

Chapter 8

Home Care Services

Overview

Chapter 8 includes the criteria that must be met for Medicare Certified home care services, some billing information regarding billing for Medicare Certified Home Health contracted services, provides information on billing for home infusion services and PCA Services it also outlines the standards for all contracted Personal Care Attendant (PCA) providers.

This Chapter Includes:

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[Billing Medicare Certified Home Care Services](#)

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I. Home Care Services Criteria

A. Medicare Programs (*UCare for Seniors*)

UCare follows Medicare criteria for coverage of home care services. Services must be delivered by a Medicare certified home health agency. Members must meet Medicare criteria.

- Medicare home health services DO NOT include coverage for custodial care, general household services such as laundry, meal preparation, shopping, or other home care services furnished mainly to assist people in meeting personal, family, or domestic needs.
- The member is responsible for 20% of the cost under the Point-of-Service coverage, if this benefit is being used.

B. Minnesota Health Care Programs

1. Dual-eligible MSHO, SNBC (*UCare Connect*)

- UCare follows both Medicare and Medicaid criteria for coverage of home health care for MSHO and SNBC (*UCare Connect* dual eligible).
- Medicare criteria will be reviewed first to determine coverage.
- If a request for home care does not meet Medicare criteria, it will be reviewed per Medicaid criteria.
- Refer to the MHCP Provider Manual for criteria guidelines for home care services or Chapter 23 of this manual.

2. MSC+, MnDHO, SNBC (*UCare Connect-Medicaid Only*), PMAP, and Minnesota Care (expanded benefit set-only)

- UCare follows Medicaid criteria for MSC+, MnDHO (*UCare Complete*), SNBC (*UCare Connect-Medicaid only*), PMAP, and MnCare (Minnesota Care- expanded benefit set only).
- For members with MSC+ and MnDHO, UCare may be the secondary payer. To verify additional coverage, please call UCare's Provider Assistance line at **612-676-3300** or **1-888-531-1493**.
- Medicaid services may be covered if the following member and provider eligibility conditions are met:
 - Services are provided to an eligible member.
 - Physician-ordered services are provided to recipients in their own residence.
 - Services may be provided in a foster care setting, assisted living or group home licensed by the Commissioner of Health. Foster care settings must have no more than four foster care residents.
 - Services are documented in a written service plan, reviewed by the member's physician at least once every 60 days for home health agency or private duty nursing* services.

**Private duty nursing for SNBC (UCare Connect) may be covered, contact the county of residence or DHS to determine approval authority for private duty nursing. Providers who provide PDN MUST be Medicare Certified.*

Note: Please refer to UCare's Provider Manual, Chapter 5: Prior Authorization and Notification, to verify PDN agency requirements.

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II. Billing Medicare Certified Home Health Services

Billing for Skilled Home Health Care services depends on which product the member is on.

UCare for Seniors, Medicare Advantage members.

- Members must meet Medicare criteria.
- Providers must bill the Medicare Rates specified under Exhibit B in your Participation Agreement.
- Providers must bill specific G-Codes along with the Revenue Codes when billing.
- Bill units in visits vs. 15 minute units.
- Must be bill on a UB-04 or 837I (electronic institutional claim form).

MSHO and SNBC (*UCare Connect – dual*) members.

- Members must meet Medicare criteria when billing Medicare rates.
- Providers must bill the Medicare rates specified under Exhibit B in your Participation Agreement.
- Providers must bill specific G-Codes along with the Revenue Codes when billing Medicare reimbursement.
- Bill units in visits vs. 15 minute units.

- If members do not meet Medicare criteria then they must meet Medicaid criteria.
- Providers must bill the specific Medicaid rates specified under Exhibit B in your Participation Agreement.
- Providers must bill specific T-Codes along with the Revenue Codes when billing for Medicaid reimbursement.
- Must be billed on an 837I.

