety needs and preferences of the individual as specified in the Individual Support Plan (ISP) or community support plan

Companion Services – Adult

Service/HCPCS

Adult Companion Service

- S5135 – 15 minutes

Definition

Non-medical care, assistance, or supervision and socialization provided to an adult according to a therapeutic goal in the community support plan that are not purely diversional.

Socialization that is therapeutic is directly tied to the member's goals as specified in the care plan such as a game or activity that enhances fine motor skills to help a member recover from a stroke.

Socialization that is diversional is for purposes of recreation and pleasure such as attending a community event or playing any game, but the activity does not necessarily address specific goals in the care plan.

However, waiver services are also specifically intended to support an individual to maintain and enhance community integration and social relationships, are not limited to remediation of a medical condition, and can be used to support community integration goals. Activities that support "therapeutic" socialization could be associated with a care plan goal to reduce social isolation or help the member maintain the most inclusive community life, for example.

Covered Services

The goals of adult companion services are directed at companionship, assistance, or supervision of the member in the home or community. Adult companion services may include the assistance or supervision of the member with such tasks as the following:

1. Meal preparation
2. Laundry
3. Shopping
4. Light housekeeping tasks incidental to care and supervision

Companions do not perform the above tasks as discrete services.

Non-Covered Services

Adult companion services do not include the following:

1. Hands-on nursing care
2. Activities that are not directed at a goal
3. Tasks as a discrete service

Additional Information

Adult companion services providers who receive payment cannot be the legal guardian or related to the member (e.g., a spouse or other relatives). A member must be over the age of 18 years to receive adult companion services.

Provider Standards and Qualifications

Providers must be licensed under MN Stat. Chap. 245D or 144A, unless they are excluded under MN Stat. sec. 245A.03, subd. 2.

Providers who meet the standards established by the Corporation for National and Community Service do not have to meet the licensing requirements of MN Stat. Chap. 245D.

Individuals licensed under MN Stat. Chap. 144A as a home care provider must meet the provider standards in MN Stat. Chap. 245D.

Individuals meeting the licensing exclusions of MN Stat., sec. 245A.03, subd. 2 (1) and (2) must meet the requirements of MN Stat. sec.245D.04, subd. 1(4), subd. 2 (1), (2) (3) (6), and subd. 3 regarding service recipient rights; MN Stat. sec. 245D.05 and 245D.051 regarding health services and medication monitoring; MN Stat. sec 245D.06 regarding incident reporting and prohibited and restricted procedures; MN Stat sec 245D.061 regarding the emergency use of manual restraint; and MN Stat. sec.245D.09 subds. 1, 2, 3, 4a, 5a, 6, and 7 regarding staffing standards as applicable.

IMCare contracts with our County to and they are responsible to ensure that whoever provides services (individual or agency) meets the following minimum standards:

1. Is able to read and write
2. Is able to follow written and oral instruction
3. Has had experience or training in homemaking skills and/or in care of people with cognitive or physical limitations or other functional impairments
4. Has the ability to perform essential job functions as identified in the person's care plan.

5. Is in good physical and mental health
6. Has the ability to converse effectively on the telephone
7. Has the ability to work under intermittent supervision
8. Has the ability to manage emergency and/or crisis situations and report them to the lead agency
9. Is able to understand, respect, and maintain confidentiality in regard to the details of any circumstances surrounding the member

An individual may be required to pass a job-related physical examination before providing services.

Consumer Directed Community Supports (CDCS)

Service/HCPCS

Consumer Directed Community Supports

- T2028 with modifier U1 for personal assistance
- T2028 with modifier U2 for medical treatment and training
- T2028 with modifier U4 for self-direction support activities
- T2028 with modifier U8 for flexible case management
- T2040 – Background checks, each check
- T2041 – Required case management, 15 minutes

Definition

CDCS is a service option that gives members greater flexibility and responsibility for directing their own services and supports, including hiring and managing direct care staff. CDCS may include services, support, and/or items currently available through EW, as well as additional allowable services that provide needed support to members.

Limitations

Members residing in a CL, 24-Hour CL, foster care, or residential care setting are not eligible to choose this option.

Service Criteria

There are specific requirements for all services, supports, and/or items that are available through Medical Assistance (Medicaid) waivers including CDCS. In order for services, supports, and/or items to be purchased under CDCS, they must meet the following criteria:

1. Be for the sole benefit of the member
2. Be the least costly alternative that reasonably meets the member's identified needs
3. Collectively provide a feasible alternative to an institution
4. Meet the identified needs and outcomes in the member's community support plan and ensure the health, safety, and welfare of the member

If all the above criteria are met, services, supports, and/or items are appropriate purchases when they are reasonably necessary to meet the following outcomes:

1. Decrease dependency on formal support services
2. Develop or maintain personal, social, physical, or work-related skills
3. Enhance community inclusion and family involvement
4. Increase the ability of unpaid family members and friends to receive training and education needed to provide support

Eligibility

To be eligible for CDCS, a member must **either** already be receiving services on a Medical Assistance (Medicaid) waiver in Minnesota **or** must meet all eligibility criteria for Medical Assistance (Medicaid) waiver and be authorized to receive waiver services by the county.

The following members are **not** eligible for CDCS:

1. CDCS members who have exited the waiver more than once during their service plan year (ineligible for CDCS for the remainder of that service plan year)
2. Members who have had their eligibility restricted at any time by the Primary Care Utilization Review (PCUR)
3. Members whose authorized representative has their eligibility restricted at any time by PCUR
4. Waiver recipients living in residential settings licensed by DHS or licensed/registered with MDH

County workers should check the Recipient Primary Care Utilization Review (RPCR) screen in MMIS to determine whether the member has been involved with PCUR before discussing the CDCS option with the member.

Covered Services

CDCS has a range of allowable services, supports, and/or items that can be tailored to meet a member's needs in addition to those currently available through Medical Assistance (Medicaid) waivers. A member can choose to receive traditional waiver services **and/or** design his/her own services using CDCS.

The flexibility built into CDCS allows members to do the following:

1. Describe services and supports in ways that are meaningful to them
2. Design services and supports that are unique to them and best meet their identified needs

Services, supports, and/or items that augment State plan services or provide alternatives to waiver or State plan services are covered under CDCS and must fit into one of the following four service categories:

1. Environmental modification and provisions
2. Personal assistance
3. Self-direction support activities
4. Treatment and training

Non-Covered Services

Services, supports, and items that **cannot** be purchased within the member's CDCS budget are as follows:

1. All prescription and over-the-counter medication, compounds, solutions, and related fees (including insurance premiums and drug copays)
2. Animals and their related costs
3. Costs related to Internet access
4. Expenses for travel, lodging, or meals related to training the member or his/her representative or paid or unpaid caregivers
5. Experimental treatments (MN Rules part 9525.3015, subp. 16)
6. Fees incurred by the member such as copays, attorney costs, or costs related to advocate agencies, with the exception of services provided as flexible case management
7. Home modifications for a residence other than the primary residence of the member or, in the event of a minor with parents not living together, the primary residences of the parents

8. Home modifications that add any square footage
9. Insurance expenses except for insurance costs related to employee coverage
10. Membership dues or costs unless related to a fitness or exercise program for adults when the service is appropriate to treat a physical condition or to improve or maintain the member's physical condition (condition must be identified in the individual's plan of care and monitored by an MHCP-enrolled physician)
11. Room and board and personal items of member that are not related to the disability
12. Services covered by the State plan, Medicare, or other liable third parties including education, home-based schooling, and vocational services
13. Services provided to or by individuals, representatives, providers, or caregivers that have at any time been assigned to the PCUR program
14. Services provided to members living in settings licensed by DHS or MDH or registered as a housing with services (HWS) establishment
15. Tickets and related costs to attend sporting or other recreational events
16. Vacation expenses other than the cost of direct services
17. Vehicle maintenance that does not include maintenance to modifications related to the disability

Provider Standards and Qualifications

Each member will need to consider his/her needs and requirements when deciding the qualifications he/she would like the provider/staff to have. For example, a member who has frequent seizures may want to hire somebody who has training in how to react when someone is having a seizure or experience working with people who have seizures.

Additional qualifications are to be documented in the community support plan. The provider/staff must meet these qualifications in order to provide CDCS. The member and/or his/her authorized representative must maintain documentation indicating how the qualifications are met.

When choosing other formal waiver services, all provisions of the waiver service must be followed including the services description, provider qualifications, and quality assurance mechanisms of the service.

Criminal Background Studies

Criminal background studies are not required under CDCS. A member can choose to request a criminal background study on any or all of his/her staff. If a criminal background study is completed, the member must abide by the results of the study.

If a criminal background study is requested by the member/authorized representative or when the member has chosen a waiver service that requires background studies (MN Stat. Chap. 245C), Human Services Background Studies guidelines apply to determine if the staff person is disqualified. An individual who is disqualified through this process may not be paid under CDCS.

The cost of criminal background studies is not deducted from the individual budget amount when the member uses a background study as a staff requirement for an individually designed service. The cost will be covered as a service expense through the counties' waiver budget allocations.

If the member chooses to use an agency as his/her fiscal support entity **and** that agency requires background checks, the cost of the criminal background study is included in the administrative rate for that agency.

If the member selects waiver services in which a background study is a required provider qualification for that waiver service, the cost is included in the rate for that waiver service.

For more information, please refer to the [Community Based Services Manual \(CBSM\)](#).

Customized Living (CL) Services

Service/HCPCS

Customized Living (CL) Services

For dates of service *before July 1, 2016*: T2030 – monthly

For dates of service *on and after July 1, 2016*: T2031

- Monthly codes may not be used after July 1, 2016.

Providers must not bill for full days in which the member is absent.

Definition

CL services are up to 24 hours of supervision, individualized home care aide tasks, home health aide tasks, and home management tasks provided to residents of a congregate living setting licensed as a home care provider and registered as an HWS establishment.

Individualized means that services are designed specifically for each resident's needs.

Covered Services

1. Up to 24-hour supervision and oversight
2. Home care aide tasks
3. Home management tasks including laundry and meal preparation
4. Arranging for or providing transportation
5. Assisting the member with setting up meetings or appointments
6. Socialization
7. Assisting the member with personal funds management

The following additional services may be available through providers licensed to provide Medical Assistance (Medicaid) home care services:

1. Home health aide (HHA)
2. Incidental nursing
3. Central storage of medications

Criteria for Authorization of 24-Hour CL

MN Stat. sec. 256B.0915, subd. 3h, paragraphs (a) and (b), include requirements for local agency authorization of 24-Hour CL. These criteria are based upon the need for any of the following:

1. Cognitive or behavioral intervention
2. Clinical monitoring
3. Staff assistance in toileting, positioning, or transferring
4. Assistance in medication management **and** 50 hours of direct CL services per month as determined by the member's case manager to be part of the 24-Hour CL services plan

Non-Covered Services

1. Room and board
2. Waiver-funded homemaker, chore, and respite are not billable services during the period that the person is receiving CL services
3. Payment for CL services when the member is not in the setting (see *Waiver Leave Days*)
4. Socialization when it is diversionary or recreational in nature

Establishment or Housing with Services Establishment

An establishment or housing with services establishment provides sleeping accommodations to one or more adult residents, at least 80 percent of whom are age 55 or over, and offers or provides, for a fee, one or more regularly scheduled health-related services or two or more regularly scheduled supportive services, whether offered or provided directly by the establishment or by another entity arranged for by the establishment. An establishment or housing with services establishment can also be an establishment that registers under MN Stat. [sec. 144D.025](#).

CL services must be provided by the management of the congregate living setting or by providers under contract with the management or lead agency. Individuals receiving CL services are not eligible for homemaking in addition to CL services.

Additional Information

1. Service delivery is directed by the member, or provider, with oversight from the case manager
2. The case manager is the primary party responsible for negotiations with the provider to ensure that the needs of the member are fully met through the package that is created specifically for that member
3. All homemaker and chore services needed by a member are included in the CL services package that is initially negotiated with the provider. These services are not separately authorized or billed.
4. CL services may be provided in any number of apartments in a residential center for members who rent or own distinct units
5. CL services are covered under the waiver program costs. Room and board, or raw food (groceries), and rent, while a member receives CL services, are paid by the member's income, which may include Supplemental Security Income; Retirement, Survivors, Disability Insurance (RSDI), and/or other options. If the member has inadequate income for room and board or rent charges, he/she may be eligible for a Group Residential Housing (GRH) payment to the provider. Information regarding GRH is available from the county lead agency.
6. CL rates are negotiated based on the level of service needed and provided.

IMCare adheres to the DHS rate schedule

Provider Standards and Qualifications

CL service providers must meet the standards of licensure, certification, or registration where they exist in state law and administrative rule.

Services must be provided by a provider who holds one of the following:

1. Basic home care license
2. Comprehensive home care license

A provider who holds a comprehensive home care license must furnish the services in a registered Housing with Services Establishment.

Customized Living service providers who are not licensed under [Minnesota Rules, parts 9555.5105 – 9555.6265](#) (Adult Foster Care), and who provide services in settings of one to five residents, must comply with [Minnesota Rules, part 9555.6205, subps. 1 – 3](#); [part 9555.6215, subps. 1 and 3](#); and part [9555.6225, subps. 1, 2, 6, and 10](#).

