CFI MEDICAID DOCUMENTATION GUIDELINES AND BILLING

January 9, 2019

Housekeeping Details

- Please make sure you have signed the attendance sheets.
- Restrooms (2) are located across the hall from the auditorium entrance.
- Please take the time to complete the evaluation for those on the webinar it will be available to complete after the webinar.

Topics to Be Discussed

- Review of the providers billing manual and administrative rules related to billing and what required documentation is needed for billing accurately to ensure efficient and timely payments.
- Discussion of service authorizations and what it means for billing and payment.
- Review of when provider changes require notification to the PI unit and/or MMIS.
- Examples of claims submitted with documentation issues.

General Medicaid Rules

- There are some general rules that apply to all State Medicaid programs. These rules include:
  - Beneficiaries are eligible for services at the time they are furnished;
  - Services are furnished by licensed, qualified, Medicaid-approved providers;
  - To the extent required by the State, services are medically necessary;
  - To the extent required by the State, Medical necessity and medical rationale are documented and justified in the medical record (remember, each State adopts its own medical necessity definition)
  - Accurate, clear, and concise medical records are maintained and available for review and audit;
  - Physicians' orders or certifications are in the medical record when required (for example, inpatient hospitalizations or home health services);
  - All medical record entries are legible, signed, and dated;
  - Medical records are never altered;
  - Services are correctly coded;
  - Only covered services are billed; and
  - Overpayments are returned within 60 days.

Choices for Independence (CFI) – Home & Community-Based Care Provider Manual Volume II December 1, 2017

GENERAL BILLING

Provider Manual

Volume I

December 2018

This has been recently updated and is now posted on the MMIS site.

CFI Administrative Rules

- CHAPTER He-E 800 MEDICAL ASSISTANCE

  PART He-E 801 CHOICES FOR INDEPENDENCE PROGRAM

All Services:
Service documentation must include the following, at a minimum:

- The member's name;
- The date(s) of service delivery;
- The type(s) of service(s) delivered;
- The total amount of time in which service was delivered;
- An evaluation, which shall include information on the member's progress and the outcome of service provision; and
- The name of the member's caregiver.

CHAPTER He-E 800 MEDICAL ASSISTANCE
PART He-E 801 CHOICES FOR INDEPENDENCE PROGRAM

He-E 801.05 Development of the Comprehensive Care Plan.

(a) The case manager assigned to the participant shall develop and maintain a comprehensive care plan through a person-centered planning process in accordance with He-E 805.

(b) The case manager shall request authorization from the department of the CFI services contained in the comprehensive care plan, including the specific service providers selected by the participant.

CHAPTER He-E 800 MEDICAL ASSISTANCE
PART He-E 801 CHOICES FOR INDEPENDENCE PROGRAM

He-E 801.06 Service Authorization.

(a) Upon review of the information provided in He-E 801.05(b), the department shall authorize services that are consistent with services that meet the needs identified in the clinical assessment in He-E 801.04(a) and other verified long-term care needs not previously identified through the assessment.

(b) Service authorizations shall consist of specific types, units, and frequencies of medical and other services.

(c) Service authorizations shall be issued to specific service providers identified by the participant's case manager as a result of person centered planning.

He-E 801.30 Required Documentation

- (a) Each participating provider, with exceptions noted in (b) below, shall develop, maintain, and implement a written care plan as follows:
  - (1) The care plan shall be developed in consultation with the participant and the participant's legal representative, if any;
  - (2) The provider shall communicate with the participant's case manager in order to ensure the care plan is consistent with and addresses the applicable service needs identified in the comprehensive care plan;

He-E 801.30 Required Documentation (cont.)

- (3) The care plan shall contain, at a minimum:
  - a. A description of the participant's needs and the scope of services to be provided;
  - b. The dates upon which services will begin and end;
  - c. The frequency of the services;
  - d. The total number of service units authorized and the number that will be provided on each date of service;
  - e. Information on the participant's health condition, medications, allergies, and special dietary needs as it relates to the provision of the service; and
  - f. The anticipated goals and outcomes of service provision;

He-E 801.30 Required Documentation (cont.)

- (4) The care plan shall be updated at least annually and as necessary; and
- (5) The provider shall communicate the elements of the care plan to the participant's case manager, upon the completion or revision of the plan, and document the date it was communicated.

He-E 801.30 Required Documentation (cont.)

- (b) Providers of the following services shall not be required to develop a care plan:

  - (1) Environmental accessibility adaptations;
  - (2) Home-delivered meals services;
  - (3) Non-medical transportation services;
  - (4) Personal emergency response system services;
  - (5) Specialized medical equipment services; and

Environmental accessibility adaptations and Specialized medical equipment services

- The participant's case manager shall submit the following when requesting prior authorization for specialized medical equipment:
- (1) A completed Form 3715, "Choices for Independence Prior Authorization Request Form" (4/2011);
- (2) A copy of the evaluation by a NH Medicaid-enrolled licensed practitioner or physical or occupational therapist that describes:
- a. The medical or functional need for the equipment or adaptation;
- b. The description and any measurements required for the equipment or adaptation ; and
- c. The proposed training plan for the client and caregiver to ensure safe use of the equipment or adaptation ;
- (3) Proposals from at least 2 enrolled providers,

In addition for EAA requests

Payment for EAAs shall not be made until the department receives the following: (Half payment upfront and remainder based on below)

- (1) A copy of any required building permit and written confirmation from the building inspector that the work was completed as allowed by the permit;
- (2) A signed statement from the participant stating that the work has been completed according to the approved bid and plans and to the satisfaction of the participant; and
- (3) A signed confirmation from the case manager stating that the work was completed.

He-E 801.30 Required Documentation (cont.)

- (c) Each participating provider shall:

  (1) Maintain documentation in accordance with applicable licensure, certification or other requirements;

  - (2) Maintain any other supporting records in accordance with He-W 520; and

  - (3) Maintain documentation in their records to fully support each claim billed for services including the specific service provided, the number of service units provided, the name of the employee who provided the service, and the date and time of service provision, as applicable.

- **(d) In addition to (c) above, documentation of personal care services shall include verification of the personal care services worker's time, including, when paper timesheets are used, the signature of the participant or PCS representative indicating that the service was provided in accordance with the care plan and to the participant's satisfaction.**

He-E 801.30 Required Documentation (cont.)

- (e) The documentation required by this section shall be made available to the department upon request.
- (f) The documentation required by this section shall be maintained for a period of at least 6 years from the date of service or until the resolution of any legal action(s) commenced during the 6 year period, whichever is longer.

CFI billing manual Section5 Service Authorizations (SA) pg. 5-1

- Service Authorizations (SA), also referred to as Prior Authorizations (PA), is an advanced request for authorization of payment for a specific item or service.