Minnesota Health Care Program members, including MA, GA, MinnesotaCare, and MnDHO.

- Members must meet Medicaid home health criteria.
- Providers must bill the Medicaid rates specified under Exhibit B in your Participation Agreement.
- Providers must bill the appropriate T-Code along with the Revenue Code.
- Must be billed on an 837I.

Billing for more than one visit on the same day.

When billing for more than one visit on the same day for the same services such as, SNV, PT, OT, ST or HHA, the second visit must be billed using a 76 modifier to prevent the second visit on the same from denying for a duplicate.

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III. Enrollee Rights, Provider Responsibilities for Medicare Advantage (*UCare for Seniors*)

A. Medicare Advantage (MA) (*UCare for Seniors*) members have the right to an expedited review by a Quality Improvement Organization (QIO) when they disagree with their MA plan's decision that Medicare coverage of their services from a home health agency (HHA) should end.

B. Regulations

Home health agencies must provide an advance notice of Medicare coverage termination to Medicare Advantage members no later than 2 days before coverage of their services will end. If the member does not agree that covered services should end, the member may request an expedited review of the case by the QIO in that state. The provider must furnish a detailed notice explaining why services are no longer necessary or covered. The review process will be completed within 48 hours of the member's request for a review.

1. Unless otherwise notified in writing by UCare, all UCare contracted providers are required to determine the discharge date and provide the explanation of termination of services notices to members.
2. The provider delivers the [Notice of Medicare Non-Coverage \(NOMNC\) Form - Minnesota](#); [Notice of Medicare Non-Coverage \(NOMNC\) Form - Wisconsin](#) to the member no later than 2 days before their covered services end.
3. The member (or authorized representative) must acknowledge receipt of the NOMNC and contact the QIO (within specified timelines) if they wish to obtain an expedited review.
4. The QIO contacts the Medicare Advantage organization and the provider if a member requests an expedited review. The QIO makes a determination no later than the day Medicare coverage is predicted to end.

C. When to Deliver the NOMNC

Based on UCare or the delegated approval authority's determination of when services should end, the provider is responsible for delivering the NOMNC no later than 2 days before the end of coverage. If services are expected to be fewer than 2 days, the NOMNC should be delivered upon admission. If there is more than a 2-day span between services (e.g., in the home health setting), the NOMNC should be issued on the next to last time services are furnished. Providers should deliver the NOMNC as soon as the service termination date is known. A provider need not agree with the decision that covered services should end, but has a responsibility under its Medicare provider agreement to carry out this function.

D. How to Deliver the NOMNC

The provider must deliver the NOMNC. The member, (or authorized representative) must sign and date the notice to acknowledge receipt. Authorized representatives may be notified by telephone if personal delivery is not immediately available. The authorized representative must be informed of the contents of the notice, the call must be documented, and the notice must be mailed to the representative.

E. Expedited Appeal Process

If the enrollee decides to appeal the end of coverage, he or she must contact the QIO no later than noon of the day before services are to end (as indicated in the NOMNC) to request a review. The QIO will inform UCare and the provider of the request for a review. The provider is responsible for providing the QIO and member with a second notice, the Detailed Explanation of Non-Coverage (DENC). The provider may need to present additional information needed for the QIO to make a decision. Providers must cooperate with the QIO's requests for assistance in gathering required information. The QIO decision should take place by close of business of the day coverage is to end.

F. Timely notification

Providers should structure their notice delivery and discharge patterns to ensure arrangements for follow-up care are in place; scheduling equipment to be delivered (if needed), and writing orders or instructions in advance.

More Information

Further information on this process, including frequently asked questions, and the required notices and related instructions can be found on the CMS website at www.cms.hhs.gov/healthplans/appeals. The regulations are at 42 CFR 422.624, 422.626, and 489.27, and Chapter 13 of the Medicare Advantage Manual includes information on the process. (Link to CMS website).