Home care licenses are issued under [Minnesota Statute, sections 144A.43 – 144A.484](#).

Staff Qualifications

1. Home Care Aides qualifications are listed in [MN Rules part 4668.0100](#), subp. 2.
2. Home Health Aide qualifications are listed in [MN Rules part 4688.0100](#), subp 5.

Staff providing supervision, oversight, and supportive services must meet all of the following criteria:

1. Be able to read, write, and follow written or oral instructions
2. Have had experience or training in caring for individuals with functional limitations
3. Have good physical and mental health, and maturity of attitudes toward work assignments
4. Have the ability to converse on the telephone, to work under intermittent supervision, to deal with minor emergencies arising in connection with the assignment, and to work under stress in a crisis situation
5. Understand, respect, and maintain confidentiality
6. Have a valid state driver's license and insurance coverage in accordance with State requirements if providing transportation to waiver clients

24-Hour Customized Living (CL) Services

Service/HCPCS

24-Hour Customized Living (CL) Services

For dates of service *before July 1, 2016*: T2030 with modifier TG – monthly

For dates of service *on and after July 1, 2016*: T2031 with modifier TG

- Monthly codes may not be used after July 1, 2016.

Definition

A group of individualized health-related and supportive services provided to a member residing in a residential center (apartment building) or other congregate living setting licensed as a home care provider or an HWS establishment or contracted for by IMCare with a Class A home care agency.

Must include 24-hour on-site supervision in addition to services provided by home care aides, HHAs, or residential staff.

HWS establishment: An establishment providing sleeping accommodations to one or more adult residents, at least 80 percent of whom are age 55 or over, and offering or providing, for a fee, one or more regularly scheduled health-related services or two or more regularly scheduled supportive services, whether offered or provided directly by the establishment or by another entity arranged for by the establishment; or an establishment that registers under [MN Stat. sec. 144D.025](#).

Covered Services

24-Hour CL services include individualized supports that are chosen and designed specifically for each member's needs and can only be provided in a registered HWS establishment. The services include the following:

1. 24-hour supervision and oversight
2. Home care aide tasks
3. Home management tasks
4. Meal preparation
5. Arranging for or providing transportation
6. Assisting the member with setting up meetings or appointments
7. Socialization
8. Assisting the member with personal fund management

Additional services may be available through providers that are licensed to provide home care.

24-Hour On-Site Supervision

1. Ongoing awareness of member's needs and activities provided by an employee of the CL services provider, who is not a recipient of services and whose primary job responsibility is to provide supervision to individuals in the setting
2. The provider must have a means for the member to summon assistance and a 24-Hour CL services employee available to respond in person to the request within a reasonable amount of time. See [Comprehensive Policy on Elderly Waiver \(EW\) Customized \(Formerly Assisted\) Living \(PDF\)](#).

Additional Information

1. Service delivery is directed by the member, or the provider, with oversight from the case manager/service coordinator.
2. The case manager is the primary party responsible for negotiations with the provider to ensure that the needs of the member are fully met through the package that is created specifically for that member.
3. Lead agencies can negotiate individualized monthly rates up to the member's budget cap based on the level of service needed and provided.
4. All homemaker tasks and chore services are a part of the 24-Hour CL services package initially negotiated with the provider and that meet all of the home management task service needs for the member.

Non-Covered Services

1. Room and board
2. Waiver-funded homemaker, chore, and respite are not billable services during the period that the person is receiving CL services
3. Payment for CL services when the member is not in the setting (see *Waiver Leave Days*)
4. Socialization when it is diversionary or recreational in nature

Waiver Leave Days

IMCare may only make payment for waiver services actually provided to an eligible person. This does not include leave days. The overhead expense of days when the person is away from a residence is accepted by CMS as part of a waiver provider's cost of doing business. Overhead expenses may be factored into a provider's rate.

Billing for Leave Days

Providers may not bill for days the member is away from the home. IMCare providers are required to bill only for days they provide services. The time allocation per unit determines if multiple providers can provide service on the same date of service. How the provider submits the claim will depend on the situation.

The provider who bills overnight services depends on where the member is at midnight. Providers may only bill for days on which the member was present in the CL establishment at midnight, regardless of whether the member received services that day.

When the member leaves the facility overnight, whether it is for a hospital admission or a leave for personal reasons such as a visit with family, the provider must bill to reflect the leave days. CL claims should include span billing, using additional lines to note the day's service was provided to the member. The following are two billing examples:

1. If a member resides in the facility all month without leaving for an overnight stay, the claim should be billed with one line item reflecting the span dates from the first of the month to the end of the month. This line item should include the amount noted on the service agreement.
2. If a member was admitted to a hospital for three days in a month (e.g., July 15 – 18), the claim should be submitted with one line item for dates of service (DOS) July 1 – 14; a second line item should be entered with DOS for July 18 – 31. When billing span dates, the provider should calculate the daily rate and then bill the correct amount for each date span.

The provider can bill if the member leaves the home after midnight. The hospital then uses the next day as the admission date. If the member returns to the home before midnight on the following night, the hospital bills the claim as is before midnight. The inpatient hospital claim indicates the admission hour and discharge hour, so the system can tell if the member was in the home until midnight.

Provider Standards and Qualification

The State agency requires that 24-Hour CL service providers meet the standards of licensure, certification, or registration where they exist in State law and administrative rule.

24 Hour CL Provider Requirements

Basic home care license

2. Comprehensive home care license under [MN Rules parts 4668 – 4669](#) is available only to a setting registered as “Housing with Services” establishment.
3. 24-Hour CL services can be provided only in settings registered as “Housing with Services” establishments under [MN Stat. Chap. 144D](#).
4. CL service providers who are not licensed under [MN Rules parts 9555.5105 – 9555.6265](#) (adult foster care), and who provide services in settings of one – four residents, must comply with [MN Rules part 9555.6205](#), subp. 1 – 3; part [9555.6215](#), subps. 1 – 3; and parts [9555.6225](#), subps. 1, 2, 6, and 10

Home care licenses are issued under Minnesota Statute sections 144A.43 – 144A.484.

Staff Qualifications

1. Home care aide qualifications are listed in [MN rules part 4668.0100](#), subp. 2.
2. HHA qualifications are listed in [MN Rules part 4688.0100](#), subp. .5

3. Staff providing supervision, oversight, and supportive services must meet the following criteria:
 - a. Be able to read, write, and follow written or oral instructions
 - b. Have had experience or training in caring for individuals with functional limitations
 - c. Have good physical and mental health and maturity of attitudes toward work assignments
 - d. Have the ability to converse on the telephone, to work under intermittent supervision, to deal with minor emergencies arising in connection with the assignment, and work under stress in a crisis situation
 - e. Understand, respect, and maintain confidentiality
 - f. Have a valid state driver’s license and insurance coverage in accordance with State requirements if they provide transportation to waiver clients

Environmental Accessibility Adaptations

Service/HCPCS
Environmental Accessibility Adaptations – Home Install <ul style="list-style-type: none"> • S5165
Assessment of Environmental Accessibility Adaptations for Home Authorization of assessments to determine the most appropriate adaptation or equipment <ul style="list-style-type: none"> • T1028
Environmental Accessibility Adaptation –Vehicle Install Authorization of vehicle installations that may include, but are not limited to: adapted seat devices, door handle replacements, lifting devices, roof extensions, and wheelchair securing devices <ul style="list-style-type: none"> • T2039
Assessment of Environmental Accessibility Adaptations for Vehicle Authorization of assessments to determine the most appropriate vehicle modifications <ul style="list-style-type: none"> • T2039 with modifier UD

Definition

Physical adaptations to the home or vehicle required by the member’s community support plan, which are necessary to ensure the health and safety of the member with mobility problems, sensory deficit, or behavior problems, or which enable the member to function with greater independence in the home, and without which he/she would require institutionalization. The adaptations are made to the member’s primary place of residence and are of direct and specific benefit to the member. Environmental accessibility adaptations also include modifications to vehicles that allow the individual to function with greater independence in the community. Adaptations must be documented in the community support plan and must be the most cost-effective solution.

Environmental modification: Modification items that are not permanently attached to the residence or vehicle and can be transitioned with the member to another location.

Environmental accessibility adaptations also cover the necessary assessments to determine the most appropriate adaptation or equipment and the most appropriate vehicle modification

Covered Services

Covered adaptations may include, but are not limited to, the following:

1. Installation and maintenance of ramps and grab bars, widening of doorways
2. Modification of bathrooms and kitchens
3. Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies
4. Floor coverings (e.g., allergy flooring, accessibility flooring)
5. Modifications to meet egress
6. Alarm systems and other requirements of the applicable life safety and fire codes, if any

Equipment purchase for personal emergency response systems (PERS) as defined in Bulletin [#13-25-04](#) when the system entails changes to the physical structure and becomes a permanent part of the member's home and is not easily removed should be authorized as an environmental accessibility adaptation. (PERS equipment that is easily removable should be authorized as Specialized Supplies and Equipment.) PERS equipment purchase is subject to a \$1,500 annual limit. Non-covered PERS items and services include the following:

1. Participants receiving 24-hour CL, except for use outside of their residence
2. Telehealth and biometric monitoring devices
3. Supervision or monitoring of activities of daily living that are provided to meet the requirements of another service
4. Equipment used in the delivery of Medical Assistance (Medicaid) or other waived service
5. Video equipment (Use of video equipment authorized under other services must meet criteria negotiated with CMS described in Bulletin [#13-25-04](#), Appendix A.)

Covered modifications and adaptations include those which meet the following criteria:

1. Are for the health, welfare, and safety of the member
2. Enable the member to function with greater independence
3. Are of direct and specific benefit due to the member's disability
4. Are the most cost-effective solutions

Covered vehicle modifications to the member's primary means of transportation (one operating vehicle) may include, but are not limited to the following:

1. Door handle replacements
2. Door widening
3. Roof extensions
4. Wheelchair lifts
5. Wheelchair securing devices
6. Adapted seat devices
7. Handrails and grab bars
8. Acceleration and breaking controls

Vehicle modifications must be provided according to applicable State and Federal safety and motor vehicle standards.

Covered environmental modifications and adaptations include modifications to adaptive equipment as required by the member, such as the following:

1. Adaptive furniture,
2. Positioning devices
3. Utensils

The purchase, installation, maintenance, and repairs (repairs must be cost efficient compared to the replacement of the items) will be covered for environmental modifications and equipment

Limitations

Adaptations and modifications are limited to a combined total of \$10,000 per member waiver year for recipients of EW services. This limit is subject to changes authorized by CMS.

Modifications and adaptations are limited to the member's home and/or vehicle, with the vehicle limited to one operating vehicle. The limit of one vehicle does not prohibit vehicle modifications or adaptations when a vehicle must be replaced.

Non-Covered Services

1. Adaptations adding to the total square footage of the home
2. Adaptions for comfort or convenience
3. General utility
4. Household appliances
5. Adaptions not of direct medical or remedial benefit to the member
6. Supplies covered by a Medical Assistance (Medicaid) State plan

Items that are generally not covered include, but are not limited to, the following:

1. Carpeting
2. Central air conditioning
3. Roof repair
4. Plumbing
5. Kitchen/laundry appliances
6. Swimming pools

Authorization Criteria

In order to be authorized, the item must meet the following criteria:

1. Not able to be funded through any other source
2. Necessary to avoid institutionalization of the member
3. For the sole utility of the member
4. Used in the member's primary place of residence

All services must be provided according to applicable State or local building codes.

Authorization Procedures

Review and authorization must occur before purchase. The description of the minor environmental adaptation or modification must be included in the member's community support plan.

When appropriate and cost effective, EW funding is available for the following:

1. Purchase or rental
2. Installation
3. Maintenance and repairs

Provider Standards and Qualifications

Provider type is dependent on type of modification.

Modification and adaptation service providers must comply with all of the following:

1. Have a current contract or purchase of services agreement with the county agency
2. Hold a current license or certificate, if required by Minnesota Statutes or Administrative Rules, to perform the service
3. Meet all professional standards and/or training requirements that may be required by State law or rule for the service(s) they provide

Local county agencies are responsible to ensure the following:

1. Providers are qualified to provide necessary modifications and adaptations
2. Modifications to the home are completed in accordance with all applicable State and city building codes
3. Providers have a contract or a purchase agreement with the local agency for the service

The provider must have a contract or a purchase agreement with the local agency for the service and the service must be provided in accordance with applicable State and local building codes by a qualified and bonded provider.