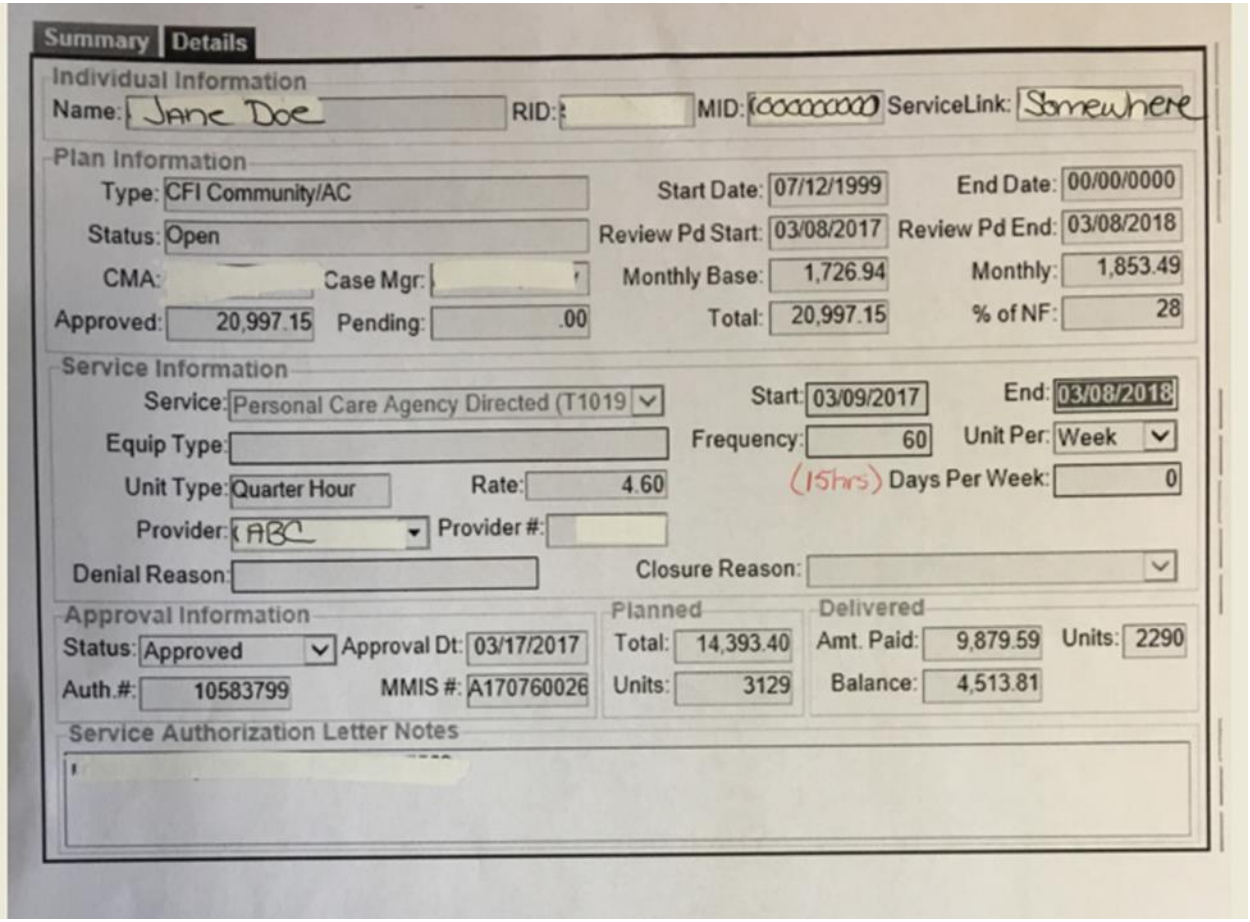
- CFI services are covered only as authorized by BEAS, based on the needs identified in the clinical assessment completed by an RN, and the comprehensive care planning process completed with the member by the case manager. **Providers receive automated notifications of service authorization through** either the Options Information System or the **Medicaid Management Information System (MMIS).**

- A service authorization (SA) does not guarantee payment. Providers must verify the following before providing a service.
- • The member is eligible on the date(s) of service;

- • The performing and billing NH Medicaid providers are actively enrolled providers on the date(s) of service; and

- • The HCFA Common Procedure Coding System (HCPC) or Current Procedural Terminology (CPT) procedure code(s) and billing modifier(s) are active codes and valid combinations for billing under the NH Medicaid.

Service Authorization



Summary | Details

Individual Information

Name: Jane Doe RID: MID: ooooooooo ServiceLink: Somewhere

Plan Information

Type:	CFI Community/AC	Start Date:	07/12/1999	End Date:	00/00/0000
Status:	Open	Review Pd Start:	03/08/2017	Review Pd End:	03/08/2018
CMA:		Case Mgr:		Monthly Base:	1,726.94
Approved:	20,997.15	Pending:	.00	Total:	20,997.15
				Monthly:	1,853.49
				% of NF:	28

Service Information

Service:	Personal Care Agency Directed (T1019	Start:	03/09/2017	End:	03/08/2018
Equip Type:		Frequency:	60	Unit Per:	Week
Unit Type:	Quarter Hour	Rate:	4.60	(15hrs) Days Per Week:	0
Provider:	ABC	Provider #:			
Denial Reason:		Closure Reason:			

Approval Information

Status:	Approved	Approval Dt:	03/17/2017	Planned Total:	14,393.40	Delivered Amt. Paid:	9,879.59
Auth.#:	10583799	MMIS #:	A170760026	Units:	3129	Balance:	4,513.81
						Units:	2290

Service Authorization Letter Notes

Providers automated notification from MMIS

Jeffrey A. Meyers
Commissioner

Deborah H. Fournier, Esq.
Medicaid Director

NEW HAMPSHIRE TITLE XIX MEDICAID PROGRAM

NOTICE OF SERVICE AUTHORIZATION CHANGE

May 9, 2017

ABC Home Health Care
First St
Somewhere, NH

RE: Member Name: Jane Doe
Member ID: 00000000000
Service Authorization ID: A170760026

The previously approved Service Authorization noted above has been re-reviewed and one or more line items have changed as a result of the review. The results of this review are documented in the following Service Authorization Detail.

Additional Reviewer Comments:
· 15 hrs A week - John Doe C.M.

If you have any questions, please contact the client's case manager.

0051550467

Notice of Services Authorized Change
OPR-SA-L003

Providers automated notification from MMIS detail page

SERVICE AUTHORIZATION DETAIL

Member ID: 00000000000 **Member Name:** Jane Doe **Service Authorization ID:** A170760026		**Requesting Provider Name:** ABC Home Health Care **Header Status:** Approved	
Service Authorization Line Item Number	1		
Servicing Provider Name	ABC Home Health Care		
Status	Approved		
Approved Begin Date	03/09/2017		
Approved End Date	03/08/2018		
Service Code	T1019		
Service Description	Personal Care Agency Directed		
Modifier 1	HC		
Modifier 2	U1		
Approved Units	3,129.00		
Approved Amount	$14,393.40		
Approved Rate/Unit			
Approved Frequency	Week		
Last Updated Date	05/08/2017		

MEDICAID ELIGIBILITY DISCLAIMER: This form is notification of the approved service, the proper billing codes, units of service, rate of payment, and authorization number to be used upon submission of claim. The member's Medicaid eligibility must be checked prior to providing any medical services for valid eligibility dates and possible third party insurance coverage.

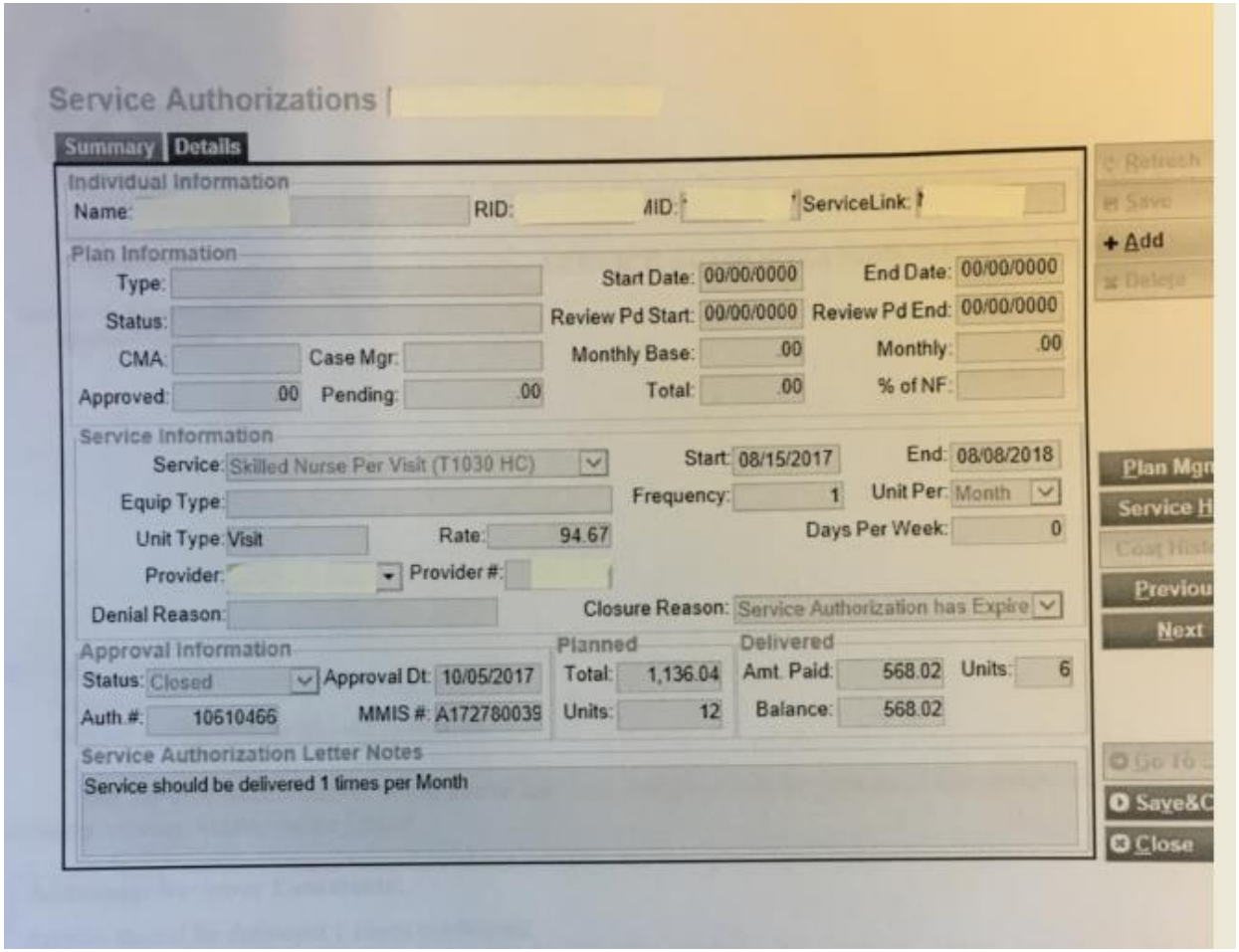
What does it mean?