[Notice of Medicare Non-Coverage \(NOMNC\) Form - Minnesota](#)
[Notice of Medicare Non-Coverage \(NOMNC\) Form - Wisconsin](#)

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IV. Notice of Denial of Medical Coverage (NDMC) Process

The [Notice of Denial of Medical Coverage Form](#) is issued to *UCare for Seniors* members when home health care services are being denied.

A. Denial Process

1. Medicare has approved reasons for denial of service for CMS Region IX. These approved reasons have been adopted by UCare for use in this process.
2. The Notice of Denial of Medical Coverage Form must be given to the member at the time of the decision. The provider fills out the notice and indicates the service and reason for denial. The member must sign the notice. A physician must review all denial for medical necessity. If the member was not given the form at the time of decision, the provider must document that the notice was mailed to the member. A copy of the notice is retained in the member's chart.

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V. Home Infusion Services

On January 1, 2010, UCare re-contracted its home infusion network. Providers will now bill the Pharmacy Benefit Manager (PBM) for all home infusion drugs and continue to bill UCare for the administration services, including nurse visits and per diem therapy services.

Billing home infusion services.

- Must be contracted with UCare for per diems and home infusion nurse visits
- Must bill the per diems to UCare using most appropriate S-Code
- Must bill Skilled Nurse Visit to UCare using most applicable CPT Code
- Must be contracted with UCare's Pharmacy Benefit Manager (PBM)
- Must bill PBM for all drugs including Synagis
- If providers utilize/sub-contract with Medicare Certified agencies for SNV, the contracted Home Infusion provider bills for the SNV not the home health care agency
- Drugs dispensed to a primary care clinic are not considered home infusion services and the PCC is responsible for billing

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VI. Personal Care Attendant (PCA) Provider Standards

To ensure that UCare members have access to PCA services from qualified providers, the provider of PCA services must meet the following standards to be eligible for participation in UCare's network:

- The PCA agency must perform a criminal background check on all individual PCAs. The PCA must have a passed status before they provide services to UCare members. The agency must provide documentation upon UCare's request.
- The PCA agency must have professional liability coverage at all times. UCare requires a
- Minimum of \$1 million per incident and \$3 million aggregate.
- The PCA agency must have surety bond coverage in the amount of \$50,000 or ten percent of the provider's payments from Medicaid in the previous year, whichever is less.
- The PCA agency must have fidelity bond coverage in the amount of \$20,000.
- The PCA agency must have proof of workers compensation insurance.
- The PCA agency must support UCare's efforts in promoting self-care and independence for all UCare members. Home care as a maintenance service does not meet UCare's criteria for medical necessity.
- PCA agencies that service members who also need ongoing skilled nursing services must be Medicare Certified.
- PCA agencies, who also provide Private Duty Nursing services, must be Medicare Certified as specified in Chapter 5.
- The PCA agency must only employ individuals who have the personal background and experience that demonstrates the capacity to serve UCare members safely and competently as a PCA. Agencies must follow all requirements listed under Minnesota Statute 256B.0659 when hiring individual PCA's.
- The PCA agency must present its internal PCA written policies and procedures as stated under Minnesota Statute 256B.0659 UCare upon our request.
- The PCA agency must not solicit UCare members or engage in case finding or misrepresentation of its relationship with UCare and/or its relationship with potential clients.
- The use of the UCare name or logo in any marketing efforts by the agency is strictly prohibited without prior approval from UCare.
- All time cards must be signed by the UCare member or their responsible party. Signatures must be obtained at the time of service to confirm services provided. ***A member's name, handwritten by the PCA, will not be accepted and may be cause for further investigation***
- The PCA agency will follow Minnesota Statute 256B.0659, requirements for initial enrollment of personal care assistance provider agencies.
- Effective January 1, 2010, PCA provider agencies cannot provide both PCA services in homes owned or controlled by the provider of PCA services. Please refer to MHCP Provider Update PCA09-03.
- PCA agencies must provide PCA supervision for all members receiving PCA services.