Home Modification Installation

Individuals or agencies that provide home modification installations must meet one of the following:

1. Be licensed as a residential building contractor by the commissioner of Commerce if they meet the definition of residential building contractor as defined in MN Stat. Chap. 326B.802 subd. 11. Construction workers are exempt from licensure when the skills they perform meet the definition of “special skill” as defined in MN Stat. Chap. 326B.82, subd.15.
2. Hold a current license or certificate to perform the service if required by Minnesota Statutes or Administrative Rules
3. Meet all professional standards and training requirements that may be required by State law or rule for the service(s) they provide
4. Provide all services according to applicable local, state and city building codes

Home Modification or Assessment

Individuals or agencies that provide home modification assessments must meet one of the following:

1. Be an occupational therapist currently registered by the American Occupational Therapy Association to perform assessment or evaluation functions and have at least one-year of experience with home modification assessments
2. Be a certified aging-in-place specialist with at least one-year of experience with home modification assessments
3. Be a certified accessibility specialist, certified through the Minnesota Department of Labor and Industry with at least one year of experience with home modification assessments

Vehicle Modification or Install

Agencies that provide vehicle installation services must be accredited through the National Equipment Dealer Association’s Quality Assurance Program.

Vehicle Modification or Assessment

Individuals or agencies that provide vehicle modification assessments must meet one of the following:

1. Be a certified driver rehabilitation specialist
2. Be an occupational therapist with a specialty certification in driving and community mobility
3. Have five years of full-time experience in the field of driver rehabilitation
4. Have a four year undergraduate degree in a health related field with:
 - a. One year full-time experience in the degree area of study
 - b. Supervision by a certified driver rehabilitation specialist or an occupational therapist with a specialty certification in driving and community mobility or a person with two years of full-time experience in the field of driver rehabilitation
 - c. Continued education in the area of driving mobility and rehabilitation through the Association for Driver Rehab Specialists, Rehabilitation Engineering and Assistive Technology Society, or the American Occupational Therapy Association or any programs that have been approved by these entities

Tier 2 and Tier 3 Waiver Service Provider Requirements

1. IMCare recommends that county lead agencies consider bids from a minimum of two contractors or vendors
2. All services must be provided according to applicable State and local building codes

If it is determined by county agency that all criteria are met and the bid for the work is reasonable, the local agency enters a line item and amount on the member's service agreement using procedure code S5165.

If the item does not meet authorization criteria, documentation regarding the determination and rationale is to be kept on record at the local agency and the member is notified and given information regarding the Appeal process.

Costs may be averaged over the span of a service agreement (up to 12 months), provided the member is expected to remain on the program for the full span of the service agreement. However, should the cost of an item be spanned beyond the month the cost was authorized and incurred and the member exits the program, the program cannot pay for any service or time billed after the individual's exit date (i.e., the date the person is no longer EW eligible).

Services and items purchased prior to the LTCC screening and start date of program enrollment or services and items purchased without case manager approval are not covered.

Home Care – Extended Services

Service/HCPCS
Home Health Aide Extended
<ul style="list-style-type: none"> • T1004 – 15 minutes
LPN Regular Extended
<ul style="list-style-type: none"> • T1003 with modifier UC – 15 minutes (LPN Regular) • T1003 with modifiers TT and UC – 15 minutes (LPN Shared 1:2)
LPN Complex Extended
<ul style="list-style-type: none"> • T1003 with modifiers TG & UC – 15 minutes
PCA – Extended
<ul style="list-style-type: none"> • 1:1 – T1019 with modifier UC – 15 minutes • 1:2 – T1019 with modifier UC & TT with a “Y” in the Shared Care field of the Service Agreement – 15 minutes • 1:3 – T1019 with modifier UC & HQ with a “Y” in the Shared Care field of the Service Agreement – 15 minutes
RN, Regular, Extended
<ul style="list-style-type: none"> • T1002 with modifier UC – 15 minutes • T1002 with modifiers TT and UC and a “Y” in the Shared Care field of the Service Agreement – 15 minutes (RN Regular Shared 1:2)
RN Complex, Extended
<ul style="list-style-type: none"> • T1002 with modifiers TG and UC – 15 minutes
Occupational Therapy, Extended
<ul style="list-style-type: none"> • S9129 with modifier UC – visit
Occupational Therapy Assistant, Extended
<ul style="list-style-type: none"> • S9129 with modifiers UC and TF – visit
Physical Therapy, Extended
<ul style="list-style-type: none"> • S9131 with modifiers UC and TF – visit
Physical Therapy Assistant, Extended
<ul style="list-style-type: none"> • S9131 with modifiers UC and TF – visit
Respiratory Therapy, Extended
<ul style="list-style-type: none"> • S5181 with modifier UC – visit

See Chapter 24, Home Care Services, for more detailed information about Medical Assistance (Medicaid) State Plan services.

Home Delivered Meals (HDMs)

Service/HCPCS

Home Delivered Meal (HDM)

- S5170 – one meal/day

Definition

An appropriate and nutritionally balanced meal, delivered to the member's residence.

Covered Services

The case manager must approve HDMs as a part of the individual plan of care. In addition, the registered dietician must review and approve all menu plans

All HDMs must contain at least one-third of the current Recommended Dietary Allowance (RDA) established by the Food and Nutrition Board of the Institute for Medicine of the National Academy of Sciences. Modified diets, when appropriate, will be provided to meet the individual requirements of a member.

HDMs are provided to a member who is unable to prepare his/her meals and has no other person(s) available to do so or when the home delivered meal is the most cost-effective method to provide a member with a nutritionally adequate meal. Menu plans must be reviewed and approved by a licensed dietician or licensed nutritionist. One meal per day is covered by EW.

Participants age 60 and over and their spouses may also access congregate meals funded through Title III of the Older Americans Act. Title III services are administered by local Area Agencies on Aging (AAA). HDMs may be funded through the [Older Americans Act](#) only when the service/amount of service needed cannot be authorized within the member's EW community budget cap.

Non-Covered Services

EW cannot supplant other funding sources or pay for meals in residential settings where room and board costs are part of the residential reimbursement (e.g., for example, foster care, assisted living, and adult day care settings).

Additional Information

Eligibility

HDMs are provided to a person who is unable to prepare his/her meals and has no other person(s) available to do so **or** when home delivery of meals is the most cost-effective method to provide a person with a nutritionally adequate meal.

EW-specific funding requirements: Providers of HDMs may have multiple funding sources to support their business. To ensure the EW program is not supplanting other funds, understanding the funding source(s) and funding amounts each HDM provider receives is critical in developing provider contracts. In particular, funding distributed to HDM providers through contractual agreements with AAAs should not be supplanted by EW funding.

Title IIIC funding: HDM providers who contract with AAA for funding to support their program may be receiving funds available from Title IIIC of the [Older Americans Act](#), United States Department of Agriculture

(USDA) funding, or State grants. These funds are all distributed by AAAs through a contractual agreement with the provider. Specific revenue sources may be defined, including all other grants and anticipated client contributions in these contracts. County agencies may find these contracts helpful in identifying provider revenue resources in determining the portion of the meal cost met by other revenue sources.

No receipt of Title IIIC funding: Although some HDM providers do not receive any Title IIIC funding, USDA funding, or State grant funding, they may receive funding from other sources such as grants from other organizations (such as United Way) and grants from local government or revenue from client contributions. Information about providers' other funding sources is essential to assure EW funds are not supplanting other funds and negotiated rates do not exceed the cost of the HDM.

EW members may be required to make a contribution to their meal cost or be asked to pay for a portion of their meal cost unless, under EW, the meal is provided as an EW service and a waiver obligation is charged. Title IIIC funding may not be available and meals may be funded by EW due to geographic inaccessibility, special dietary needs, the time of day or day of the week, or if there are existing waiting lists or demands exceed the funding available.

Provider Standards and Qualifications

The following providers may offer HDMs:

1. Hospitals
2. Schools
3. Restaurants
4. Any entity that provides HDMs

Any entity that provides HDMs must comply with all State and local health laws and ordinances that regulate preparation, handling, and serving of food as defined under [MN Rules Chapter 4626](#).

Insulated hot and cold containers must be used to ensure that food is delivered at appropriate temperatures. Licensed dietitians or nutritionists must meet the requirements as specified in MN Stat. sec. 148.621 and MN Rules Chapter 3250.

Homemaker Services

Service/HCPCS

Homemaker

Service

- S5130 Homemaker/Cleaning – 15 minutes
- S5130 with modifier TF, Homemaker/Home Management – 15 minutes
- S5130 with modifier TG, Homemaker/Assistance with Personal Cares – 15 minutes

Definition

General household activities provided by a trained homemaker when a person is unable to manage the home or when the person regularly responsible for these activities is temporarily absent or unable to manage the home.

Covered Services

Homemaker services are listed in the member's community support plan and may include the following:

1. Meal preparation
2. Shopping and errands
3. Routine household care
4. Assistance with activities of daily living (ADLs)
5. Transportation arrangements
6. Companionship
7. Emotional support
8. Social stimulation
9. Monitoring the safety and well-being of the member

Non-Covered Services

Services cannot be duplicated with other Minnesota State plan-covered services or EW services or, in the case of rental property, where the service may be the responsibility of the landlord.

Homemaker/cleaning services include light housekeeping tasks. Homemaker and cleaning providers deliver home cleaning services exclusively.

Homemaker/home management activities may include assistance with the following:

1. Laundry
2. Meal preparation
3. Shopping for food
4. Clothing and supplies
5. Simple household repairs
6. Arranging for transportation

Homemaker/home management providers deliver home cleaning services in addition to home management activities.

Homemaker/assistance with activities of daily living (ADLs) includes assistance with the following:

1. Bathing
2. Toileting
3. Grooming
4. Eating
5. Ambulating

Homemaker/assistance with ADL providers deliver home cleaning services in addition to providing assistance with ADL Activity

Homemaker services must be listed in the community support plan

Provider Standards and Qualifications

Criminal background studies apply to individuals and organizations providing these services:

Homemaker/Cleaning Service

1. Providers must comply with the standards outlined in MN Stat. Chap. 245C concerning criminal background studies.
2. Providers must be able to perform the cleaning duties expected and provide a cost-effective means of meeting the member's home cleaning needs.

Homemaker Service/Assistance with ADLs

1. Providers must be licensed under Minnesota Statutes, Basic, or Comprehensive licensure unless excluded from DHS licensure under MN Stat. 245A.03, subds. 2 (1) and (2).
2. Providers licensed as a Basic or Comprehensive home care provider must meet the requirements of MN Stat. Chap. 144A.
3. As a home care provider, providers must meet the requirements of MN Stat. secs. 144a.43 – 144A.46

Homemaker Service/Home Management

1. Providers must be licensed under MN Stat., Basic or Comprehensive licensure unless excluded from DHS licensure under MN Stat. sec. 245a.03 subd. 2 (1) and (2).
2. Providers licensed as a Class B, C, or F home care provider must meet the requirements of MN Stat. Chap. 144A.
3. As a home care provider, providers must meet the requirements of MN Stat. secs.144A.43 – 144A.46.
4. Providers of homemaker services must meet the requirements of MN Stat. secs. 144A.43 – 144A.46. Homemakers are to meet the minimum training requirements. Homemakers must meet the standards under MN Rules part 9565.1200, subp. 2.
 - a. Minimum training requirements specify 24 hours of training during the first year, and six hours of training annually thereafter. Such training includes courses in homemaking skills, child and personal care, human growth and development, the aging process, nutrition, home management, and training in working with people who have physical and/or mental disabilities.

Residential Care Services**Service/HCPCS Residential Care Services**

- T2032 – monthly

Definition

Supportive and health supervision services provided to members in a residential care home as documented in the community support plan.

Covered Services

Supportive services for the member include the following:

1. Up to 24-hour supervision
2. Meal preparation
3. Individualized home management tasks
4. Socialization
5. Assistance in setting up meetings and appointments
6. Assistance in arranging medical and social services
7. Assistance with management of personal funds
8. Arranging for or providing transportation

Health supervision services are limited to minimal assistance with the following:

1. Dressing, grooming, and bathing
2. Reminding a member to take medications that are self-administered
3. Storing medications, if requested

The case manager is the primary party responsible for negotiations with the provider to ensure the needs of the member are fully met through the package created specifically for that person.

Non-Covered Services

1. Homemaking
2. Chores
3. Services duplicated by other State plan-covered services or waiver services
4. Items of comfort or convenience

Additional Information

Service delivery is directed by the member or the provider with oversight from the case manager. The unit of service is defined by the ISP/community support plan or contract.

If medications are to be distributed or stored, the residence must comply with MDH licensing regulations.

Size and Location

Residential care services **may not** be authorized for people residing in a living setting adjoined to or on the same property as a nursing facility, hospital, Intermediate Care Facility for the Developmentally Disabled (ICF/DD), or Institution for Mental Disease (IMD).

For people under age of 55, the total number of individuals residing in a living setting **cannot** exceed four. This means four people unrelated to the principal care provider. **Exception** – Residence was developed before May 1, 2001, and has continuously provided waiver services.

Provider Standards and Qualifications

Residential care services are provided to members in residential care homes licensed as board and lodging establishments that are registered with MDH as board and lodge with special-services. The standards for residential care services are defined in MN Stat. secs. 157.15 – 9157.17. The residential care home must meet the appropriate local building codes.

Staff is required to have eight hours of training and orientation by an RN in providing assistance with the following:

1. Dressing
2. Grooming
3. Bathing
3. Medication reminders or storage of medications. If medications are to be distributed or stored, an RN must provide supervision of this process.

