

# *Chapter 26*

# HCBS Waiver Services

## **Overview**

Chapter 26 includes the criteria that must be met for waiver services and outlines the standards for all providers who bill for these types of services.

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## **Background for Home and Community Based Service (HCBS) Waiver**

The purpose of HCBS waiver is to allow the member to receive Medicaid reimbursement for services normally not covered by Medicaid. The services exceed the amount, scope, and duration of regular Medicaid state plan services. HCBS waiver services promote community living and independence based on the individual needs and choices of the member.

Waiver providers do not need to contract directly with UCare but they must be Medical Assistance Eligible. UCare uses the counties' downstream contracts. If a provider has a contract with the county and is providing a waiver type service, then the provider is eligible to provide UCare members these types of services. Some providers may have waiver services contracted if they are contracted for other services, such as PCA. Providers should use the correct provider number for each service when billing. Providers must be enrolled with DHS and meet the qualifications and licensing standards required. (Providers must also determine which services they are qualified to provide). Information about provider enrollment can be found at <http://www.dhs.state.mn.us/provider/enrollment/>.

### **HCBS waiver include:\***

#### **1. Community Alternatives for Disabled Individuals (CADI).**

The Community Alternatives for Disabled Individuals Waiver provides funding for home and community-based services for children and adults, who would otherwise require the level of care provided in a nursing facility. The DHS Disability Services Division administers the CADI Waiver. Contact the member's local county agency.

#### **2. Community Alternative Care (CAC).**

The Community Alternative Care Waiver provides funding for home and community-based services for children and adults who are chronically ill. The CAC Waiver is designed to serve persons with disabilities who would otherwise require the level of care provided in a hospital. The DHS Disability Services Division administers the CAC Waiver.

#### **3. Traumatic Brain Injury (TBI).**

The Traumatic Brain Injury Waiver provides funding for home and community-based services for children and adults who have an acquired or traumatic brain injury. The DHS Disability Services Division administers the TBI Waiver.

#### **4. Developmental Disabilities (DD).**

The Developmental Disabilities Waiver provides funding for home and community-based services for children and adults with mental retardation or related conditions. The DHS Disability Services Division administers the DD Waiver.

#### **5. Elderly Waiver (EW).**

The EW funds home and community-based services for people age 65 and older who are eligible for Medical Assistance (MA) and require the level of medical care provided in a nursing home, but choose to reside in the community. The Minnesota Department of Human Services (DHS) operates the EW program under a federal waiver to Minnesota's Medicaid State Plan. Counties administer the program.

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### **UCare products that may include a HCBS waiver:**

- Prepaid Medical Assistance Program (PMAP).\*
- UCare's Minnesota Senior Health Options (MSHO).
- Minnesota Senior Care Plus (MSC Plus).

### **UCare products that DO NOT include an HCBS waiver:**

- MinnesotaCare.
- *UCare for Seniors.*
- *UCare for Senior Select.*

\*PMAP members may have waiver services. The county of residence has financial responsibility for waiver services.

## **Requests for HCBS Waivers – Working with the Member's Care Coordinator**

The role of the Care Coordinator/Case Manager for waiver services is to:

- Assess members for eligibility.
- Conduct assessments.
- Develop a plan of care that includes a waiver service plan.
- Assist members with accessing waiver services.
- Monitor the ongoing provision of waiver services.

HCBS waiver services may be requested by the member, a member's representative, the PCP, or Care Coordinator/Case Manager. Members must meet financial eligibility criteria as determined by the DHS Form 3543. Waiver services may not be provided until financial eligibility is verified.

The Care Coordinator/Case Manager must document the need for waiver services in the member's care plan. Waiver services must meet the definitions outlined in the MHCP Provider Manual for each type of waiver. Services that are not covered by waiver include:

- Room and board.
- Items of comfort and convenience.
- Payments directly or indirectly to the member.
- Costs of facility maintenance, upkeep and improvement.
- Upkeep and improvement which are not of direct medical or remedial benefit to the recipient.
- Services provided to the member's immediate family.

Costs for waiver services are limited by the member's individual case mix classification. UCare requires that a benefit exception be requested for service requests that exceed the case mix cap.

Extended transportation is a type of waiver service that may be provided to enable members to gain access to services, activities and resources as specified in their care plan. Extended transportation is offered in addition to medical transportation, and members must have a need for transportation documented in their care plan.

Home modifications as a waiver service include adaptations or improvements to a member's home which are of general utility and not of direct medical or remedial benefit to a member. Costs may be averaged over the span of a service agreement (up to 12 months) as long as the member will remain on the waiver for the full span of the service agreement. UCare does not cover the following:

- Services or items purchased prior to the LTCC screening or eligibility-begin date.
- Services not approved by the Care Coordinator/Case Manager.
- Services provided or billed for when the member is no longer eligible for coverage.

Requests for waiver services are not categorized as medical reviews, but still must meet certain standards for decision-making:

- Decisions must be made within 14 calendar days of a request.
- Denial of requests for waiver services is not subject to a Medical Director review.
- It is not necessary to notify the attending health care professional in the event of a denial, termination, or reduction (DTR) of a waiver service.
- A DTR form is not necessary when the member initiates the termination or reduction.
- The Care Coordinator/Case Manager must document in the care plan that member initiated termination/reduction.
- The Care Coordinator/Case Manager must inform and document notification to the service provider of a termination/reduction.
- It is not necessary to send a DTR for waiver services when member is hospitalized or in a SNF/NF.