- PCA's must not work more than 275 hours per month. Provider agencies must coordinate weekly work schedules with other agencies that employ the individual to ensure the PCA's combined scheduled hours do not exceed these hours.
- PCA agencies must provide each recipient or their designee, a written home care bill of rights at the time the recipient agrees to services or before services are started, whichever is earlier. Agencies must keep documentation of notice in the recipients file.
- Providers must have locked filing cabinets and computers to keep non business related personnel from obtaining private member information. Agencies must follow ALL applicable HIPPA laws and regulations pertaining to privacy.
- PCA agencies must have a business phone number and fax number specific to their PCA agency. The voicemail needs to be set up with business professional information and the phone should be answered at all times in a business professional manner.
- PCA agencies must inform UCare immediately upon ownership changes to your agency, including co-owner information.
- Providers are required to keep a copy of the member's service plan in their file.
- To ensure member does not exhaust PCA hours before prior authorization expires, PCA Agencies are responsible to develop month to month care plans for use of PCA hours and to monitor use of PCA services in accordance with Minn.Stat. 256B.0659 Subd. 15
- PCA agencies must follow all requirements listed under Minnesota Statute 256B.0659 at all times.
- The PCA Agency cannot burden recipients' free exercise of their right to choose service providers by requiring PCA's to sign an agreement not to work with any particular PCA recipient or for another PCA provider agency after leaving the agency and that the agency is not taking action on any such agreements regardless of the date signed.

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VII. PCA Individual and PCA Agency Training Requirements

Individual PCA Training requirements

Effective January 1, 2010, all PCA agencies must provide individual training to their employed PCA's. PCA training must include successful completion of the following training components:

- Basic first aid.
- Vulnerable adult.
- Child maltreatment.
- OSHA universal precautions.
- Basic roles and responsibilities of PCA's including information about assistance with lifting and transfers for recipients.
- Emergency preparedness.
- Orientation to positive behavioral practices.
- Fraud and abuse issues.
- Completion of time sheets.

Upon completion of the training components, the PCA must demonstrate the competency to provide assistance to recipients. A copy of completion of training must be provided upon UCare's request.

Individual PCA's maybe subject to monitoring by UCare. If a violation occurs the agency is required to implement a corrective action plan or take disciplinary action.

****NOTE:** DHS is in the process of developing basic individual PCA training and expects to formally implement the training module in early 2010. Once the training becomes available each individual PCA must be trained and pass a test before they are enrolled through MHCP. Please refer to MHCP Enrolled Providers – Home page and then clicking PCA Organization for more information on their web site.**

PCA Provider Agency Training requirements

Legislation requires PCA agency owners, managing employees and qualified professionals to successfully complete the 3 days Steps for Success by January 1, 2011. DHS is holding workshop sessions through 2010. You must be registered or have already taken the course and received a certificate of completion. Once a certificate of completion is provided to each required personnel within the agency, the agency is required to submit copies to UCare upon request for your files. All currently contracted agencies will have 18 months to complete the mandatory training. Any new owners and new managing employees are required to complete mandatory training as a requisite of hiring. All qualified professionals must attend Steps for Success within six months of the date hired by a PCA provider agency. Employees in Management and

supervisory positions and owners who are active in day-to-day operations of an agency and QPs who have completed the required training do not need to repeat the required training if hired by another agency within three years of completing the training. Personal care assistance provider agencies certified for participation in Medicare as a home health agency is exempt from the training.

For more information regarding the Steps for Success training, please refer to DHS enrolled provider home page and click training dates.

PCA provider agency billing staff shall complete training about PCA program financial management when it becomes available through DHS.