Staff providing supervision and supported services must meet the following criteria:

1. Be able to read and write and follow written and oral instructions
2. Have experience and/or training in caring for people with functional limitations

3. Have good physical and mental health and maturity of attitudes toward work assignments
4. Have the ability to converse on the phone, to work under intermittent supervision, to deal with minor emergencies arising in connection with the assignment, and to work under stress in a crisis situation
5. Have the ability to understand, respect, and maintain confidentiality
6. Have a valid Minnesota State driver's license if providing transportation for a person receiving waiver services

Respite Care

Service/HCPCS In-Home Respite

- S5150 –15minutes
- S5151 – per diem

Out-of-Home Respite

- S5150 with modifier UB – 15 minutes
- H0045 – per diem (includes hospital and other certified facilities providing 24-hour overnight service)

Definition

Services provided to members unable to care for themselves, furnished on a short-term basis because of the absence or need for relief of the person who normally provides the care and who is not paid or is only paid for a portion of the total time of care or supervision provided. The unpaid caregiver does not need to reside in the same house as the member.

Covered Services

1. In-home and out-of-home respite care in settings that have appropriate licensure and qualifications
2. Continuation of services that are already defined in the plan of care, to ensure continuity of services for people while receiving respite care services.

Respite care is limited to 30 consecutive days per respite stay in an out-of-home placement in accordance with the care plan.

Non-Covered Services

1. Respite care is not provided for members residing in corporate or family foster care settings or receiving 24-Hour CL services
2. Room and board payments will not be made for respite care provided in the member's home or other private residence

Provider Standards and Qualifications

Out-of-Home Respite Care

Facilities providing respite care must meet all licensing and certification requirements. Respite care must be provided in one of the following facilities approved by the lead agency:

1. Hospital
2. Nursing facility
3. Licensed adult foster home

4. Non-Medical Assistance (Medicaid)-certified facility if the facility meets applicable State licensure standards

Respite care may be provided in a private unlicensed home when the lead agency determines that the service and setting can safely meet the member's needs. The lead agency must take into account the accessibility and condition of the physical plant, ability and skill level of the caregiver, and the member's needs and preferences. The unlicensed home and caregiver cannot otherwise be in the business or routine practice of providing respite services.

In the event of a community emergency or disaster that requires an emergency need to relocate a participant, out-of-home respite services may be provided whether or not the primary caregiver resides at the same address as the participant, and whether the primary caregiver is paid or unpaid, provided the Commissioner of DHS approves the request as a necessary expenditure related to the emergency or disaster. This does not allow the primary caregiver to provide respite services. The Commissioner may waive other limitations on this service in order to ensure that necessary expenditures related to protecting the health and safety of participants are reimbursed. In the event of an emergency involving the relocation of waiver participants, the Commissioner may approve the provision of respite services by unlicensed providers on a short-term, temporary basis.

In-Home Respite Care

In-home respite care services must be provided by the following:

1. RNs or LPNs
2. HHAs
3. Personal care assistants (PCAs) specifically trained to provide care to the member
4. A HHA or PCA must be under the supervision of an RN who ensures the respite care worker is able to read, write, follow instructions, and has the skill level to meet the person's needs
5. A currently registered HWS establishment when services are delivered by a licensed home care agency

Respite care providers must meet the licensing and certification standards specific to the level of care they are providing and receive supervision as required by their respective license or service standard.

Billing

Lead agencies must define the unit of service to be billed in the contract. Daily rates must be used when respite care is provided for 12 or more hours or for overnight respite.

Respite Care Services: Provider Standards and Qualifications

I: Indicates an in-home provider/location

O: Indicates an out-of-home provider/location

- O. Certified Hospitals – Hospitals are acute care institutions defined in MN Stat. sec. 144.696, subd. 3, licensed under MN Stat. secs. 144.50 – 144.56. Providers must be licensed under MN Stat. Chaps. 245D or 144A, unless they are excluded under MN Stat. sec. 245A.03, subd. 2(a)(7). Agencies licensed under MN Stat. Chap. 144A as a home care provider must meet the HCBS provider standards in MN Stat. Chap. 245D.

Agencies meeting the licensing exclusions of MN Stat. sec. 245A.03, subd. 2 (1) and (2) must meet the requirements of: MN Stat. sec. 245D.04, subd. 1(4), subds. 2 (1), (2) (3) (6) and subdivision 3 regarding service recipient rights; MN Stat. secs. 245D.05 and 245D.051 regarding health services and medication

monitoring; MN Stat. sec. 245D.06 regarding incident reporting and prohibited and restricted procedures; MN Stat. sec. 245D.061 regarding the emergency use of manual restraint; and MN Stat. sec. 245D.09, subs. 1, 2, 3, 4a, 5a, 6, and 7 regarding staffing standards.

- O. LPNs and RNs must be licensed under MN Stat. secs. 148.171 – 142.284 4 and providers must be licensed under MN Stat. Chap. 245D or 144A, unless they are excluded under MN Stat. sec. 245A.03, subd. 2 (1) and (2). Individuals licensed under MN Stat. Chap. 144A as a home care provider must meet the provider standards in MN Stat. Chap. 245D.

Individuals meeting the licensing exclusions of MN Stat. sec. 245A.03, subd. 2 (1) and (2) must meet the requirements of: MN Stat. sec. 245D.04, subd. 1(4), subs. 2 (1), (2) (3) (6) and subd. 3 regarding service recipient rights; MN Stat. secs. 245D.05 and 245D.051 regarding health services and medication monitoring; MN Stat. sec.245D.06 regarding incident reporting and prohibited and restricted procedures; MN Stat. sec. 245D.061 regarding the emergency use of manual restraint; and MN Stat. sec. 245D.09, subs. 1, 2, 3, 4a, 5a, 6, and 7 regarding staffing standards if applicable.

- O. Adult Foster Care is licensed under MN Rules parts 9555.5105 – 9555.6265 and 2960.3000 – 2960.3230 and MN Stat. sec. 245a.03. In addition, providers must be licensed under MN Stat. Chap. 245D or 144A, unless they are excluded under MN Stat. sec. 245A.03, sub 2 (1) and (2) to provide respite services.

Agencies licensed under MN Stat. Chapter 144A as a home care provider must meet the HCBS provider standards in MN Stat. Chap. 245D.

Providers meeting the licensing exclusions of MN Stat. sec. 245A.03, subd. 2 (1) and (2) must meet the requirements of: MN Stat. sec. 245D.04, subd. 1(4), subs. 2 (1), (2) (3) (6) and subd. 3 regarding service recipient rights; MN Stat. secs. 5D.05 and 245D.051 regarding health services and medication monitoring; MN Stat. sec.245D.06 regarding incident reporting and prohibited and restricted procedures; MN Stat. sec. 245D.061 regarding the emergency use of **manual restraint**; and MN Stat. sec. 245D.09 subs. 1, 2, 3, 4a, 5a, 6, and 7 regarding staffing standards

- I. Personal care provider organizations and PCAs employed by the agencies must meet the standards under MN Stat. sec. 256B.06 59 and MN Rule part 9505.0335. Providers must be licensed under MN Stat. Chap. 245D or 144A, unless they are excluded under MN Stat. sec. 245A.03, subd. 2 (1) and (2). Agencies licensed under MN Stat. Chap. 144A as a home care provider must meet the HCBS provider standards in MN Stat. Chap. 245D. Agencies meeting the licensing exclusions of MN Stat. sec. 245A.03, subd. 2 (1) and (2) must meet the requirements of: MN Stat. sec.245D.04, subd. 1(4), subs. 2 (1), (2) (3) (6) and subd. 3 regarding service recipient rights; MN Stat. sec. 45D.05 and 245D.051 regarding health services and medication monitoring; MN Stat. sec. 245D.06 regarding incident reporting and prohibited and restricted procedures; MN Stat. sec.245D.061 regarding the emergency use of manual restraint; and MN Stat. sec. 245D.09 subs. 1, 2, 3, 4a, 5a, 6, and 7 regarding staffing standards.
- I. HHAs must meet the standards under MN Rules parts 9505.0290, subp. 3, B.
 1. Home health agencies and in-home respite care providers, including nurses employed by home health agencies, must be licensed under MN Stat. sec. 148.171 – 148.284.
 2. Providers must be licensed under MN Stat. Chap. 245D or 144A, unless they are excluded under MN Stat. sec. 245A.03, subd. 2 (1) and (2).
 3. Home health agencies must have a class A license and must meet the standards under MN Rules part 9505.0290, subp. 3, B; MN Rules Chapter 4668, and MN Stat. Chaps. 144A.45, 144a.46, 144.461, and 144.465.

4. Agencies licensed under MN Stat. Chap. 144A as a home care provider must meet the HCBS provider standards in MN Stat. 245D.
 5. Agencies meeting the licensing exclusions of MN Stat. sec. 245A.03, subd. 2 (1) and (2) must meet the requirements of: MN Stat. sec.245D.04, subd. 1(4), subds. 2 (1), (2) (3) (6) and subdivision 3 regarding service recipient rights; MN Stat. secs. 245D.05 and 245D.051 regarding health services and medication monitoring; MN Stat. sec. 245D.06 regarding incident reporting and prohibited and restricted procedures; MN Stat. sec.245D.061 regarding the emergency use of manual restraint; and MN Stat. sec. 245D.09, subds. 1, 2, 3, 4a, 5a, 6, and 7 regarding staffing standards.
- O. Certified nursing facilities – Nursing facilities must meet the standards under MN Rules part 9505.0175, subp. 23. Facilities providing respite care outside of the member’s home must be licensed in accordance with MN Stat. Chap. 144A. Providers must be licensed under MN Stat. Chaps. 245D or 144A, unless they are excluded under MN Stat. sec. 245A.03, subd. 2 (1) and (2). Providers licensed under MN Stat. Chap. 144A as a home care provider must meet the HCBS provider standards in MN Stat. Chap. 245D.

Providers meeting the licensing exclusions of MN Stat. sec. 245A.03, subd. 2 (1) and (2) must meet the requirements of: MN Stat. sec. 245D.04, subd. 1(4), subds. 2 (1), (2) (3) (6) and subd. 3 regarding service recipient rights; MN Stat secs. 245D.05 and 245D.051 regarding health services and medication monitoring; MN Stat. sec. 245D.06 regarding incident reporting and prohibited and restricted procedures; MN Stat. sec. 245D.061 regarding the emergency use of manual restraint; and MN Stat. sec. 245D.09 subds. 1, 2, 3, 4a, 5a, 6, and 7 regarding staffing standards.

- O. CL services/24-Hour CL service providers must be licensed as a home care provider and meet the standards as delineated in CL and 24-Hour CL services waiver service descriptions. Out-of-home providers must meet the standards in MN Stat. Chap.144D and be licensed as a Class A or F home care provider under MN Rules parts 4668.0002 – 4668.0870. Providers must be licensed under MN Stat. Chap. 245D or 144A, unless they are excluded under MN Stat. sec. 245A.03, subd. 2 (1) and (2). Agencies licensed under MN Stat. Chap. 144A as a home care provider must meet the HCBS provider standards in MN Stat. Chap. 245D.

Agencies meeting the licensing exclusions of MN Stat. sec. 245A.03, subd. 2 (1) and (2) must meet the requirements of: MN Stat. sec. 245D.04, subd. 1(4), subds. 2 (1), (2) (3) (6) and subd. 3 regarding service recipient rights; MN Stat. secs. 245D.05 and 245D.051 regarding health services and medication monitoring; MN Stat/ sec. 245D.06 regarding incident reporting and prohibited and restricted procedures; MN Stat. sec. 245D.061 regarding the emergency use of manual restraint; and MN Stat. sec. 245D.09 subds. 1, 2, 3, 4a, 5a, 6, and 7 regarding staffing standards.

- O. Residential care facilities – residential care providers must meet all applicable licensing standards and the standards delineated in the residential care waiver service description. Providers must be licensed under MN Stat. Chap. 245D or 144A, unless they are excluded under MN Stat. sec. 245A.03, subd. 2 (1) and (2).

Agencies licensed under MN Stat. Chap. 144A as a home care provider must meet the HCBS provider standards in MN Stat. Chap. 245D.

Agencies meeting the licensing exclusions of MN Stat. secs. 245A.03, subd. 2 (1) and (2) must meet the requirements of: MN Stat. sec. 245D.04, subd. 1(4), subds. 2 (1), (2) (3) (6) and subd. 3 regarding service recipient rights; MN Stat. secs.245D.05 and 245D.051 regarding health services and medication monitoring; MN Stat. sec. 245D.06 regarding incident reporting and prohibited and restricted procedures; MN Stat. sec. 245D.061 regarding the emergency use of manual restraint; and MN Stat. sec. 245D.09 subds. 1, 2, 3, 4a, 5a, 6, and 7 regarding staffing standards.

- O. The home of an unlicensed caregiver when the lead agency and family agree that the caregiver has met criteria to ensure the health and safety of the member. In these situations, room and board payment will not be made as part of the respite rate. Providers must be licensed under MN Stat. Chap. 245D or 144A unless they are excluded under MN Stat. sec. 245A.03, sub 2(1) and (2). Individuals providing in-home respite services must demonstrate to the case manager that they are able to provide, on a temporary, short-term basis, the care and services needed by the member.