If the member chooses hospice while receiving waiver services:

- Waiver services continue while the member is on hospice.
- Services related to the terminal condition are paid by Medicare (hospice) if the member is eligible for Medicare.
- Room and board in a Customized Living facility are not paid by EW.

Waiver services may not be provided outside the State of Minnesota except when:

- The provider is located within the member's local trade area in North Dakota, South Dakota, Iowa, Wisconsin, or
- The member is temporarily traveling outside MN but within the U.S., and services are limited to direct care staff services determined necessary and authorized in the care plan.

Providers should work with the Care Coordinator/Case Manager assigned to the member for any waiver service. Providers should contact UCare's Care Management Intake line at **612-676-6622** or **1-877-447-4384** for assistance in determining the Care Coordinator/Case Manager working with the member.

A member approved for HCBS waiver services will receive service coordination from their Care Coordinator/Case Manager who monitors their plan of care. The Care Coordinator/Case Manager is responsible for any changes made to a member's plan of care. The Care Coordinator/Case Manager ensures that the health and safety needs of the member are met under the plan of care.

Providers are reimbursed according to guidelines established by DHS. Care Coordinators/Case Managers negotiate provider payment rates in the event there is no specified rate listed under the DHS fee schedule. They also negotiate rates for certain services where DHS has provided a rate, but the rate is not to exceed the DHS published maximum allowable service rate and may be negotiated lower than the maximum rate. In some cases, the approval obtained from the member's Care Coordinator/Case Manager may list the specified code and approved rate. Providers should refer to the DHS web site for coding and rate information.

## **Coding Information for Waiver Service Providers**

### **Some coding examples for waiver providers:**

John Doe attended adult day services all day on April 11, 2009.

- Submit claim using S5102 with 1 unit as code, which is defined as adult day care services, adult; per diem.

A homemaker is at Jane Doe's home for one hour on April 14, 2009.

- Submit claim using S5130 with 4 units as the code, which is defined as homemaker service, NOS; per 15 minutes.

Jane Doe has been transported to the adult day services center. Extended transportation is listed under the member's plan of care.

- Submit claim using T2003 with a UC modifier with two units for a roundtrip, as the code is defined as per one-way trip.

### **Submission of units:**

It is very important to submit the correct number of units for each service in order to be reimbursed accordingly.

- Each code on the claim must have a unit (number) associated with it, which is entered in box 24G of the CMS 1500 (08-05) form.
- The number of units entered will depend on the specific code(s) definition found in the Healthcare Common Procedure Coding System Level II (HCPCS) manual.
- Definitions differ in that some indicate time, per item, or per day or visit.

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## **EW Billing Information**

### ***For Claim Submission Up Until Nov. 30, 2011***

#### **Billing process when the care coordination is done by the County:**

Prior to rendering services, providers are required to work directly with the county care coordinator to obtain a service agreement. UCare has a contract with DHS to allow EW providers to bill via the MN-ITS system. The county care coordinator inputs the service agreement into the state's MMIS system. The county or provider then bills the State directly for EW services provided to members on UCare's MSHO or MSC Plus. To submit bills through the state MN-ITS system, the provider must be a registered MHCP provider. Log on to <http://mn-its.dhs.state.mn.us/> to submit bills through the State's MN-ITS system.

#### **Billing process when the care coordination is done by a delegated entity or by UCare's Clinical Services:**

Entities other than counties are not allowed to access the MMIS system to input service agreements. A Delegated Entity approves the services but does not submit a bill for them. The provider is required to work directly with the member's care coordinator to obtain a service agreement/approval. The Delegated Entity Care Coordinator/Case Manager will notify UCare of the service agreement.

### ***For Claim Submission On/After Dec. 1, 2011***

Effective 12/1/11, all claims for EW services for UCare eligible members, regardless of date of service, will be submitted directly to UCare for claim adjudication rather than the state's system, MMIS. Minnesota DHS will no longer process EW claims for UCare eligible members after 11/30/11. This applies to eligible members who are in UCare's MSHO and MSC Plus plans.

In addition to submitting new claims to UCare, all claim adjustments will also need to be submitted to UCare effective 12/1/11, even if UCare was not the original payer. Please note that when you are submitting a claim adjustment to UCare, please attach a copy of the Explanation of Payment (EOP) from DHS along with your newly corrected claim for processing.

As a reminder, all claims must be submitted electronically. To submit a claim adjustment, please follow the guidelines outlined in the MN Administrative Uniformity Committee (AUC) Best Practice, "Claims Attachments," and please remember to fax in a copy of the EOP from DHS to UCare at **612-884-2186**.

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## **Waiver Obligations - Important Notice for EW Providers**

A waiver obligation is similar to a deductible for waiver services. Members must pay a dollar amount (designated by DHS) out of their pocket each month for waiver services, before the health plan pays providers for services. The waiver obligation is deducted from the first provider bill received by UCare each month. Once the waiver obligation is satisfied, UCare will pay providers as they bill.

Waiver providers are responsible to bill members directly when a member has a waiver obligation. UCare requests that the provider first submit the claim to UCare for services rendered. The provider will then receive an Explanation of Payment (EOP).

If the EOP has an explanation code of “WO: Waiver Obligation Applied – Member Responsibility for Balance”, the member should be billed directly for this amount.

This is the ONLY amount that can be billed directly to the member. Balance billing members is prohibited per Minnesota Statute, section 236D.03.

## **Additional Information Regarding Waiver Services**

Additional information regarding waiver services is available on the DHS website. Providers may log on to the DHS web site under the Provider Manual by going to:

[http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionS electionMethod=LatestReleased&dDocName=id\\_000094](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionS electionMethod=LatestReleased&dDocName=id_000094)

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