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VIII. PCA Authorization Process

Authorization is required for payment of all PCA services. PCA providers must follow the specified authorization procedures and cooperate with all phases of the authorization process

A. Member Eligibility (Ref: Minnesota Rules **9505.0335 Personal Care Services Subpart 1 (H)**)

"Qualified recipient" means a recipient who needs personal care services to live independently in the community, is in a stable medical condition, and does not have acute care needs that require inpatient hospitalization or cannot be met in the recipient's residence by a nursing service as defined by Minnesota Statutes, section [148.171](#), subdivision 15. Member eligibility should be verified monthly via MINITS or Electronic Verification System (EVS).

B. Member Programs with PCA Benefits

PCA services are available only to members enrolled in PMAP, MSC+, MSHO, MNDHO or Minnesota Care Expanded Benefit set (pregnant women and children under age 21).

NOTE: There is no PCA benefit for GAMC, UCare for Seniors, and adult, non-pregnant MinnesotaCare members. For SNBC (UCare Connect) please contact county of residence or DHS. Member may be eligible for PCA, however UCare or its delegates are not the approval authority for PCA Services for members covered in SNBC.

C. Starting PCA Services

1. For all members on UCare WITHOUT previously authorized PCA Services

- An independent assessment is required to begin PCA services for a member.
- The member, member's family, member's representative, primary care clinic, Care Coordinator, PCA agency, or physician must contact the authorizing entity to request the assessment.
- The authorizing entity will accept the request by phone, fax or mail.

2. For Members new to UCare WITH previously authorized PCA Services, the PCA Agency must submit:

- A request for authorization.
- A copy of the current service authorization from DHS, OR
- An authorization from another PMAP Health Plan.

3. Authorizing Entity will:

- Issue an authorization that is for the same level of service AND is valid to the end of the service period on an existing authorization.
- Provide for transition of care to a UCare contracted provider when the existing authorization is to a non-participating provider.

- Require a MAHSA re-assessment **only** at the end of the existing authorization period except where otherwise noted (see instructions for **Long Term Increase in Service**).

D. Initial Assessment

1. Public Health Nurse (PHN)

State Statute requires use of the Personal Care Assistance (PCA) Assessment and Service Plan (DHS-3244-ENG) for the independent PCA Assessment.

Ref: **Minnesota Statutes 256B** 0659 Subdivision 3a.

- The PCA Assessment and Service Plan is the tool that establishes the need for and level of PCA services.
- The assessment must be performed by a PHN from the County or an UCare contracted agency or delegate.
- A county PHN agency that is also a provider of PCA services cannot conduct assessments for their PCA clients. These counties must contract with another PHN agency or an independent certified PHN they do not employ, or who is not employed or under contract with an enrolled PCPO to conduct the assessment and reassessments.
- The county or agency must complete the assessment within 30 days of the request and provide a copy of the service plan to the member and the PCA agency with 10 days of the assessment.
- The PCA Assessment and Service Plan must be complete and legible when submitted to the authorizing entity.

2. The PCA agency must:

- Contact the authorizing entity for approval before providing service.
- Allow 30 days from request date for the completion of the PCA Assessment.
- Allow 14 days for an authorization decision from the authorizing entity after completion of the PCA assessment.

3. Authorizing Entity

1. Upon receipt of a request for initial PCA services the authorizing entity will:
 - Send notification for the assessment to the PHN agency or the County PHN.
 - Allow up to 30 calendar days from the date of the request for the PHN to complete the PCA assessment.
2. Within 14 calendar days of receipt of the PCA assessment, the authorizing entity will:
 - Review the PCA assessment recommendation for service.
 - Make a determination based on the PCA assessment recommendation and medical necessity.

E. Approval

When the recommendation for service on the PCA assessment is equal to or greater than the number of hours requested by the member or the primary care physician, the authorizing entity will:

- Issue an initial authorization for PCA services up to one year in length.
- Give verbal notice of the approval to the PCA provider.
- Send written notice of the approval to the PCA provider, the member and the PCP.