The case manager must evaluate and document whether the provider meets the standards to provide respite services.

In addition, in-home respite providers who are excluded from licensing requirements must meet the following qualifications to ensure the health and safety of the member:

1. The provider is physically able to care for the member
2. The provider has completed training identified as necessary in the care plan
3. The provider complies with monitoring procedures as described in the care plan

Out-of-Home Respite Care

Facilities providing respite care must meet all licensing and certification requirements. Respite care must be provided in one of the following facilities approved by the lead agency:

1. Hospitals licensed under [MN Stat. secs. 144.50 – 144.56](#).
2. Nursing facilities (long-term care facilities) licensed in accordance with MN Stat. Chap. 144A and defined under MN Rules part [9505.0175, subp. 23](#)
3. Adult foster cares licensed under [MN Rules parts 9555.5050 – 9555.6265](#)

Respite care may be provided in a private unlicensed home when the lead agency determines that the service and setting can safely meet the member's needs. The lead agency must take into account the accessibility and condition of the physical plant, ability and skill level of the caregiver, and the member's needs and preferences. The unlicensed home and caregiver cannot otherwise be in the business or routine practice of providing respite services.

Specialized Supplies and Equipment

Service/HCPCS

Specialized Supplies and Equipment

- T2029 – Per item negotiated based on the needs of the person and county or lead agency contract
- Effective January 1, 2016, the following modifiers must be used in conjunction with code T2029 to authorize Specialized Supplies and Equipment:
 - NU: Supplies and equipment – new
 - UE: Supplies and equipment – used
 - RB: Supplies and equipment – repair
 - RR: Supplies and equipment – rental

Definition

Devices, controls, or mobility aids, and assistive technology devices including augmentative communication devices and personal emergency response systems (PERS), sensing equipment, controls, or medical appliances as specified in the plan of care that enable the person to increase his/her ability to do the following:

1. Perform ADLs

2. Perceive, control, or interact with the environment or communicate with others

State plan medical equipment and supplies are defined under MN Rules part 9505.0310.

Covered Services

The service covers the following:

1. Items necessary for life support
2. Ancillary supplies necessary for the proper functioning of such life support items
3. Durable and non-durable medical equipment not available under the Medicaid State plan

The State plan will cover some medical equipment and supplies. If certain medical equipment and supplies exceed the limits set for State plan-covered services, they may be reimbursed with waiver funds. To determine which medical equipment and supplies are covered by the State plan and which are covered with waiver funds, see Chapter 23, Equipment and Supplies.

Elderly Waiver (EW)

Supplies and equipment include durable medical supplies and equipment provided as a necessary adjunct to direct treatment or remediation of the member's condition. These may include grab bars, handrails, and stair lifts.

Non-Covered Services

1. Items that are covered by Medical Assistance (Medicaid), Medicare, private insurance, and/or other funding resources and items that do not provide direct medical or remedial benefit to the person.
2. Items and services purchased prior to the LTCC screening and program begin-date or without case manager approval are not covered.

Items reimbursed with waiver funds are in addition to any medical equipment and supplies provided under Medical Assistance (Medicaid). Supplies and equipment that exceed the limits set for Medical Assistance (Medicaid)-covered services may be covered through the waiver.

All prescription and over-the-counter medications, compounds, and related fees including premiums and copayments are not covered.

Personal Emergency Response Systems (PERS)

Equipment purchase (S5162) for personal emergency response systems (PERS) as defined in Bulletin [#13-25-04](#) when the PERS does not entail changes to the physical structure and does not become a permanent part of the member's home and is easily removed should be authorized as specialized supplies and equipment. (PERS equipment that is **not** easily removable should be authorized as environmental accessibility adaptation.)

Personal Emergency Response Systems (PERS) Limits

1. PERS equipment purchase (S5162) is subject to a \$1,500 annual limit
2. PERS monthly services fees (S5161) are limited to \$110/month
3. PERS installation and testing (S5160) is limited to \$500
4. The total annual authorization for PERS is \$3,000 during a participant's "waiver" year, for EW and AC participants, which begins each time an opening, reopening, or reassessment screening document is approved

Non-covered PERS items and services include the following:

1. Participants receiving 24-Hour CL except for use outside of their residence
2. Telehealth and biometric monitoring devices
3. Supervision or monitoring of ADLs that are provided to meet the requirements of another service
4. Equipment used in the delivery of Medical Assistance (Medicaid) or other waived service
5. Video equipment (use of video equipment authorized under other services must meet criteria negotiated with CMS described in Bulletin #13-25-04, Appendix A)

Authorization Criteria

Before purchase of the supply or equipment, case managers must ensure and document in the community support plan that the item meets all of the following criteria:

1. Not able to be funded through any other source. If an item is never covered by Medical Assistance (Medicaid), it is not necessary to seek a written denial from Medical Assistance (Medicaid). If an item may be covered by Medical Assistance (Medicaid), the medical supplier must seek authorization from Medical Assistance (Medicaid) before seeking authorization of coverage under the EW program.
2. Specified in a community support plan as necessary to avoid institutionalization
3. For the sole utility of the member
4. Determined by prevailing community standards or customary practice and usage to be the following:
 - a. Medically necessary – appropriate and effective for the medical needs and health and safety of the member; or
 - b. Remedially necessary – appropriate to assist a member in increased independence and integration in his/her environment/community
 - c. Appropriate and effective for the medical needs, diagnosis, and condition of the member
 - d. Of an acceptable quality
 - e. Timely (e.g., the accommodation is provided at the time it is needed)
 - f. The most cost-effective health service available to meet the medical needs of the member
 - g. An effective and appropriate use of Medical Assistance (Medicaid) waiver funds

When cost effective, funding is available for the following with extended supplies and equipment:

1. Individual evaluation or assessment
2. Purchase or rental
3. Installation
4. Maintenance and repairs

Medical supplies and equipment are available through Medical Assistance (Medicaid) but with limitations. When an item is covered by Medical Assistance (Medicaid), bill Medical Assistance (Medicaid) first to the extent of the limitations. If an item is never covered by Medical Assistance (Medicaid), the case manager may decide to cover this item under the EW if it meets criteria. After an item is purchased, it becomes the property of the member it is purchased for.

Add-Ons vs. Upgrades

An **add-on** is a Medical Assistance (Medicaid) non-covered service that the provider adds to a Medical Assistance (Medicaid)-covered service. In this case, the Medical Assistance (MA)-covered item is billed to Medical Assistance (Medicaid). The add-on may be billed to the waiver, or the member may choose to pay for the add-on out of other available funding sources.

Example: A member wants a Medical Assistance (Medicaid) non-covered basket added to a Medical Assistance (Medicaid)-covered walker. The supplier can bill IMCare for the walker and bill the member for the

basket; or the case manager may determine that the basket is covered by EW program but the supplier still must bill IMCare for the Medical Assistance (Medicaid)-covered service.

For IMCare members, the provider may receive payment for the covered service under Medical Assistance (Medicaid) and charge the member or waiver program for the add-on.

An **upgrade** is a non-covered Medical Assistance (Medicaid) service (and often a more desirable service) that is substituted for a covered service.

1. The provider may choose to provide the upgrade and receive payment for the basic service as payment in full for the upgrade.
2. The member may choose an upgraded service instead of a Medical Assistance (Medicaid)-covered service, even though IMCare will not pay for this item. The member is responsible for the entire cost of the upgraded item as long as the provider informed the member that he/she is responsible for payment before providing the service. In this case, IMCare recommends that the provider have the member sign a waiver acknowledging that the item is not covered by IMCare and agrees to pay the entire cost for the upgraded item before the service is provided.
3. The case manager may authorize an upgraded item to be covered under an HCBS program, if determined to be medically necessary, and cover the entire cost of the item under HCBS program.

Example: A member wants a total electric bed, but does not meet the medical necessity criteria for Medical Assistance (Medicaid) to cover the bed. IMCare will only cover a semi-electric bed.

A case manager may elect to cover the entire cost of a total electric bed under the EW program.

If the supplier will not accept Medical Assistance (Medicaid) payment for a semi-electric bed and the case manager does not approve the upgrade for payment under the HCBS program, the member may still get the total electric bed. The member would be responsible for the entire charge for the bed as long as the provider informed the member that he/she is responsible for payment before providing the item or service.

The supplier may not provide a total electric bed to the member, bill IMCare, and charge the difference related to the upgrade to the member or to the HCBS program.

The case manager may need prior approval from IMCare for some specialized supplies and equipment depending on the cost of the item. The item must be entered on the service agreement.

Cost of Providing Supplies and Equipment under a Member's EW Cap

The cost of specialized supplies and equipment must be included in the waiver cap. Costs of supply and equipment items may be averaged over the span of a service agreement provided the member maintains program eligibility for the available span of the service agreement. The HCBS program can only pay for these items when the member is eligible for EW services.

For example: If the cost of an item is averaged for a number of months beyond the month the cost was incurred, and the member exits the HCBS program before the item is fully paid, the HCBS program cannot pay for any service or item billed after the exit date (the date the person is no longer eligible).

Determining Appropriate Payer

The local lead agency is responsible to authorize covered services according to the appropriate payer. The provider is responsible to bill the appropriate payer for the covered services.

For EW, all other private and public payers (private insurance, long-term care insurance, Medicare, Medical Assistance [Medicaid]) must be exhausted before using EW funds for coverage. The provider submits copies of the denials from those payment sources to the lead agency. If inappropriate billing shows up in an audit, the provider is responsible and risks payment recovery.

Doctor's Orders for Medical Supplies and Equipment

When a doctor's order is needed for Medical Assistance (Medicaid)/Medicare reimbursement, the medical supply and equipment provider is responsible to gather and send whatever documentation is needed to IMCare before ordering/billing. Generally, doctor's orders are not required for purchases through waiver funds. The provider is ultimately responsible to bill the appropriate payer (insurance, Medicare, Medical Assistance [Medicaid], etc.) if the item is reimbursable through those payers, regardless of whether the case manager has authorized waiver reimbursement through a service agreement or not. When other sources of payment are exhausted, the provider must submit copies of the denials from those payment sources to the case manager. If inappropriate billing shows up in an audit, the provider is responsible and risks payment recovery.

Incidental Maintenance on Adaptive Equipment and Supplies While Providing a Direct Care Service

IMCare only covers maintenance on a few items. Maintenance on adaptive equipment and supplies can be covered through all of the waivers if that service is not Medical Assistance (Medicaid)-reimbursable. For example, if a waiver provider does incidental maintenance on a wheelchair during the course of providing direct care, the provider cannot bill for this through the HCBS program or IMCare as a separate service, as this is considered duplicate billing.

Long-Term Care Facility Providing Supplies and Equipment during Discharge Process to Home or Community Setting

The nursing facility is required to provide certain types of supplies and equipment to a member to support his/her transition home from the nursing facility.

1. Providers cannot bill through EW for specialized supplies and equipment until the program span for HCBS has been opened in MMIS by the local lead agency.
2. A provider may bill for assistive technology, adaptations/modifications, and extended medical supplies and equipment on the date of discharge, as long as the item(s) is/are provided after the time of the person's discharge.

Rental

Rental contracts for supplies and equipment may be approved only for items that meet authorization criteria when it is determined as cost effective. Requirements for approval of rental include the following:

1. Item is needed for a defined amount of time and rental is less expensive than purchase
2. All rental contracts should include a "rent to purchase" clause
3. The cost of renting a supply or equipment must not exceed the cost of purchase
4. The written contract must be clear that the vendor is responsible for repairs over the duration of the rental agreement
5. The equipment item cannot be rented for an indefinite period of time
6. New and upgraded equipment must be made available to replace the older currently rented item during the rental period

Once the rental fee equals the purchase price, the item is considered to be the property of the member (normally after 10 – 12 months' rental).

Repair and Maintenance

1. The HCBS program can pay for repair of equipment when the equipment meets the authorization criteria and the repair is a cost-effective alternative (e.g., is expected to last and, without repair, the equipment would have to be purchased new at a greater cost).
2. A maintenance agreement may be purchased for items that meet authorization criteria when the maintenance agreement is expected to be cost effective.

For example, a maintenance agreement that covers evaluating an item but not actual repair may not be cost effective. Consideration should also be given to other payment sources for repairs. IMCare covers the repair costs of certain items such as communication devices, wheelchairs, etc.

Shipping, Handling, Installation, Repair Maintenance

Shipping and handling costs may be paid by an HCBS program if the shipping cost is included in the price of the item, and the waiver is purchasing the item.

Installation can be covered regardless of who purchased the item, if the item meets HCBS program authorization criteria. If installation involves attaching an item to, or altering the existing physical structure of, a home or vehicle, the costs are billed under minor environmental adaptations and modifications.

Used Equipment

Used equipment may be purchased if the county determines that all authorization criteria are met and the item is considered of adequate quality, expected to be durable, and the cost is commensurate with the age and condition of the item (e.g., if a new item could be purchased at the similar cost, it may be worthwhile to purchase the new item).