NEW HAMPSHIRE TITLE XIX MEDICAID PROGRAM
SERVICE AUTHORIZATION DETAIL

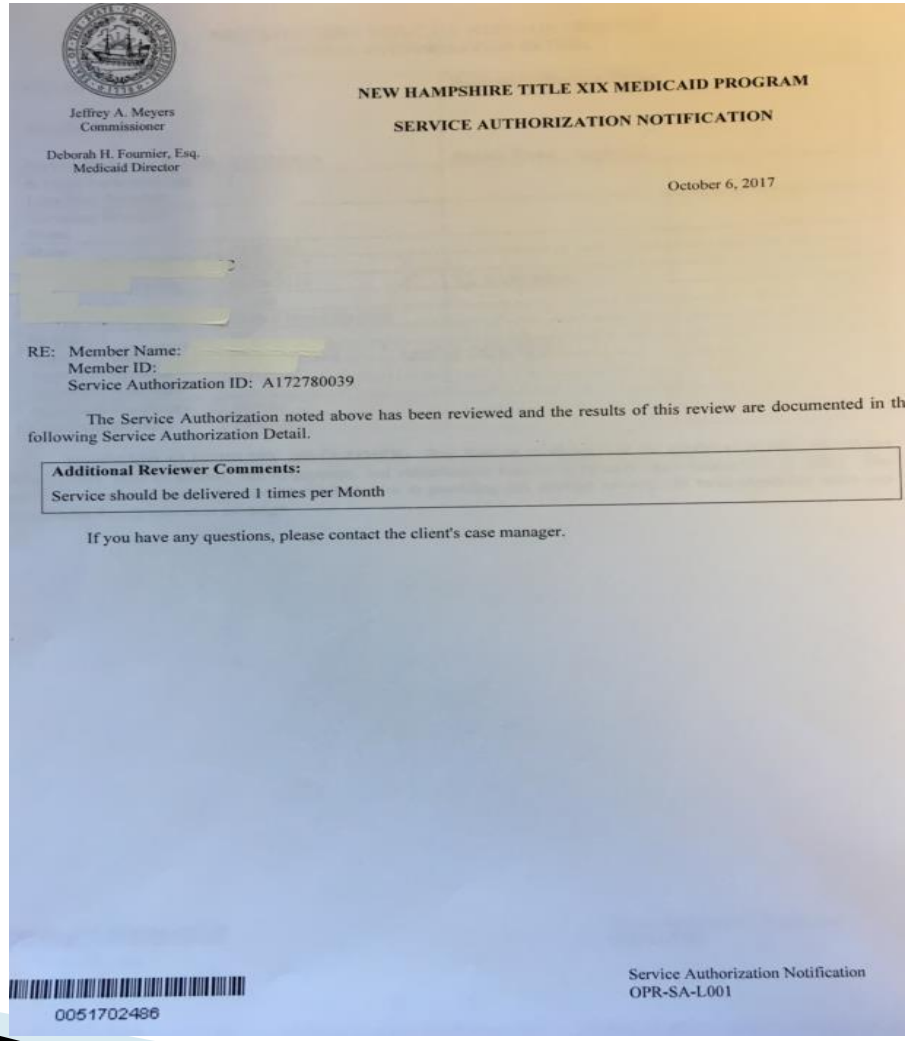
Member ID: 00000000000		**Requesting Provider Name:** ABC Home Health Care	
Member Name: Jane Doe		**Header Status:** Approved	
Service Authorization ID: A170760026			
Service Authorization Line Item Number	1		
Servicing Provider Name	ABC Home Health Care		
Status	Approved		
Approved Begin Date	03/09/2017	>= 52wks 1day	
Approved End Date	03/08/2018		
Service Code	T1019		
Service Description	Personal Care Agency Directed		
Modifier 1	HC		
Modifier 2	U1		
Approved Units	3,129.00	÷ 52 wks = 60.17	
Approved Amount	$14,393.40		
Approved Rate/Unit			
Approved Frequency	Week		
Last Updated Date	05/08/2017		

MEDICAID ELIGIBILITY DISCLAIMER: This form is notification of the approved service, the proper billing codes, units of service, rate of payment, and authorization number to be used upon submission of claim. The member's Medicaid eligibility must be checked prior to providing any medical services for valid eligibility dates and

Authorized nurse visit monthly



Providers automated notification from MMIS



Jeffrey A. Meyers
Commissioner

Deborah H. Fournier, Esq.
Medicaid Director

NEW HAMPSHIRE TITLE XIX MEDICAID PROGRAM

SERVICE AUTHORIZATION NOTIFICATION

October 6, 2017

RE: Member Name:
Member ID:
Service Authorization ID: A172780039

The Service Authorization noted above has been reviewed and the results of this review are documented in th following Service Authorization Detail.

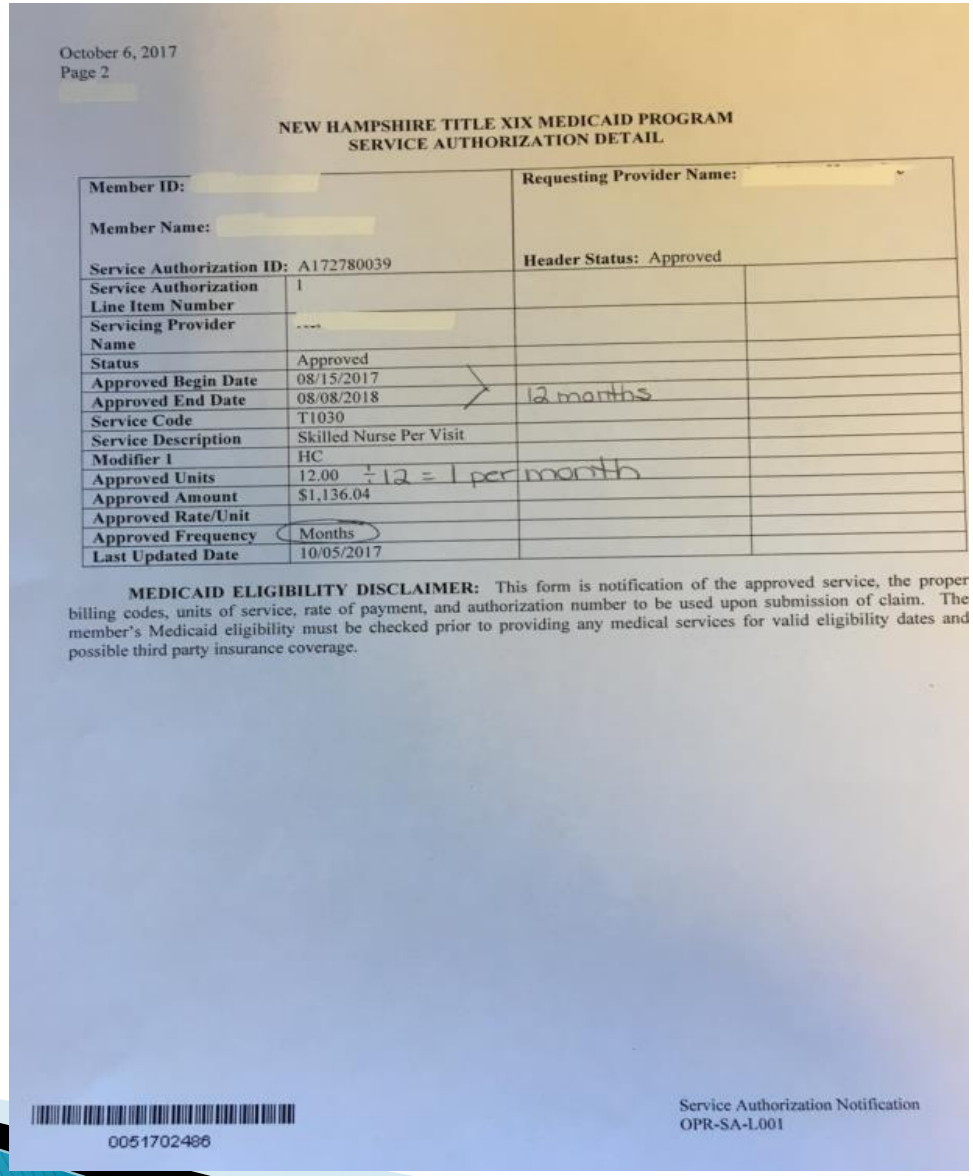
Additional Reviewer Comments:
Service should be delivered 1 times per Month