F. Medical Director Review

When the recommendation for service on the PCA assessment is for zero “0” service hours, or for less than the amount of service requested by the member or the primary care physician, authorizing approval authority will send the PCA assessment and available physician input or supporting medical documentation to the authorizing entity’s Medical Director for review.

G. Denial, Termination and Reduction (DTR) Notice

When the decision from the Medical Director is to deny PCA services the authorizing entity will:

- Give verbal notice of the decision to deny services to the PCA provider within one business day of the decision.
- Send written notice of the decision to deny services, including the member appeal rights, to the PCA provider, the member and the primary care clinic.
- Specify an effective date of the termination that is 30 calendar days from the date the notice was issued.

H. Partial Denial-Approval Letter and DTR Notice

When the decision from the Medical Director is to approve PCA services at a level that is less than the amount of service requested by the member or the primary care physician, the authorizing approval authority will:

- Give verbal notice of the partial denial to the PCA provider.
- Send a written notice of the decision to approve and level of service approved to the PCA provider, the member and the physician or primary care clinic.
- Send a written notice of the decision to deny services, with member appeal rights, to the PCA provider, the member and the primary care clinic.

I. Temporary Start of PCA Services (Minnesota Statutes 256B. 0652 Subdivision 9)

A temporary start of PCA services requires authorization prior to or at the start of service.

The agency nurse, independently enrolled private duty nurse, or county PHN must:

- Request authorization from the authorizing entity upon receipt of the request for a temporary start of care.
- Provide documentation to support the immediate need for the service.

A. Authorizing Entity

The authorizing entity may issue an approval for up to 45 days. The level of services authorized under this provision shall have no bearing on future authorizations.

J. Request for Increase in PCA Services:

A request for increase in services may be made when a member has a temporary, long term or permanent change in medical status, as described below:

- Temporary changes are those that last 45 days or less.
- Long term changes are those that are longer than 45 days and up to 365 days.
- Permanent changes are those that are chronic or lifetime in nature.

1. Medical or Caregiver Status Changes

These include, but are not limited to:

- A change in the member's health or level of care.
- Change in physician request for services.
- Recent facility placement.
- A change in the primary caregiver's availability.

2. PCA Agency

The PCA agency should contact the authorizing entity and submit the following:

- A request for the increase in service, including the estimated length of time required.
- The primary care physician's request for the increase in service.
- Documentation that supports the requested change in service.

3. Authorizing Entity

a. Short Term Increase in Service

The authorizing entity may authorize the increase for up to 45 days when the following conditions exist:

- The temporary change in condition supports the need for PCA services.
- The documentation submitted supports the requested change in service increase.
- The primary care physician validates the condition change and requests the increase in service.

NOTE: the authorizing entity cannot approve back-to-back temporary requests.

b. Long Term Increase in Service

The authorizing entity may approve a PCA assessment when the change will persist for longer than 45 days:

- A new in-person PCA assessment is required to establish the need for a long-term increase in service.
- If the need is established by the PCA assessment, the existing authorization **must** be ended AND a new authorization issued for a span of up to one year.

K. Annual Reassessment for PCA Services

1. PCA Agency

- Completes a UCare PCA Assessment Request Form.

- Submits the request for reassessment to the authorizing entity 60 days prior to the expiration of the current PCA authorization.
- Allows 6 weeks for the completion of the assessment and authorization process.

2. PHN

- Performs the re-assessment in-person with the member.
- Completes the PCA assessment within 30 days of PCA agency request to the authorizing entity.
- Submits the completed PCA Assessment and Service Plan to the authorizing entity.
- Provides a copy of the service plan to the member and PCA Agency with 10 days of the assessment.

3. Authorizing Entity

Upon receipt of a request for annual reassessment for PCA service the authorizing approval authority will:

- Send an approval for the PCA assessment request to the PHN agency or the county PHN.
- Send notification of the assessment to the member.
- Allow 30 days from the date of the initial request to complete the assessment.
- Ensure completion of the assessment within the 30 day time frame.