Provider Standards and Qualifications

The following agencies have signed a Medical Supply Performance Agreement:

1. Home Health Agencies
2. Pharmacies
3. Medical suppliers (including wheelchair and oxygen vendors)

Entities approved by the local county agencies are also eligible to sign a purchase agreement.

Billing

Before billing for specialized supplies and equipment, the lead agency and the provider must fulfill its Authorization and Billing Responsibilities when authorizing and requesting reimbursement.

Transitional Services

Service/HCPCS

- T2038 – per service

Definition

Community transitional support services include expenses related to establishing community-based housing for individuals transitioning to an independent or semi-independent community residence from a certified nursing facility or other setting.

Covered Services Examples

1. Lease and rental deposits
2. Essential furniture
3. Utility set up fees and deposits
4. Personal supports to assist in locating and transitioning to the community-based housing
5. Basic household items
6. Personal items
7. One-time pest and allergen treatment of the setting

Expenses must be reasonable and do not include services or items that are covered under other waiver services. For example:

1. Chore services
2. Homemaker services
3. Home modifications and adaptations
4. Supplies and equipment

If there is an unforeseen reason the person does not open to the waiver (due to death or significant change in condition), the local agency may bill for the service and be reimbursed through Medicaid administrative funds. Managed Care Organizations (MCOs) may not bill for administrative funds under these circumstances.

Authorization Criteria

The member must meet the following criteria:

1. The member must not have another source to fund or attain the items or support
2. The member must be moving from a living arrangement where the items were provided to a residence where these items are not normally furnished
3. The service will be considered to be provided and may be billed after the waiver is opened
4. When not presently using EW, the local agency must evaluate and reasonably expect that the person will be eligible to open to the waiver within 180 days
5. Incur the expense within 90 days of the waiver opening date
6. Services must be identified on the individual's plan of care

Non-Covered Services

1. Recreational or diversional items
2. Expenses related to ongoing expenses such as rent, housing costs, food, or clothing

Provider Qualifications

Providers of personal supports must, as determined by the lead agency, have the following:

1. General knowledge of disabilities and chronic illnesses and their effect on a member's ability to live independently in the community
2. The ability to assess the member's community-based housing needs
3. Functional knowledge of housing options in the community
4. Sufficient understanding of housing procurement procedures and funding mechanisms to advise the member regarding these matters
5. The ability to assist the member in attaining the services and supports that are covered by transitional services
6. A contract with the lead agency or MCO that outlines their service responsibilities including maintaining client confidentiality

The case manager must do the following:

1. Ensure that the transitional support items are necessary and reasonable
2. Prior authorize the items and include the items in the member's care plan
3. Contract or obtain purchase agreements for vendors of personal support
4. Maintain receipts and documentation for all transitional support items in the member's file for auditing purposes
5. Make sure providers obtain and maintain other applicable licenses, permits, registration, or other governmental approvals required to provide the transition service
6. Consider reconditioned items if they are safe by reasonable standard and determined appropriate

Transportation

Service/HCPCS
• T2003 with modifier UC – Per one-way trip
• S0215 with modifier UC – Per mile
• X5603 – Extra attendant
• T2003 – Per one-way trip
• S0215 with modifier UC – Per mile

The county lead agency determines the transportation needs and resources. Medical transportation should never be authorized as a waiver service if covered by the State plan. Costs of State plan medical transportation do not count toward the member's EW community budget cap and are not added to the service agreement.

Definition and Covered Services

The case manager may approve transportation services to enable members to gain access to EW services, along with other community services, activities, and resources. The case manager must specify the goals and needs for the service in the plan of care. Whenever possible, family, neighbors, friends, or community agencies that provide this service without charge must be utilized.

Transportation services may be authorized and billed using the mileage rate when simultaneously provided by an individual or organization providing adult companion services.

Adult day services and transportation are always separately covered, but are sequentially, not simultaneously provided.

For EW, the adjective “extended” is not applicable as a waiver service because waiver transportation services are not an extension of the Medical Assistance (Medicaid) State plan access (i.e., medical) transportation service but rather a separate and distinct service.

Use of special transportation services (STS) may be provided for transporting a member with physical or mental impairment who is unable to safely use a common carrier and does not require ambulance service.

Physical or mental impairment means any of the following:

1. A physiological disorder
2. A physical condition
3. A mental disorder that prohibits access to, or safe use of, common carrier transportation

EW Non-Covered Services

1. Access transportation as defined in Chapter 1, Requirements for Providers
2. Transportation reimbursement already included in the contracted rate for other services
3. Non-covered services for a personal vehicle include the following:
 - a. Any payment beyond negotiated mileage or trip reimbursement
 - b. Reimbursement to a person for the purpose of transporting him/herself or the use of his/her own vehicle

Do not separately bill transportation when other EW services are provided by the same person. Adult companion services are an exception to this rule.

Provider Standards

EW common carrier transportation standards

1. Bus, taxicab, or other commercial carriers, private automobile, or a lead agency owned or leased vehicle can be used to transport a member.
2. Private individuals may be designated to provide transportation when they meet the member’s needs and preferences in a cost-effective manner. Examples may include supports such as family, neighbors, friends, community agencies, volunteer driver programs, or companion service providers.
3. Drivers must have a valid driver’s license and adequate insurance coverage as required by [MN Stat. Chap. 65B](#).

EW Special Transportation Standards

Providers of special transportation services not excluded in [MN Stat. sec. 174.30](#) must be certified by the Minnesota Department of Transportation under [MN Stat. secs. 174.29 – 174.30](#). The driver must provide driver-assisted services. Driver-assisted services include passenger pickup at and return to the individual’s residence or place of business and assistance in securing passengers/wheelchairs/stretchers in the vehicle.

Responsibilities of the EW Case Manager/Care Coordinator

The EW case manager or service coordinator is responsible for assessing and planning access to services as follows:

1. Help members understand available transportation services through Medicaid State Plan and the EW programs

2. Help members select transportation services through EW that support their community participation and access to resources and social networks
3. Determine if the contracted rate for the other needed and authorized services does or does not include transportation
4. Clearly and accurately describe in the care plan transportation provided by different entities
5. Determine and document in the care plan if member will use a family member, friend, neighbor, common carrier, and/or special transportation, and if a non-driver attendant is required
6. Determine if the need for transportation meets criteria. See Chapter 21, Transportation Services.
7. Confirm member eligibility for special transportation using MN-ITS or IMCare's provider web portal

Other Resources

It is recommended that the case manager review Chapter 21, Transportation Services, of this *Provider Manual* as well as the MHCP Manual for information regarding the Medical Assistance (Medicaid) State plan transportation services and the certification for use of special transportation.

Level of Need Assessments (LONs)

The case manager/service coordinator requests a work assessment from the potential provider, who, in conjunction with the member, recommends the amount of services needed based on the member's needs, functioning, and preferences.

Authorization

After ensuring the access criteria, assessment, and service planning have been completed, services can be authorized as part of the care plan.

Enter the information from the individualized comprehensive care plan into the MMIS Screening Document and Service Agreement section of the IMCare electronic care plan. The service may be authorized by the number of units required or by the daily rate.

Authorization Billing

The case manager completes the service agreement by adding the vendor's name, National Provider Identifier/Unique Minnesota Provider Identifier (NPI/UMPI), appropriate HCPCS code, and number of units and rate authorized.

1. The intent of the transportation service mileage rate is to pay for the vehicle, not the associated staff time.
2. The negotiated trip rate may or may not include staff time.
3. The mileage rate and the trip rate cannot be authorized/billed for the same trip.

Limitations

1. The mileage rate cannot be used when payment for transportation is received for more than one rider for any portion of the trip regardless of payer.
2. The mileage rate cannot be authorized or billed for miles when the member is not in the vehicle.

The trip rate may be used when transporting and receiving payment for more than one person on any portion of a trip.

Factors to consider when negotiating one-way trip rates include the following:

1. Distance
2. Time
3. Number of individuals for whom transportation payment is received
4. Special vehicle
5. Driver requirements

Use transportation services funded through the [Older Americans Act](#) only when the service or amount of service needed cannot be authorized within the member's community budget cap.

The case manager or care coordinator completes the service agreement by adding the vendor's name, the provider's NPI/UMPI, appropriate HCPCS code, and number of units and locally negotiated rate authorized.

Provider Standards and Qualifications

Drivers must have a valid driver's license and required insurance coverage. Additional requirements may apply.

Moving Home Minnesota (MHM)

Overview

Moving Home Minnesota (MHM) is a Federal demonstration project administered by the Minnesota Department of Human Services (DHS). The goal of MHM is to create opportunities for Minnesotans to move from institutions to their own homes in the community. MHM promotes the development and implementation of transition plans that reflect the preferences of those receiving services and the opportunity to receive services in the most integrated setting.

The MHM recipient will have a transition coordinator to assist with planning the transition from a qualified institution to the community and to create a transition plan. IMCare covers MHM for members age 65 and over.

Participant Eligibility

IMCare members that are age 65 and over who receive MHM services must be transitioning from a qualified institution where they have resided for 90 days or more to a qualified community residence.

Qualified Institution

A qualified institution can be any of the following:

1. Hospital
2. Nursing facility
3. Intermediate Care Facility for People with Developmental Disabilities (ICF/DD)
4. Institution for Mental Disease (IMD) to the extent that these services are covered by Medical Assistance (Medicaid) for individuals under age 21 or age 65 and over
5. Community behavioral health hospitals

Qualified Community Residences

Those receiving MHM services must live in a qualified community residence. These include the following:

1. A home owned or leased by the individual or his/her family

2. An apartment leased by the individual or his/her family in which there is lockable access and egress, including living, sleeping, bathing and cooking areas
3. A community-based residential setting in which no more than four unrelated individuals reside (e.g., adult foster care)

MHM Transition Coordination

Eligible Providers

The transition coordinator can be any of the following:

1. Case manager
2. MCO care coordinator
3. Relocation services coordinator (RSC)
4. Other individual who meets the qualifications listed below.

Transition coordinators must meet the minimum qualifications of an RSC outlined in the MN Stat. sec. 256B.0621, subd. 5.

These services may be delivered by an organization or individual that is any of the following:

1. A lead agency (county, Tribal Nation, or MCO)
2. Under contract with a lead agency
3. Registered with the state

Transition Coordination Services

Transition coordination services are activities that help a person in a qualified institution access medical, social, educational, financial, housing, and other services and supports needed so they can move to the community. The transition coordinator will begin meeting with the member in the institution and does all of the following:

1. Facilitates signing of enrollment and informed consent forms
2. Conducts assessment or arranges assessment within 30 days of assignment
3. Develops an individualized person-centered transition plan
4. Leads the transition planning process
5. Works with lead agency to arrange details of waiver services if appropriate
6. Works with the housing specialist to locate housing
7. Works with the Disability Linkage Line™ to identify appropriate employment supports (if necessary)
8. Sets up transportation to look for housing and/or employment for member
9. Coordinates details in order to set up home for participant
10. Coordinates meeting, medical follow-up appointment, delivery of medical equipment, etc.
11. Coordinates day of discharge. Transition coordinator is present the day of the move. Ensures medications and required services are in place.

The following are required forms for MHM enrollment and participation:

1. **[Intake Form](#)**: Must be completed and sent to DHS for an eligibility determination.
2. **[Informed Consent](#)**: Must be completed when the transition coordinator meets with the member. It is then forwarded to DHS. Once received at DHS, the member can begin to receive MHM services.
3. **[Moving Home Minnesota Transition Planning Tool](#)**: Must be completed with the member and the transition coordinator.
4. **[Communication Form](#)**: Must be completed and sent to DHS once the transition coordinator has an estimated date of when the member will be moving. DHS needs this information in order to schedule a

quality of life survey with Vital Research before the member moves. The Communication Form needs to be completed a second time with the date the member moved as well as the housing information.

The transition coordinator ensures an orderly transition to the case manager, community providers, or to the member to coordinate the community services. If the member will have a different case manager after transition, the transition coordinator must facilitate an in-person meeting with the participant and the community case manager.

The case manager or community provider helps with issues that come up during the year of transition and arrange support for the member in the community.

The transition care plan is person-centered to ensure a member receives the right services and supports at the right time and according to his/her wishes and needs.

Providers must complete and submit [Moving Home Minnesota – Transition Planning, Transition Coordination and Demonstration Case Management Providers – Applicant Assurance Statement](#) (DHS-3879) if they want to enroll to provide transition planning and coordination and be authorized to pay for the following:

1. Furnishing, supplies, and costs for securing housing and environmental modifications
2. Durable Medical Equipment
3. Person Emergency Response Systems
4. Tools, clothing, and equipment necessary for employment

Providers of Other MHM Services

IMCare allows any providers who are currently enrolled to provide services in the *Covered Services* section below to provide the same services to MHM recipients. Tier 1 waiver providers must be enrolled with MHCP and contracted directly with IMCare. Qualified Tier 2 and Tier 3 waiver providers may choose to either enroll with MHCP and contract directly with IMCare or they may deliver services as lead-agency affiliate vendors. Signed service purchase agreements are required for non-enrolled Tier 2 (Community Market Services) vendors. Both Tier 2 and Tier 3 vendors must be listed on the Waiver Vendor Review and Approval Log which includes vendor name, the date approved, and verification of vendor qualifications in compliance with Federal waiver standards.