If you have any questions, please contact the client's case manager.

0051702486

Service Authorization Notification
OPR-SA-L001

Providers automated notification from MMIS detail page



October 6, 2017
Page 2

NEW HAMPSHIRE TITLE XIX MEDICAID PROGRAM
SERVICE AUTHORIZATION DETAIL

Member ID:		**Requesting Provider Name:**	
Member Name:			
Service Authorization ID:	A172780039	**Header Status:** Approved	
Service Authorization Line Item Number	1		
Servicing Provider Name	---		
Status	Approved		
Approved Begin Date	08/15/2017		
Approved End Date	08/08/2018	12 months	
Service Code	T1030		
Service Description	Skilled Nurse Per Visit		
Modifier 1	HC		
Approved Units	12.00	÷12 = 1 per month	
Approved Amount	$1,136.04		
Approved Rate/Unit			
Approved Frequency	Months		
Last Updated Date	10/05/2017		

MEDICAID ELIGIBILITY DISCLAIMER: This form is notification of the approved service, the proper billing codes, units of service, rate of payment, and authorization number to be used upon submission of claim. The member's Medicaid eligibility must be checked prior to providing any medical services for valid eligibility dates and possible third party insurance coverage.

0051702486

Service Authorization Notification
OPR-SA-L001

Targeted Case Management

- Case managers monitor the implementation of the person centered plan and participant health and welfare through direct communication and face to face meetings with participants, as required by NH state administrative rule He-E 805.

Specifically:

805.05 (d) The designated case manager shall monitor the services provided to a participant, as follows:

(1) Conduct the case management contacts required for each participant, as follows:

- a. Case management contacts shall include no less than one monthly telephonic contact and one face-to-face contact every 60 days; and

- b. **Each case management contact shall be documented** in a contact note;

- Case managers may increase the frequency of monitoring and contact with each participant, based on an assessment of need and the participant's support system.

Medicaid Personal Care Services

- Medicaid PCS are services provided to eligible beneficiaries according to a State's approved plan, waiver, or demonstration in the beneficiary's home or at other locations.
- PCS are optional Medicaid services, except when they are medically necessary for children eligible for early and periodic screening, diagnostic, and treatment services.
- PCS are categorized as a range of human assistance provided to persons with disabilities and chronic conditions to enable them to accomplish activities of daily living or instrumental activities of daily living.
- An independent or agency-based personal care attendant (PCA) may provide these services.
- Medicaid PCS are different from home health aide services provided through the Medicaid or Medicare home health benefit. However, home health aides may perform PCS in the course of their duties.

Personal Care Services, cont.

- Audits of State Medicaid programs identified five common types of improper PCS payments. They are payments for:
  - Claims without supporting documentation;
  - Services not eligible under State Medicaid policy;
  - Services provided without required supervision;
  - Services provided without State verification of PCA qualifications and
  - Care provided while a beneficiary was in an institution

  Another reason for improper payments in State Medicaid programs involves fraud, waste, and abuse. PCS fraud may subject a provider to State and Federal civil, monetary, and criminal penalties, and exclusion from participation in Federal health care programs like Medicaid.

SERVICE CLAIMS

- All Documentation that supports any service claims billed must be kept in the record.
- All Service claims must include the following;
- The specific service provided.
- The name of the employee who provided the service.
- The date and time the service was provided.
- The actual amount of time the employee was at the home providing the service.

Payment Policies

- Skilled nursing services are reimbursed a flat rate per visit, and **only for one visit per day**, at a rate set by the Department.

- A home health aide visit composed of **fewer than 8 units** (with a unit being 15 minutes) of direct care time is **reimbursed a flat rate per visit** at a rate set by the Department. (T1021)

- A home health aide visit composed of **8 or more units** (with a unit being 15 minutes) of direct care time is **reimbursed a flat rate per unit** of direct care time at a rate set by the Department. (G0156)

Date Range Billing

- Billing over a range of dates obscures the dates on which services were actually provided as well as how many units of service are billed for each date of service, preventing opportunities to use this information to detect conflicts involving individual dates of service through prepayment review, data mining, or post-payment audits and investigations.

- Office of Inspector General. (2008, August) report indicated an HHS-OIG audit revealed a major billing vulnerability was PCS claims paid that overlapped with institutional care claims due to date-range billing.

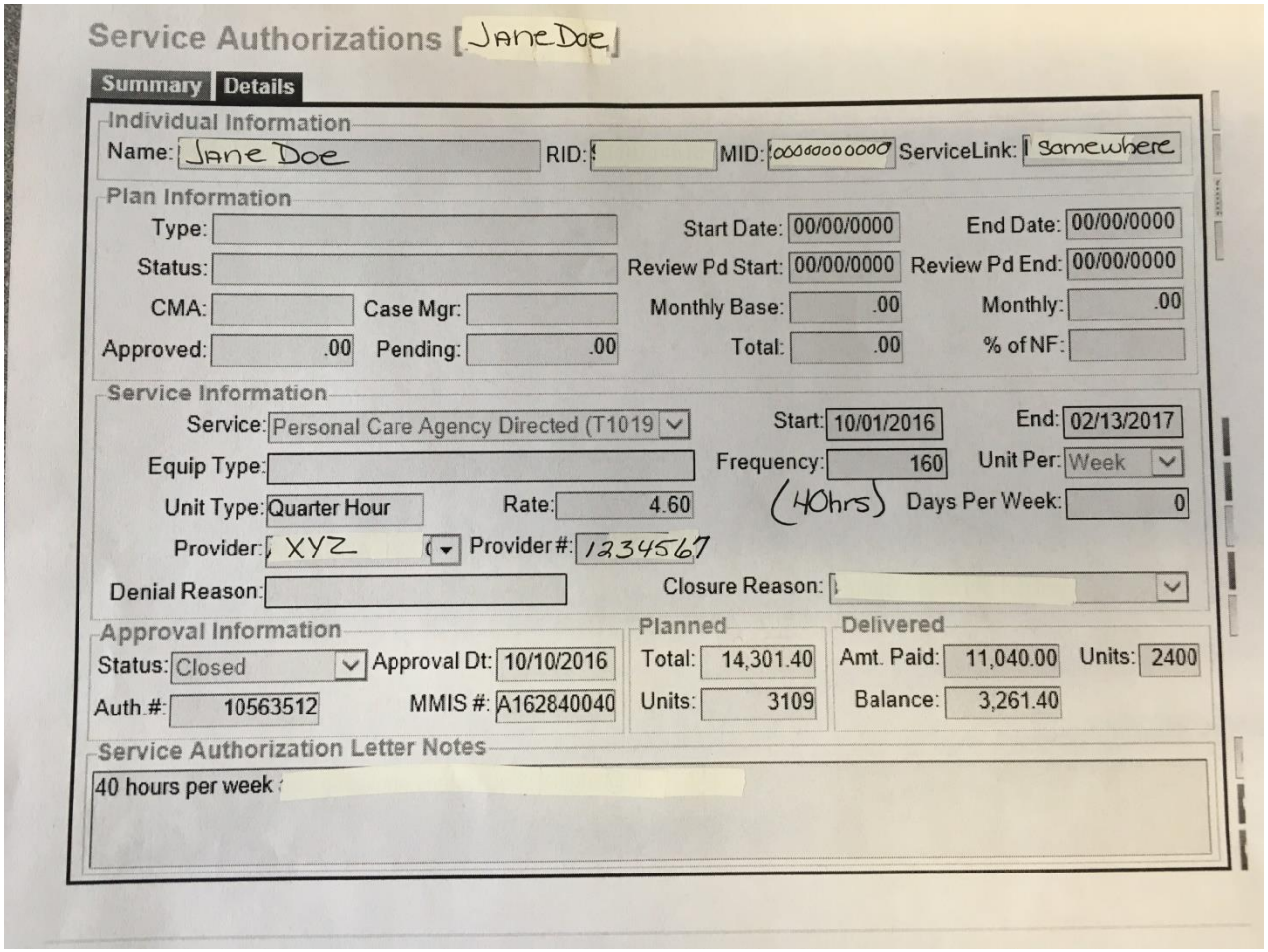
- The State at this time may allow date-range billing for services, but to avoid this vulnerability, providers should address date-range billing in their policies. One option is not to use date-range billing when services were not provided on each day within the date range. Under this approach, providers would also retain documentation that verifies which days services were provided and submit an itemized bill for those periods.