Within 14 calendar days of receipt of the PCA Assessment and Services Plan the authorizing entity will:

- Review the PCA assessment recommendation for service.
- Make a determination based on the PCA assessment recommendation.

4. Approval

When the recommendation for service on the PCA Assessment is equal to or greater than the number of hours previously approved, the authorizing entity will:

- Issue an authorization for long term PCA services up to one year in length.
- Give verbal notice of the approval to the PCA provider.
- Send a written notice of the approval to the PCA provider, member, and PCP.

5. Medical Director Review

When the recommendation for service on the PCA assessment is for zero “0” service hours, or for less than the number of hours previously approved, the authorizing entity will send the PCA assessment and supporting medical documentation to the authorizing entity’s Medical Director.

6. Denial, Termination and Reduction (DTR) Notice

When the decision from the Medical Director is to deny PCA services that were previously approved, the authorizing entity will:

- Give verbal notice of the decision to deny services to the PCA provider within one business day of the decision.
- Send a written notice of the decision to deny services, with member appeal rights, to the PCA provider, the member and the primary care clinic.
- Specify an effective date of the termination that is 30 calendar days from the date the notice was issued.

7. Reduction of Services – Approval Letter and Reduction Notice (DTR)

When the decision from the Medical Director is to authorize PCA services at a level that is less than the number of hours previously approved, the authorizing entity will:

- Give verbal notice of the reduction in services to the PCA provider.
- Send a written notice of the decision to approve, including level of service approved, to the PCA provider, the member and the primary care clinic.
- Send a written notice of the decision to deny services, with member appeal rights, to the PCA provider, the member and the primary care clinic.
- Specify an effective date for the reduction that is at least 30 calendar days from the date the notice was issued.

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IX. PCA Billing Guidelines

When billing for PCA services, please use the correct agency's provider identification number. Your agency could be set up in our system with either an NPI (if you provided one to UCare) or it will be set up with a 6 digit UCare provider legacy number along with a 4 digit UCare Group Practice number.

Billing PCA Services:

- Bill on an 837P EDI Format.
- Bill NPI in box 33, loop 2010AA (if you have an NPI).
- If no NPI, bill 4 digit UCare group practice in box 33, loop 2010AA.
- Bill UMPI (Individual PCA number provided by DHS) in box 24J, loop 2310B, Rendering provider loop.

DATE SPAN BILLING FOR PCA SERVICES: Date span billing is no longer allowed when billing PCA services. You must line item bill for EACH DAY a PCA service is rendered.

BILLING FOR MORE THAN ONE PCA FOR THE SAME DAY: If you are billing for more than one PCA on the same day, separate the claim and bill **EACH** individual PCA on a different claim for each day along with each of their UMPI numbers.

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X. Making changes to individual PCA UMPI numbers (additions/changes/deletions)

PCA numbers are not automatically updated in our systems when you receive the DHS letter with the PCA's UMPI number. If you have a new PCA with a new UMPI number, it is your responsibility to provide us that information. When there are additions, changes, or deletions to your PCA listing, please notify UCare by sending the information to us on the "UCare PCA UMPI Information Form." A link to the online form is listed below, or it can also be found in the "Forms" page on the navigational link of our UCare Provider web site at www.ucare.org.

Effective 10/1/10, UCare will no longer accept paper submitted requests to have the PCA UMPI numbers added, deleted, or changed. UCare now has an online form that can be used and it must be completed and submitted electronically beginning 10/1/10. This is particularly important if you currently submitting paper requests, whether by e-mail or fax.