Providers who want to provide overnight assistance must complete an assurance document, DHS-6808-ENG.

The following services require specific qualifications and may only be delivered with DHS approval. These services include the following:

1. Certified Peer Specialist services
2. Family memory care intervention
3. Supported employment

Contact IMCare Members Service at 1-800-843-9536 (toll free) for details regarding seeking IMCare authorization to provide these services.

MHM Recipient Enrollment

Individuals may enroll for MHM demonstration services by contacting the [Disability Linkage Line](#)[™], [Senior LinkAge Line](#)[®], or by completing the online MHM Intake Form, [DHS-5032](#), and sending it to DHS. The Intake Form can also be submitted via fax to **1-651-431-7745** or mailed to:

Moving Home Minnesota
PO Box 64250
Saint Paul, MN 55164-0250

A MHM enrollment specialist at DHS will work with the transition coordinator to confirm if a member meets the eligibility requirements for the demonstration services. Once a member has been determined eligible for MHM, he/she must complete the Moving Home Minnesota Informed Consent ([DHS-6759I](#)) and return it to DHS before he/she can begin to receive MHM services.

MHM Evaluation

As part of the demonstration, all MHM participants will be part of a national Quality of Life (QoL) study. Each MHM participant will receive a face-to-face QoL Survey at the following three points:

1. Prior to discharge from the institution
2. At the 11th month using the program
3. At 24 months from beginning the demonstration program

This survey is intended to capture participants' satisfaction with services prior to discharge from the institution, just before the end of their participation in the demonstration, and one year following the end of their demonstration period.

Assessment for MHM Services

All MHM services require an evaluation to determine the member's needs and eligibility for MHM services. The assessment will be completed by the appropriate lead agency, using the appropriate home and community based screening tool. MHM will make the conversion to MnCHOICES at the time other services are converted.

Upon completion of the assessment, if approved for MHM services, the member will receive an authorization letter. The transition coordinator and the member develop a transition care plan. An individual may have been assessed prior to being referred to MHM.

People under Age 65

People under age 65 may enroll in the demonstration and choose to use demonstration services in conjunction with State plan services.

However, people must be eligible for Medical Assistance (Medicaid) and the services must be medically necessary. MHM services for people under age 65 are billed to DHS.

If services under both the demonstration and State plan do not meet the needs, the transition coordinator may conduct an assessment or refer the person to request a Long-Term Care Consultation, Developmental Disabilities Screening, or MnCHOICES Assessment to determine eligibility for a Home and Community Based Services (HCBS) waiver program.

Individuals must meet the hospital or institutional level of care to qualify for one of the HCBS waivers programs, and /or the MHM demonstration.

People Age 65 and Over

For individuals age 65 and over who are enrolled in Minnesota Senior Health Options (MSHO) or MSC+, IMCare is responsible for Elderly Waiver services and for relocation services. In this case, IMCare will serve as

the lead for transitions. IMCare may arrange for another entity such as a private relocation services provider or a county agency to serve in this capacity.

Re-Institutionalization

If an MHM participant returns to an institution for less than 30 days, he/she continues enrollment in the demonstration while in the institution.

If an MHM participant returns to an institution for more than 30 days, DHS will suspend him/her from the demonstration. However, such people may do the following:

1. Use any time left of their 12-month demonstration allotment once they return to their qualified community residence; or
2. Re-enroll in the demonstration if they continue to reside in a qualified institution for another 90 days

Covered Services

MHM covers services approved in the person's transition care plan.

MHM Services

IMCare requires that individuals enrolled in MHM are provided MHM transition planning and transition coordination services, rather than some other form of case management or relocation coordination services. Note that only one type of case management can be billed for at any one time. Transition coordination costs such as furnishings, supplies, and expenses associated with securing housing may be paid under MHM so long as they are not available to the individual under a waiver. Costs for these items may be claimed upon the discharge of the individual.

It is not uncommon for an individual to have already exhausted their 180-day benefit relocation coordination services without being discharged. It is allowable to use MHM transition planning and transition coordination services for an additional 180 days.

The MHM program includes a range of services (see table below). The services listed here are available to individuals in addition to the State plan and waiver services they are eligible to receive and can be delivered without affecting an individual's waiver budget. They include the following:

1. Pre- and post-discharge case consultation
2. Comprehensive community supports
3. Certified Peer Specialist services for individuals with mental illness
4. Family memory care
5. Costs associated with finding housing or employment
6. Membership fees for health clubs or fitness centers
7. Overnight assistance

MHM services are not intended to duplicate, supplement, or extend services that are already covered within an individual's State plan or waiver benefit set. If the service is already available under the member's waiver, it is not available under MHM.

The following services are available only to members who are not on a waiver:

1. MHM demonstration case management
2. Environmental modifications
3. Durable Medical Equipment

4. Person Emergency Response Systems
5. Tools, clothing, and equipment necessary for employment (less than 65 years of age)

MHM State Plan Services

MHM recipients may also be eligible to receive State plan services based upon medical necessity and the eligibility requirements for the services. These services include, but are not limited to, the following:

1. Home care
 - a. Skilled nurse visits
 - b. Home health aide visits
 - c. Private duty nursing
 - d. Home care therapies
 - e. PCA
2. Adult mental health rehabilitation services
 - a. Assertive Community Treatment (ACTS)
 - b. Adult Rehabilitative Mental Health Services (ARMHS)
 - c. Adult crisis response services

Demonstration (D) or Supplemental (S) Service	HCPCS Codes	Eligibility Requirements beyond Money Follows the Person (MFP)	Rates	Unit of Service	Service Authorization	Limits Time Span
D – Transition Planning and Transition Coordination Services Including: <ul style="list-style-type: none"> • Identification and engagement of program participants • Development of a transition plan • Implementing the transition plan, including coordination of services, arranging for needed HCBS or other services, coordinating with housing services, and purchasing items relating to establishing individual in the community 	T2038 (U6 only) Transition plan development (COS 022)	None	See Continuing Care Provider Rate and Grant Changes for rate limit documents	Paid upon completion of activity	No prior authorization or utilization review for transition planning	Up to 180 days prior to discharge; Federal financial participation (FFP) claimed only upon discharge; one plan per discharge
	T2038 (U6 + UD) Transition Coordination (COS 022)					
	T2038 (U6 + U1) furnishing	None		15 minutes	No prior authorization or utilization review for transition coordination	Up to 180 days prior to discharge; FFP claimed only upon discharge; one transition coordination per discharge
	T2038 (U6 + U2) supplies					
	T2038 (U6 + UA) expenses associated with securing housing (e.g. deposits, moving expenses, transition coordination services on the	None		Actual cost for items purchased	No prior authorization or utilization review for	Up to 180 days prior to discharge; FFP claimed

	day of discharge) (COS 022)				furnishings, supplies, or expenses associated with securing housing	only upon discharge; one transition coordination per discharge
D – Pre-Discharge Case Consultation and Collaboration Services in support of transition planning	H2000 (U6) Comprehensive Multidisciplinary evaluation in the development of a transition or service plan (COS 109)	None		H2000 (U6) per session	Allowed at the request of the transition planner	
D – Post-Discharge Case Consultation and Collaboration Services to support member’s ongoing adjustment the community. Service is provided to providers on behalf of the MFP participant.	T2013 (U6) Community intervention – Training and consultation with a provider to support placement in the community (COS 109)	None		T2013 (U6) per hour	Service agreement	Post-discharge services governed by service plan
D – Comprehensive Community Support Services Sort-term supportive services, including: <ul style="list-style-type: none"> • Assisting an individual to connect with and establish informal supports in the community • Ongoing support in maintaining housing: <ul style="list-style-type: none"> ○ Tenancy support, including dispute resolution with landlords and neighbors ○ Household management and budgeting 	H2015 (U6) Comprehensive Community Support Services per 15 minutes (COS 109)	None		15 minutes	Service agreement	Up to two 90-day periods allowed without state approval; additional 90-day periods allowed as needed with State approval, not to exceed 360 total days

<p>○ Assistance in organizing schedules and appointments and information and education provided to individuals who play key supportive roles for the MFP participant.</p>						
<p>D – Certified Peer Specialist (CPS) Coaching, mentoring, and assisting peers in skills building, goal setting, problem solving, and helping to build self-directed recovery tools such as Wellness Recovery Action Plans</p>	<p>Self-help/Peer services by Level I CPS – H0038 (U6) Peer services by Level II CPS – H0038 (U5 + U6) Self-help/Peer services in a group setting – H0038 (HQ + U6) (COS 046)</p>	<p>Diagnosis of mental illness and demonstrated medical necessity for rehabilitative services in diagnostic assessment</p>	<p>15 minutes</p>	<p>Service agreement</p>	<p>Up to two 90-day periods allowed without additional State authorization ; additional 90-day periods allowed as needed, with State approval, not to exceed 360 total days</p>	
<p>D – Family Memory Care Intervention Services utilizing the NYU Caregiver Counseling and Support Intervention model. The model consists of components that include counseling sessions and support groups</p>	<p>S5115 (U6) 15-minute unit (COS 034)</p>	<p>Provided to family or informal caregivers of MHM participants with Alzheimer’s disease or a related disorder (regardless of age)</p>	<p>15 minutes</p>	<p>Service agreement</p>		
<p>D – Costs for Finding Housing and Employment</p>	<p>A0160 (U6) – Non-emergency transportation, case worker, per mile (COS 036);</p>	<p>None</p>	<p>Per mile amount; actual cost</p>	<p>No prior authorization or utilization review for non-medical transportation</p>	<p>No limit</p>	

	<p>A0170 (U6) – Transportation ancillary: parking fees, tolls, other (COS 036);</p> <p>A0180 (U6) – Non emergency transportation: ancillary lodging, recipient (COS 036)</p> <p>A0190 (U6) – Meals, recipient (COS 036)</p> <p>A0200 (U6) – Lodging escort (COS 036)</p> <p>A0210 (U6) – Meals, escort (COS 036)</p>					
<p>D – Overnight Assistance Services in support of initial transition to the community: on-site monitoring, availability, and response as needed to address safety and security needs, for a period of no more than 12 hours in a 24-hour period.</p>	<p>S5135 (U6 + UA) 15 minutes (COS 094)</p>	<p>None</p>		<p>15 minutes</p>	<p>Service agreement</p>	<p>Up to two 90-day periods allowed without additional State authorization ; additional 90-day periods allowed as needed, with State approval, not to exceed 360 total days</p>

Authorization

Individuals are enrolled in MHM as follows:

All MHM services require an assessment to determine the member’s needs. Members must apply for MHM by completing an application and an informed consent form. The member will receive an authorization letter confirming his/her enrollment in the program. He/she will also receive a letter if he/she is determined to be ineligible for the MHM program. Once the individual is approved for the program, the transition coordinator

and the member shall develop a transition care plan. The transition care plan is to be developed in a manner consistent with person-centered principles, which means that the member's preferences and choices shall be identified and reflected in the plan.

After the 12-month transition period, people continue to receive the same services through State plan or waiver. If demonstration services are needed for a limited time beyond the 12 months, DHS may cover the costs using State-only funds. The MHM Enrollment Specialist must authorize use of demonstration services beyond the 12-month enrollment period. These requests can be made by the individual receiving the services or anyone acting on the individual's behalf such as a transition coordinator or case manager.

Most of the MHM services require a service agreement, with the exception of those that occur prior to discharge, including the following:

1. Transition planning and coordination
2. Pre-discharge case consultation
3. Costs associated with finding housing or employment

Authorization Letters

Once services are approved, MHCP will provide the member, the provider of service(s), and the case manager a copy of an authorization letter. Both the provider and case manager letter will be placed into their prospective MN-ITS mailbox. The letter shows the services authorized through MHM. Providers must include a copy of the authorization number on their claims.

The provider and member are responsible for reviewing the authorization letter for accuracy before receiving or billing for services.

Billing

To submit claims for home care and mental health services, follow the billing guidelines in the home care services and mental health services sections of the IMCare Provider Manual.

1. Submit MHM services approved on a waiver authorization and all other MHM services using the Professional (837P) claim transaction.
2. Enter the Service Authorization number on the claim.
3. Enter the diagnosis code on the claim.
4. Submit claims only after the services have been delivered.
5. Submit claims for MHM services according to the additional instruction in the table above.

IMCare is responsible for EW services and for relocation services coordination for members age 65 and over who are enrolled in IMCare Classic or MSC+. In this case, IMCare will serve as the lead agency for transitions. IMCare may arrange for another entity, such as a private relocation services provider or a county agency, to serve in this capacity.