Medical & Social Suspensions

- Case managers request a medical suspension for no longer than a 30 day sequence when the participant has been hospitalized.
- Case managers request a social suspension for no longer than a 30 day sequence when a participant is going to be away with friends or family members.
- Case managers should be documenting the notification to the providers when the suspension starts and ends to divert the opportunity for a provider to continue billing for services when the participant is not in the home. This would be considered a fraudulent claim that would be referred to the Medicaid Fraud Control Unit (MFCU).

EXAMPLES OF CLAIMS SUBMITTED WITH DOCUMENTATION PROBLEMS

Jane Doe example 1



Service Authorizations [Jane Doe]

Summary | Details

Individual Information

Name: Jane Doe RID: MID: 0000000000 ServiceLink: somewhere

Plan Information

Type:			Start Date: 00/00/0000	End Date:	00/00/0000
Status:			Review Pd Start: 00/00/0000	Review Pd End:	00/00/0000
CMA:		Case Mgr:	Monthly Base: .00	Monthly:	.00
Approved:	.00	Pending: .00	Total: .00	% of NF:	

Service Information

Service: Personal Care Agency Directed (T1019 Start: 10/01/2016 End: 02/13/2017

Equip Type: Frequency: 160 Unit Per: Week

Unit Type: Quarter Hour Rate: 4.60 (40hrs) Days Per Week: 0

Provider: XYZ Provider #: 1234567

Denial Reason: Closure Reason:

Approval Information

Status: Closed Approval Dt: 10/10/2016

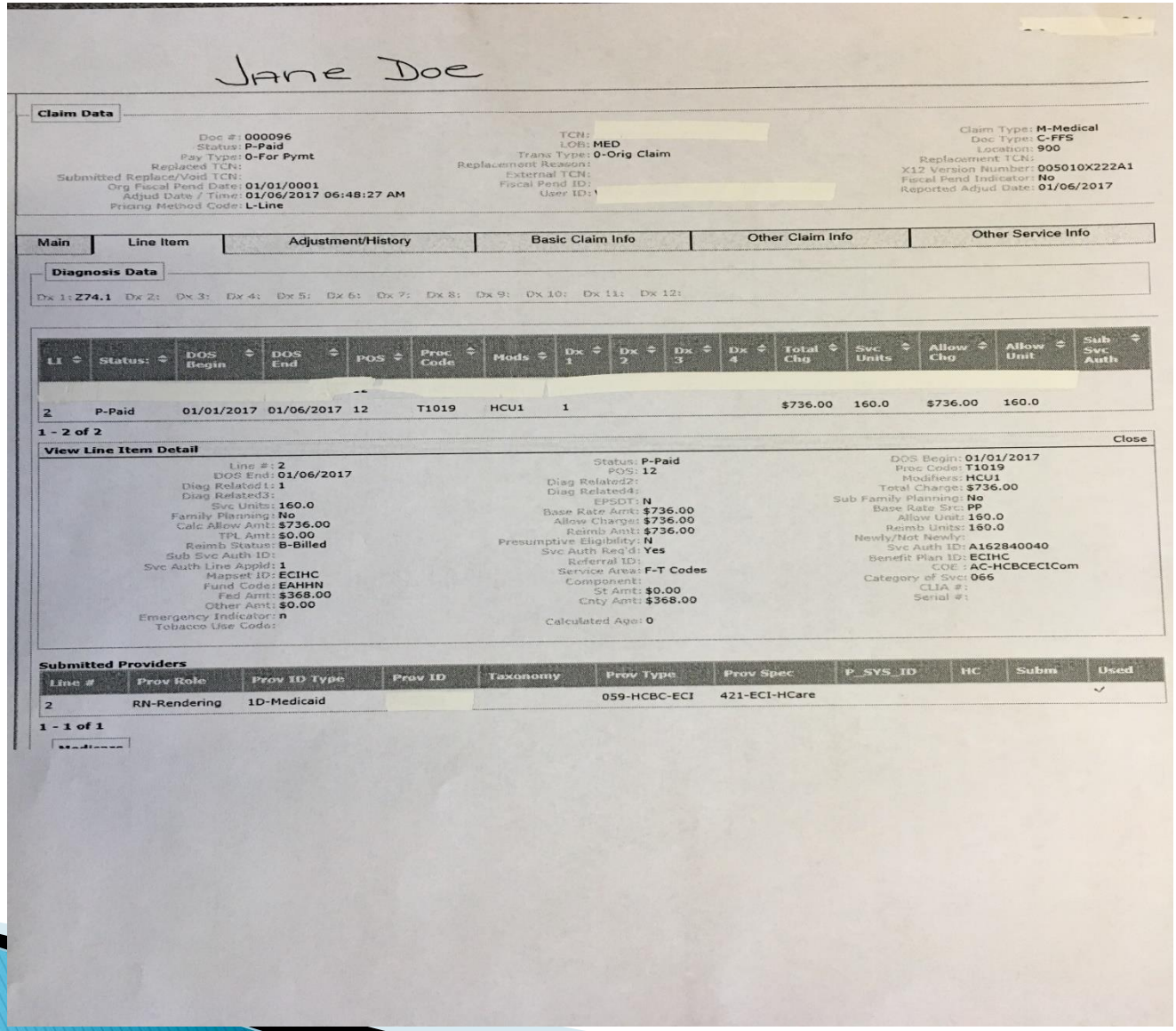
Auth.#: 10563512 MMIS #: A162840040

Planned		Delivered		
Total:	14,301.40	Amt. Paid:	11,040.00	Units: 2400
Units:	3109	Balance:	3,261.40	

Service Authorization Letter Notes

40 hours per week

Jane Doe ex 1 claim submitted



Jane Doe

Claim Data

Doc #: 000096
Status: P-Paid
Pay Type: 0-For Pymt
Replaced TCN:
Submitted Replace/Void TCN:
Org Fiscal Pend Date: 01/01/0001
Adjud Date / Time: 01/06/2017 06:48:27 AM
Pricing Method Code: L-Line

TCN:
LOB: MED
Trans Type: 0-Orig Claim
Replacement Reason:
External TCN:
Fiscal Pend ID:
User ID:

Claim Type: M-Medical
Doc Types: C-FFS
Location: 900
Replacement TCN:
X12 Version Number: 005010X222A1
Fiscal Pend Indicator: No
Reported Adjud Date: 01/06/2017

Main | Line Item | Adjustment/History | Basic Claim Info | Other Claim Info | Other Service Info

Diagnosis Data

Dx 1: Z74.1 Dx 2: Dx 3: Dx 4: Dx 5: Dx 6: Dx 7: Dx 8: Dx 9: Dx 10: Dx 11: Dx 12:

LI	Status:	DOS Begin	DOS End	POS	Proc Code	Mods	Dx 1	Dx 2	Dx 3	Dx 4	Total Chg	Svc Units	Allow Chg	Allow Unit	Sub Svc Auth
2	P-Paid	01/01/2017	01/06/2017	12	T1019	HCU1	1				$736.00	160.0	$736.00	160.0	

1 - 2 of 2

Close

View Line Item Detail

Line #: 2
DOS End: 01/06/2017
Diag Related1: 1
Diag Related3:
Svc Units: 160.0
Family Planning: No
Calc Allow Amt: $736.00
TPL Amt: $0.00
Reimb Status: B-Billed
Sub Svc Auth ID:
Svc Auth Line Appld: 1
Mapset ID: ECIHC
Fund Code: EAHHN
Fed Amt: $368.00
Other Amt: $0.00
Emergency Indicator: n
Tobacco Use Code:

Status: P-Paid
POS: 12
Diag Related2:
Diag Related4:
EPSDT: N
Base Rate Amt: $736.00
Allow Charge: $736.00
Reimb Amt: $736.00
Presumptive Eligibility: N
Svc Auth Req'd: Yes
Referral ID:
Service Area: F-T Codes
Component:
St Amt: $0.00
Cnty Amt: $368.00

Calculated Age: 0

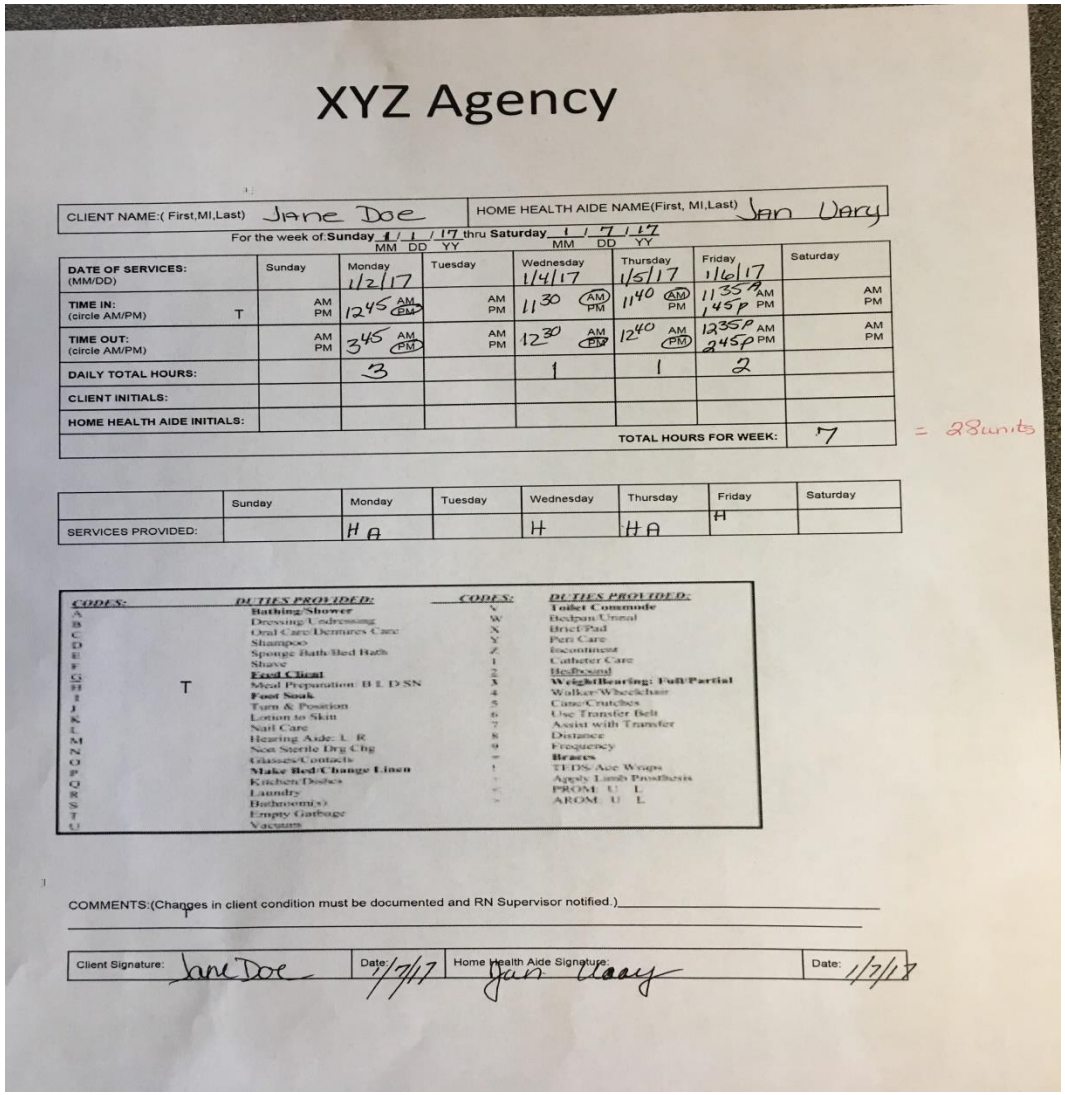
DOS Begin: 01/01/2017
Proc Code: T1019
Modifiers: HCU1
Total Charge: $736.00
Sub Family Planning: No
Base Rate Src: PP
Allow Unit: 160.0
Reimb Units: 160.0
Newly/Not Newly:
Svc Auth ID: A162840040
Benefit Plan ID: ECIHC
COE : AC-HCBCECICom
Category of Svc: 066
CLIA #:
Serial #:

Submitted Providers

Line #	Prov Role	Prov ID Type	Prov ID	Taxonomy	Prov Type	Prov Spec	P_SYS_ID	HC	Subm	Used
2	RN-Rendering	1D-Medicaid			059-HCBC-ECI	421-ECI-HCare				✓

1 - 1 of 1

Jane Doe ex 1 time sheet review for claim submitted 1/1/17-1/6/17



XYZ Agency

CLIENT NAME:(First,MI,Last) Jane Doe

HOME HEALTH AIDE NAME(First, MI,Last) Jan Vary

For the week of: **Sunday** 1 / 1 / 17 (MM DD YY) thru **Saturday** 1 / 7 / 17 (MM DD YY)

DATE OF SERVICES: (MM/DD)	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
TIME IN: (circle AM/PM) T	AM PM	1245 AM (PM)	AM PM	1130 (AM) PM	1140 (AM) PM	1135 AM 145p PM	AM PM
TIME OUT: (circle AM/PM)	AM PM	345 AM (PM)	AM PM	1230 AM (PM)	1240 AM (PM)	1235p AM 245p PM	AM PM
DAILY TOTAL HOURS:		3		1	1	2	
CLIENT INITIALS:							
HOME HEALTH AIDE INITIALS:							
					TOTAL HOURS FOR WEEK:		7