When you complete and submit the UCare PCA UMPI Form online, you will get a confirmation number that it has been received. If you need to know the status of the request, you may contact the Provider Assistance Center at **612-676-3300** or **1-888-531-1493** (toll free) to find out the status. If you provide us your e-mail address in your request, you will receive an e-mail message from us when your request has been completed. **Please allow 15 days for your request to be reviewed and completed.**

****When sending updated or new UMPI information to be loaded with UCare, please do NOT send your entire PCA individual UMPI roster/listing. This only hinders and slows down the process, and will only take longer get the changes made.****

[UCare PCA UMPI Form](#)

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XI. Qualified Professional (QP) Supervision Standards

UCare requires agencies to comply with the supervision practices and standards written in Minnesota Rules, Chapter 9505.0335 subpart 4. Supervision of personal care services. You may access the rule at: <http://www.revisor.leg.state.mn.us/arule/9505/0335.html>

Definition of Qualified Professional (QP): A registered nurse, mental health professional or licensed social worker or a qualified developmental disabilities specialist who is responsible for supervision of PCA services.

NOTE: For the purposes of this document, “days” means calendar days.

The QP performs supervision through direct observation of the assistant's work or through consultation with the qualified recipient.

- Authorization is required for all supervision services.
- Direct observation is required, at a minimum, for new PCA services AND for a change in PCA to a member with established PCA services.
Supervision must occur at the frequency cited in **Rules 9505.0335 Subpart 4 (D):**
- within 14 days after the placement of a personal care assistant with the qualified recipient
- at least once every 30 days during the first 90 days after the qualified recipient first receives personal care services according to the plan of personal care service; and
- at least once every 120 days following the period of evaluations in # 2.

PCA SUPERVISION TABLE – START OF SERVICE

1 st Year of PCA Service	1 st 2 weeks	Month 1	Month 2	Month 3	Month 4 - 12	1 st Year
Time Period & Frequency	On or before Day 14	1 st 90 Days @ 30 day intervals			@ 120 day intervals	Total Authorized Supervision
Supervision Visits (Each Visit = 8 Units)	1 visit	1 visit	1 visit	1 visit	2 Visits	6 Visits (48 Units)

PCA SUPERVISION TABLE – ESTABLISHED SERVICE

2 nd and Subsequent years of PCA service	@ 120 day intervals			Calendar Year
Timing of Visit	Month 4	Month 8	Month 12	Total Authorized Supervision
Supervision Visits (Each Visit = 8 Units)	1 visit	1 visit	1 visit	3 Visits (24 Units)

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XII. PCA Supervision Responsibilities (Ref: Minnesota Rules 256B.0659 Subd. 14)

1. Ensure and document that the PCA meets the required qualifications and is

- Capable to provide the required personal care services
- Knowledgeable about the plan of personal care services before the PCA performs those services
- Knowledgeable about the essential observations of the members health
- Knowledgeable about any conditions that should be immediately reported to the nurse or the physician

2. Perform all required supervisory functions at each evaluation visit

- Direct observation of the PCA's work
 - Record in writing the results of the observations
 - Identify any deficiencies in the work of the PCA
 - Record all actions taken to correct any deficiencies in the work of the PCA
 - Review the plan of personal care services with the member
 - Work with the member to revise, as necessary, the plan of personal care services
 - Ensure that the PCA and the member are knowledgeable about a change in the plan of personal care services
 - Ensure that records are kept that show the services provided and the time spent providing those services by the PCA
 - Determine that a qualified member is capable of directing his or her own care or resides with a responsible party
 - Determine with a physician that a recipient is a qualified recipient
- NOTE: "Plan of personal care services" means a written plan of care specific to personal care services.

3. Provide for the member's cultural and linguistic needs

- Identify and provide for interpretation services when necessary
- Refrain from use of family members and the PCA as interpreters for evaluation visits and assessments
- Use a UCare contracted agency for all interpretation needs

UCare reserves the right to monitor for compliance to the above requirements. The PCA agency is required to enforce compliance, to implement a corrective action plan if deficiencies occur, or to take immediate disciplinary action if so directed by UCare.

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