Minnesota Department of Human Services (DHS) Forms and Documents

1. [Minnesota Health Care Programs \(MHCP\) Provider Agreement \(DHS-4138\)](#)
2. [Lead Agency Provider Enrollment Request Form \(DHS-6383\)](#)
3. [Provider Not Required to Receive a 245D Program License Applicant Assurance Statement \(DHS-6189Z\)](#)
4. [Disclosure of Ownership and Control Interest of an Entity \(DHS-5259\)](#)

5. [Designation of HCBS Waiver or AC Program Billing Person \(DHS-6855\)](#)
6. [Supported Employment Service Providers – Moving Home Minnesota – Applicant Assurance Statement \(DHS-3873\)](#)

Coordinated Service and Support Plan (CSSP)

Definition

CSSP is the map that identifies the needed services, supports, goals, and outcomes for services provided to an individual in a 245D-licensed program.

Individual Community Living Support (ICLS)

Definition

ICLS is an EW service that provides training, assistance, and support to participants choosing to remain in their own homes. This service offers a broad range of supports including assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), active cognitive support, community living support, and health services as defined in MN Stat. Chap. 245D.

Individual Community Living Supports (ICLS): Bundled service that includes six service categories. ICLS services offer assistance and support for people who need reminders, cues, intermittent/moderate supervision, or physical assistance to remain in their own homes.

[ICLS Planning Form \(DHS-3751\)](#): Required communication and planning tool for the member, lead agency, and ICLS provider.

Covered Services

ICLS covers assistance and support in the following six service categories:

1. Active cognitive support
2. Adaptive support service
3. Activities of daily living (ADLs)
4. Household management
5. Health, safety and wellness
6. Community engagement.

The following sections provide more information about and examples of each of the six ICLS service categories.

Active cognitive support

This category includes interventions intended to address cognitive issues and challenges important to the person. Active cognitive supports are the only ICLS services that the person can receive both in-person and remotely. For more information, see the [Settings](#) section of the ICLS web page.

Examples of ICLS services covered under this category include the following:

1. Problem solving the person's concerns related to daily living
2. Providing assurance to the person
3. Observing and redirecting to address behavioral, orientation, or other cognitive concerns.

Adaptive support service

This category includes services intended to help the person adopt ways to meet his or her needs. ICLS adaptive support services include the following:

1. Encouraging the person's self-sufficiency
2. Reducing the person's reliance on human assistance.

Examples of ICLS services covered under this category include the following:

1. Verbal, visual, and/or touch guidance to help a person complete a task
2. Developing and demonstrating cueing or reminder tools (e.g., calendars, lists)
3. Providing verbal, visual, and/or touch guidance to help the person complete a task
4. Working through instructions for assistive technology with the person to help him/her function with greater independence.

Activities of daily living (ADLs)

This category includes services intended to assist the person with ADLs.

Household management

This category includes services intended to help the person manage his/her home. Examples of ICLS services covered under this category include the following:

1. Assisting with cleaning, meal planning/preparation, and shopping for household/personal needs
2. Assisting with budgets and money management
3. Assisting with communications (e.g., sorting mail, accessing email, placing phone calls, making appointments)
4. Providing [transportation](#) when transportation is integral to ICLS household management goals and community resources and/or informal supports are not available.

Health, Safety, and Wellness

This category includes services intended to help the person maintain his/her overall well-being. Examples of ICLS services covered under this category include the following:

1. Identifying changes in health needs, and notifying the case manager and/or informal caregivers as needed
2. Coordinating or implementing changes to mitigate environmental risks in the home
3. Providing reminders about and assistance with exercises and other health maintenance/improvement activities
4. Providing medication assistance (e.g., medication refills, reminders, administration, and/or preparation)
5. Monitoring the person's health according to written instructions from a licensed health professional
6. Using medical equipment devices or adaptive technology according to written instructions from a licensed health professional.

Community Engagement

This category includes services intended to help the person have meaningful integration and participation in his/her community. Examples of ICLS services covered under this category include the following:

1. Facilitating the person in socially valued roles through engagement in relevant activities that lead to desired outcomes
2. Helping the person access activities, services, and resources that facilitate meaningful community integration and participation
3. Helping the person develop and/or maintain his or her informal support system
4. Providing [transportation](#) when transportation is integral to ICLS community engagement goals and community resources and/or informal supports are not available.

Non-Covered Services

ICLS does not cover the following:

1. Specialized and/or adapted equipment for remote support
2. Transportation service

Note: An ICLS provider may enroll as a waiver transportation provider and simultaneously provide ICLS to participants.

EW only

The person cannot receive ICLS if he/she receives any of the following EW-funded services:

1. Consumer directed community supports (CDCS)
2. Customized Living
3. Foster care
4. Residential care.

Planning Form

The purpose of the [ICLS Planning Form \(DHS-3751\)](#) is to communicate to the ICLS provider the specific ICLS

service components the person will receive. In the form, the case manager/care coordinator does the following:

1. Identifies the individual goals the ICLS service is intended to support
2. Describes and provides detail about the type of services the person will receive within each ICLS service category
3. Calculates the total amount of ICLS services the person will receive each week (i.e., total number of units)
4. Calculates the total costs each week.

Process

The case manager/care coordinator completes the [ICLS Planning Form \(DHS-3751\)](#) with the person. The person, case manager/care coordinator, and provider must sign the completed form. Both the lead agency and provider must keep a copy of the completed and signed form.

Settings

The person can receive active cognitive support services either:

1. In person
2. Remotely via real-time, two-way communication between the person and the provider (e.g., phone, live video).

The person must receive all other service categories in-person. The person must receive in-person ICLS services in a single-family home or apartment that he/she or his/her family owns or rents (as demonstrated by a lease agreement). In a rental scenario, the person or his/her family must maintain control over the individual unit.

The person must receive ICLS services in-person once per week.

Transportation

An ICLS provider also may enroll with PrimeWest Health as a waiver transportation provider. An ICLS provider who is also an MHCP-enrolled waiver transportation provider can bill separately for mileage reimbursement. For the current waiver transportation mileage rates, see [Long-Term Services and Supports \(LTSS\) Service Rate Limits \(DHS-3945\)](#).

Provider Standards and Qualifications

ICLS is a DHS enrollment-required service. For more information, see [CBSM – Waiver/AC service provider overview](#).

License requirements

An ICLS provider must have a license under Minnesota Stat. Chap. 245D as a basic support service provider.

Additional requirements

An ICLS provider cannot meet any of the following:

1. Be the person's landlord
2. Be an arranged home care provider for a housing with services establishment where the person resides
3. Have any financial interest in the person's housing
4. Serve a family member

Authorization, Rates and Billing

1. H2015 (U3) In-person and remote. If a provider delivers in-person services, the provider will bill using the 15-minute unit. If the provider also delivers remote services on the same day as in-person services are delivered, the provider will bill for their remote time also using HCPC code H2015 (U3).
2. Face-to-face in-person support must be provided at least once weekly. The maximum time billed for **remote service** using H2015 (U3) is 15 minutes or one unit per day.
3. H2016 (U3) Remote-daily rate. If the only service provided in a day is remote services, the provider will bill using the daily remote rate, H2016 (U3). A full day constitutes 24 hours, beginning 12:00 a.m. and ending at 11:50 p.m.

Additional Resources

[CBSM – Alternative Care](#)

[CBSM – Elderly Waiver](#)

[CBSM – Rate methodologies for EW service authorization](#)

[New Service for Elderly Waiver and Alternative Care: Individual Community Living Support \(DHS bulletin #17-25-02\)](#)

Provider Quick Reference**Service Agreement Changes**

The case manager is responsible for any changes made to the service agreement of any member.

1. If the rate, procedure code(s), or begin and end dates on the service agreement are incorrect, contact the case manager to initiate corrections.
2. If additional services are necessary, the provider must communicate with the case manager before providing any additional services.

Service Agreement Letters

The case manager has the ability to generate additional copies of the provider service agreement letters as needed.

Multiple Providers Providing the Same Service at the Same Time

More than one provider may be authorized to provide the same service for the same member. Each provider has a separate line item on the member's service agreement.

Some services may also be provided by more than one provider, on the same date of service, except if the service has a daily or monthly procedure code.

If two providers are providing the same service to one member, services **must** be coordinated.

1. Each provider bills for the actual dates of service.
2. Use date spans on claims when services are provided on consecutive days.

In addition, the case manager should contact all providers who will bill for the same daily or monthly procedure over the same period to coordinate services.

Changes in the Status of a Member

1. The case manager informs providers and the county financial worker of any member status changes, such as the living arrangement, address, phone number, or incorrect birth date.
2. The county financial worker notifies the case manager of any changes in the member's eligibility for Medical Assistance (Medicaid) or enrollment in managed care.
3. Providers and the lead agency notify one another when a member is hospitalized so that a provider can bill around the dates of hospitalization.
4. County financial worker and the lead agency notify one another when a member is admitted to a long-term care facility so the financial worker can update the living arrangement and appropriate changes can be made to the service agreement line items.

Change in Member Need

Providers need to contact the case manager when a member's needs change. The case manager is responsible for reassessing the member and amending the community support plan.

Changes may include the following:

1. Change of provider
2. Increasing or decreasing services
3. Addition of a new service
4. Other appropriate assessed needs

Transitioning from Medical Assistance (Medicaid) Home Care to Waiver Services OR Waiver Services to Medical Assistance (Medicaid) Home Care Services

Refer to Chapter 24A, Home Care Services, for more information.

Waiver Recipient Who Elects Hospice

Refer to Chapter 28, Hospice Services for more information regarding covered services.

Waiver Services in an Institutional Setting

Waiver services are not covered during a hospital, nursing facility, or ICF/DD stay. Providers may bill IMCare for waiver services provided on the date of the admission and the date of discharge, if services were provided prior to the time of admission or after the time of discharge, except when EW allows payment for respite care services provided in a hospital or long-term care facility utilizing respite care procedure codes. See [Respite Service](#) description.

Waiver Services in a Residential Setting

The following waiver services are covered in a residential setting:

1. CL
2. 24-Hour CL
3. Residential care
4. Foster care

Waivers do not pay for room and board. Room and board may be covered by other sources such as the following:

1. The member's income
2. Social Security Disability Insurance (SSDI)
3. General Assistance (GA)
4. Supplemental Security Income (SSI)

When the above sources do not cover the total cost of room and board, Group Residential Housing (GRH) funding may be accessed up to the base rate. The county financial worker must determine all appropriate payment sources for room and board.

Reimbursement for Overhead Expenses Due to Residential Absence

Definition

Days when the member is **not** receiving residential services are days a member is **not** in the residential setting.

Examples of residential absence include days for the following:

1. Hospitalization
2. Therapeutic leaves
3. Crisis services
4. Any days away such as home visits and vacation days

The [CMS](#) policy states Medicaid payment is made for services actually provided to an eligible member.

Legal References

[MN Stat. secs. 245A.01 – 245A.16](#)

[MN Stat. sec. 245A.143](#)

[MN Stat. sec. 245A.03](#)

[MN Stat. secs.148.171 – 148.285](#)

[MN Stat. sec. 256.012](#)

[MN Stat. sec. 256B.02](#), subd. 7

[MN Stat. sec.256B.49](#), subd. 8

[MN Stat. sec. 256B.0913](#)

[MN Stat. Chap. 144D](#)

[MN Stat. sec. 245A.03](#), subd. 2 (1) and

(2) [MN Stat. Chap. 144A](#)

[MN Stat. secs. 144a.43 – 144A.484](#)

[MN Stat. sec. 148.621](#)

[MN Stat. Chap.](#)

[245C MN Chap.](#)

[245D](#)

[MN Stat. sec. 148.623](#)

[MN Stat. sec. 157.17](#)

[MN Stat. sec. 144.696](#), subd. 3, licensed under [MN Stat. secs. 144.50 – 44.58](#)

[MN Stat. sec. 148.171 – 148.285](#)

[MN Stat. sec. 148.171 – 142.285](#)

[MN Stat. Chap.](#)

[65B MN Stat.](#)

[sec. 174.30](#)

[MS Stat. secs. 174.29 – 174.30](#)

[MN Stat. sec. 326B.802, subd. 11](#)

[MN Rules parts 9555.9600 – 9555.9730](#)

[MN Rules parts 9555.5050 – 9555.6265](#).and [2960.3000 – 2960.3230](#)

[MN Rules parts 9575.0010 – 9575.1580](#)

[MN Rules parts 9555.5105 – 9555.6265](#)

[MN Rules parts 9555.6205, subps. 1 – 3](#)

[MN Rules parts 9555.6215, subps. 1 and 3](#)

[MN Rules parts 9555.6225, subps. 1, 2, 6, and 10](#)

[MN Rules Chapter 4668 and 4669](#)

[MN Rules parts 4668.0100, subp. 2](#)

[MN Rules parts 4688.0100, subp. 5](#)

[MN Rules Chapter 4626](#)

[MN Rules Chapter 3250](#)

[MN Rules parts 9555.5105 – 9555.6265](#)

[MN Rule part 9505.0335](#)

[MN Rules 9505.0290, subp. 3,](#)

[B MN Rules part 9505.0175,](#)

[subp. 23](#)

[MN Rules part 9505.0310](#)

[MN Rules part 9505.0195](#)

[Title 42 Code of Federal Regulations \(CFR\) Part 441.310\(a\)\(2\)\(ii\)](#)