= 28units

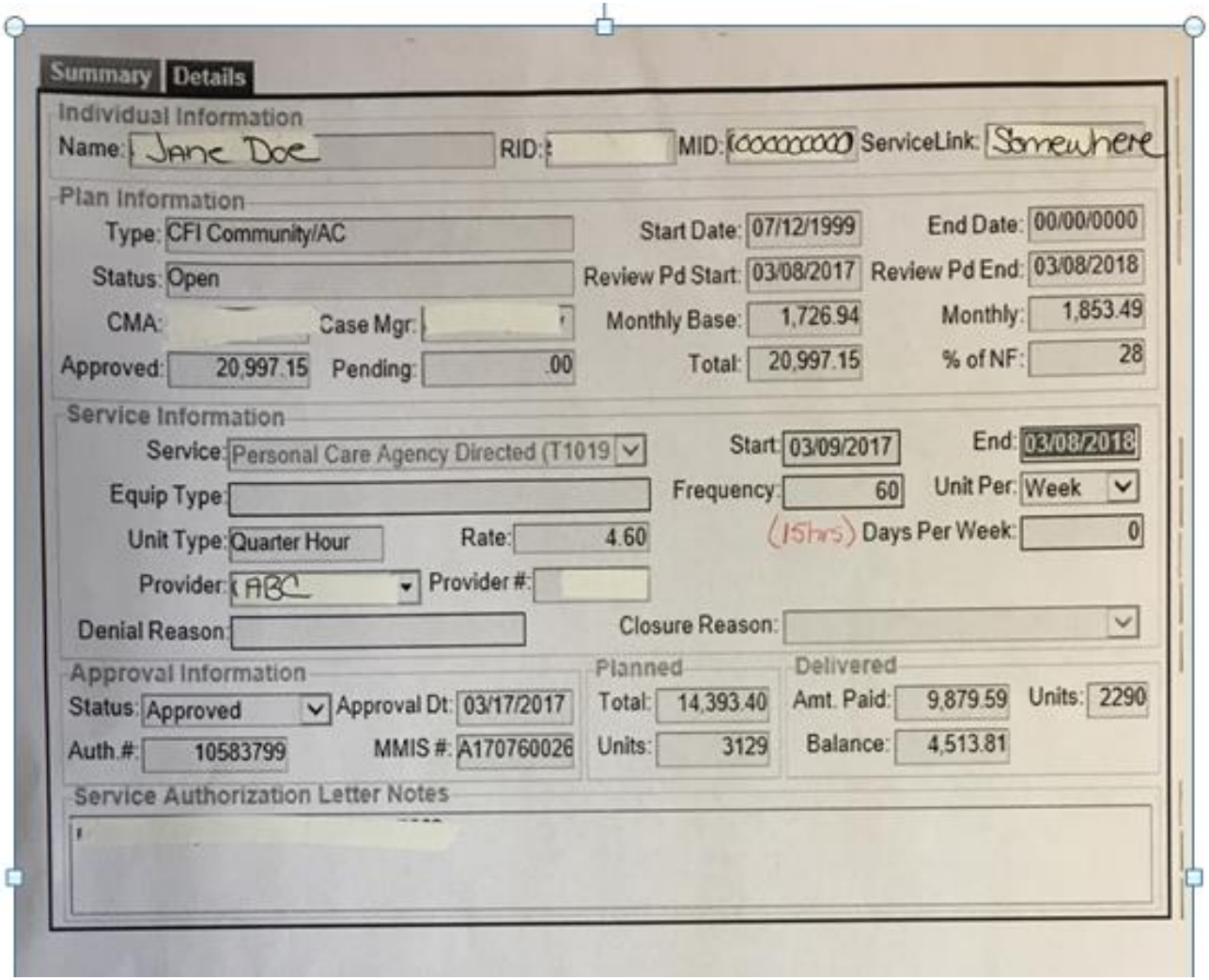
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
SERVICES PROVIDED:		H A		H	H A	H	

CODES:	DUTIES PROVIDED:	CODES:	DUTIES PROVIDED:
A	**Bathing/Shower**	V	**Toilet Commode**
B	Dressing/Undressing	W	Bedpan/Urinal
C	Oral Care/Dentures Care	X	Brief/Pad
D	Shampoo	Y	Peri Care
E	Sponge Bath/Bed Bath	Z	Incontinent
F	Shave	1	Catheter Care
G	**Feed Client**	2	Re-Positnl
H T	Meal Preparation: B L D SN	3	**Weightbearing: Full/Partial**
I	**Foot Soak**	4	Walker/Wheelchair
J	Turn & Position	5	Cane/Crutches
K	Lotion to Skin	6	Use Transfer Belt
L	Nail Care	7	Assist with Transfer
M	Hearing Aide: L R	8	Distance
N	Non Sterile Dry Clg	9	Frequency
O	Glasses/Contacts	=	**Braces**
P	**Make Bed/Change Linen**	!	TEDS/Ace Wraps
Q	Kitchen/Dishes	+	Apply Limb Prosthesis
R	Laundry	-	PROM: U L
S	Bathroom(s)	>	AROM: U L
T	Empty Garbage		
U	Vacuum		

COMMENTS:(Changes in client condition must be documented and RN Supervisor notified.)

Client Signature: Jane Doe	Date: 1/7/17	Home Health Aide Signature: Jan Vary	Date: 1/7/17

Jane Doe example 2



Summary | Details

Individual Information

Name: Jane Doe RID: MID: (00000000) ServiceLink: Somewhere

Plan Information

Type: CFI Community/AC
Start Date: 07/12/1999
End Date: 00/00/0000
Status: Open
Review Pd Start: 03/08/2017
Review Pd End: 03/08/2018
CMA:
Case Mgr:
Monthly Base: 1,726.94
Monthly: 1,853.49
Approved: 20,997.15
Pending: .00
Total: 20,997.15
% of NF: 28

Service Information

Service: Personal Care Agency Directed (T1019
Start: 03/09/2017
End: 03/08/2018
Equip Type:
Frequency: 60
Unit Per: Week
Unit Type: Quarter Hour
Rate: 4.60
(15hrs) Days Per Week: 0
Provider: ABC
Provider #:
Denial Reason:
Closure Reason:

Approval Information

Status: Approved
Approval Dt: 03/17/2017
Auth.#: 10583799
MMIS #: A170760026

Planned

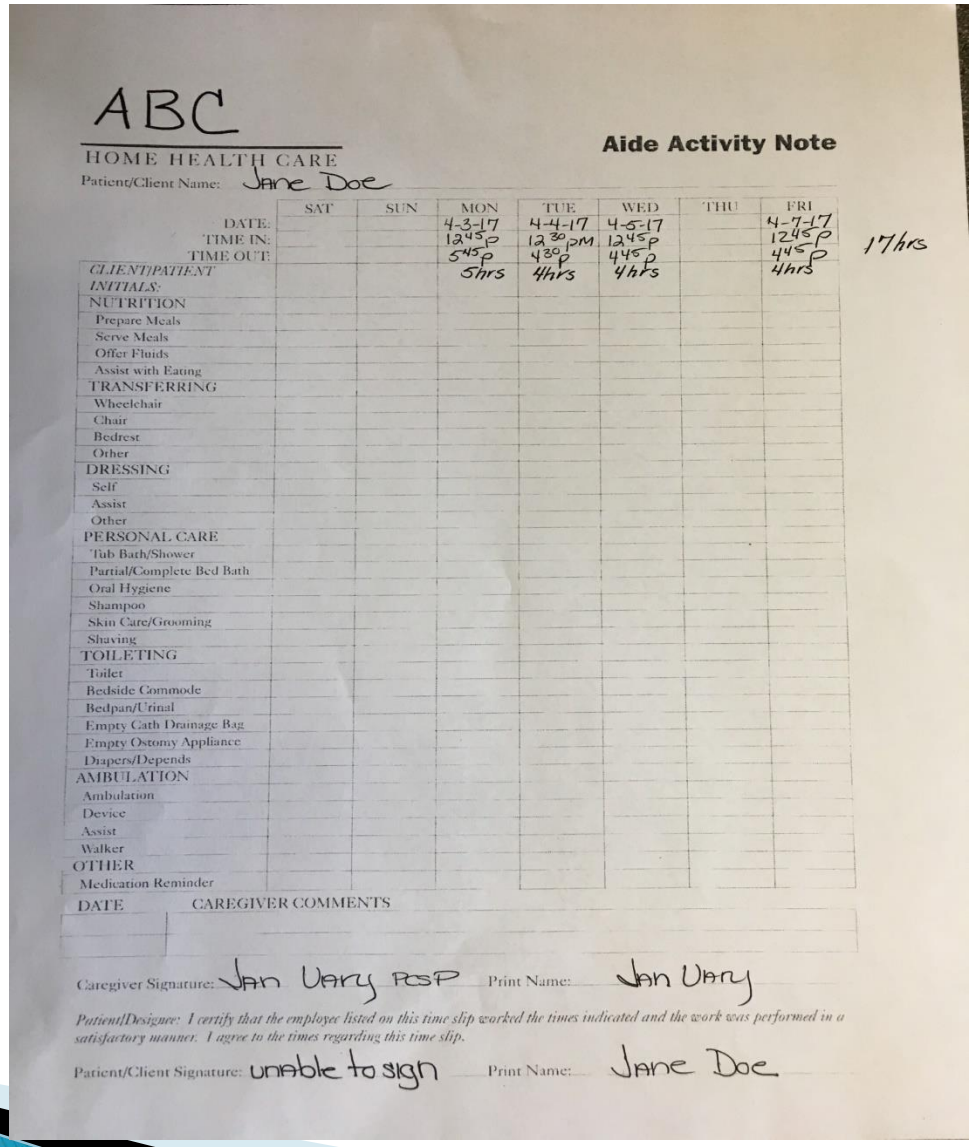
Total: 14,393.40
Units: 3129

Delivered

Amt. Paid: 9,879.59
Units: 2290
Balance: 4,513.81

Service Authorization Letter Notes

Jane Doe ex 2 time sheet review



ABC

HOME HEALTH CARE

Aide Activity Note

Patient/Client Name: Jane Doe

	SAT	SUN	MON	TUE	WED	THU	FRI
DATE:			4-3-17	4-4-17	4-5-17		4-7-17
TIME IN:			1245p	1230pM	1245p		1245p
TIME OUT			545p	430p	445p		445p
CLIENT/PATIENT INITIALS:			5hrs	4hrs	4hrs		4hrs
NUTRITION							
Prepare Meals							
Serve Meals							
Offer Fluids							
Assist with Eating							
TRANSFERRING							
Wheelchair							
Chair							
Bedrest							
Other							
DRESSING							
Self							
Assist							
Other							
PERSONAL CARE							
Tub Bath/Shower							
Partial/Complete Bed Bath							
Oral Hygiene							
Shampoo							
Skin Care/Grooming							
Shaving							
TOILETING							
Toilet							
Bedside Commode							
Bedpan/Urinal							
Empty Cath Drainage Bag							
Empty Ostomy Appliance							
Diapers/Depends							
AMBULATION							
Ambulation							
Device							
Assist							
Walker							
OTHER							
Medication Reminder							

17hrs

DATE CAREGIVER COMMENTS

Caregiver Signature: Jan Uary RCSP Print Name: Jan Uary

Patient/Designee: I certify that the employee listed on this time slip worked the times indicated and the work was performed in a satisfactory manner. I agree to the times regarding this time slip.

Patient/Client Signature: unable to sign Print Name: Jane Doe

Jane Doe example 3

Jane Doe 3 is a CFI client who is authorized to receive the following services:

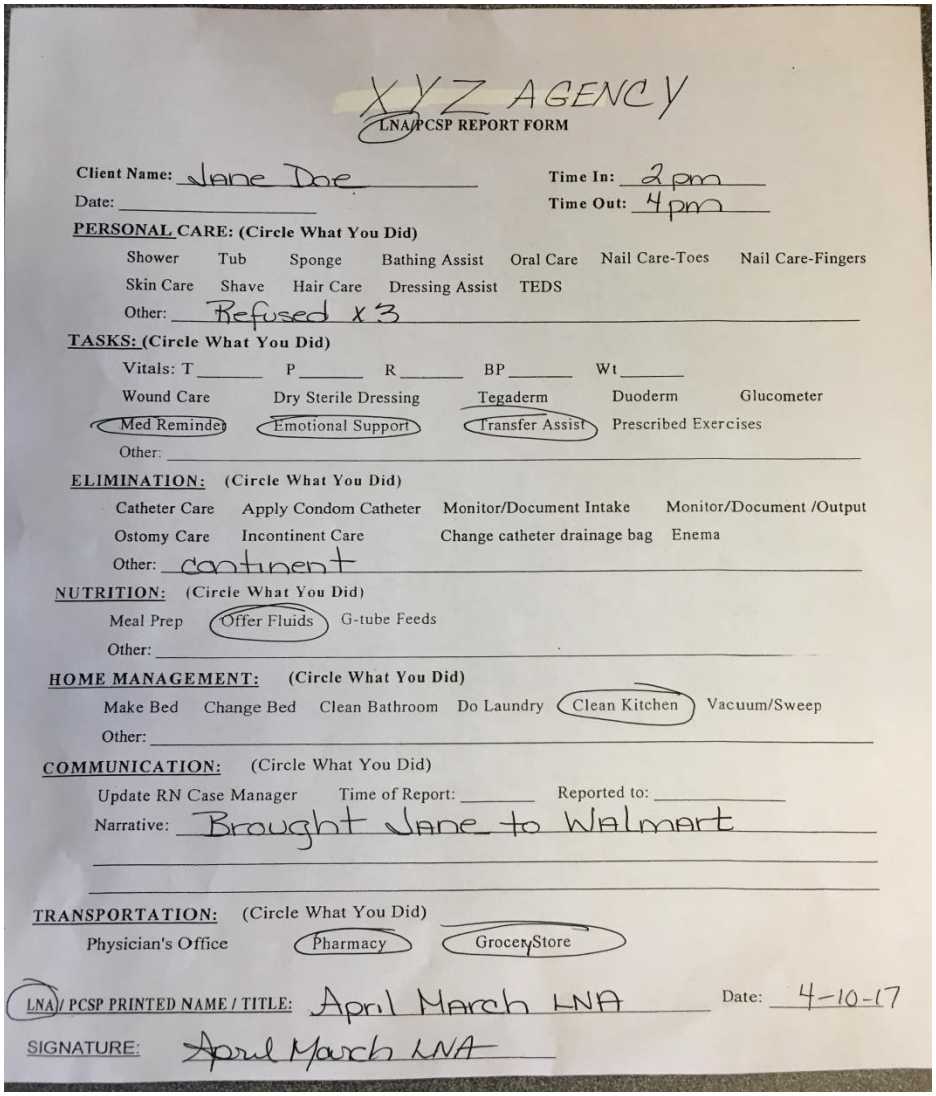
- Case Manager
- Home Health Aide 3 visits per week
- Personal Care Service Provider 16units/week (4hrs)
- Nurse visit once per month
- Personal emergency response system

Jane Doe ex 3 Claim Review

During a review of Jane's service claims it revealed:

- no personal care service provider claims since October 2016.
- The home health aide claims were over the authorized 3x/week.
- Records were requested for review.

Jane Doe example 3



XYZ AGENCY

LNA/PCSP REPORT FORM

Client Name: Jane Doe Time In: 2pm

Date: _____ Time Out: 4pm

PERSONAL CARE: (Circle What You Did)

Shower Tub Sponge Bathing Assist Oral Care Nail Care-Toes Nail Care-Fingers

Skin Care Shave Hair Care Dressing Assist TEDS

Other: Refused x 3

TASKS: (Circle What You Did)

Vitals: T _____ P _____ R _____ BP _____ Wt _____

Wound Care Dry Sterile Dressing Tegaderm Duoderm Glucometer

(Med Reminder) (Emotional Support) (Transfer Assist) Prescribed Exercises

Other: _____

ELIMINATION: (Circle What You Did)

Catheter Care Apply Condom Catheter Monitor/Document Intake Monitor/Document /Output

Ostomy Care Incontinent Care Change catheter drainage bag Enema

Other: continent

NUTRITION: (Circle What You Did)

Meal Prep (Offer Fluids) G-tube Feeds

Other: _____

HOME MANAGEMENT: (Circle What You Did)

Make Bed Change Bed Clean Bathroom Do Laundry (Clean Kitchen) Vacuum/Sweep

Other: _____

COMMUNICATION: (Circle What You Did)

Update RN Case Manager Time of Report: _____ Reported to: _____

Narrative: Brought Jane to Walmart

TRANSPORTATION: (Circle What You Did)

Physician's Office (Pharmacy) (Grocery Store)

(LNA) / PCSP PRINTED NAME / TITLE: April March LNA Date: 4-10-17

SIGNATURE: April March LNA

Jane Doe example 4

- Jane through the CFI program is authorized to received 80 units/week (20hrs) of personal care service from XYZ agency.

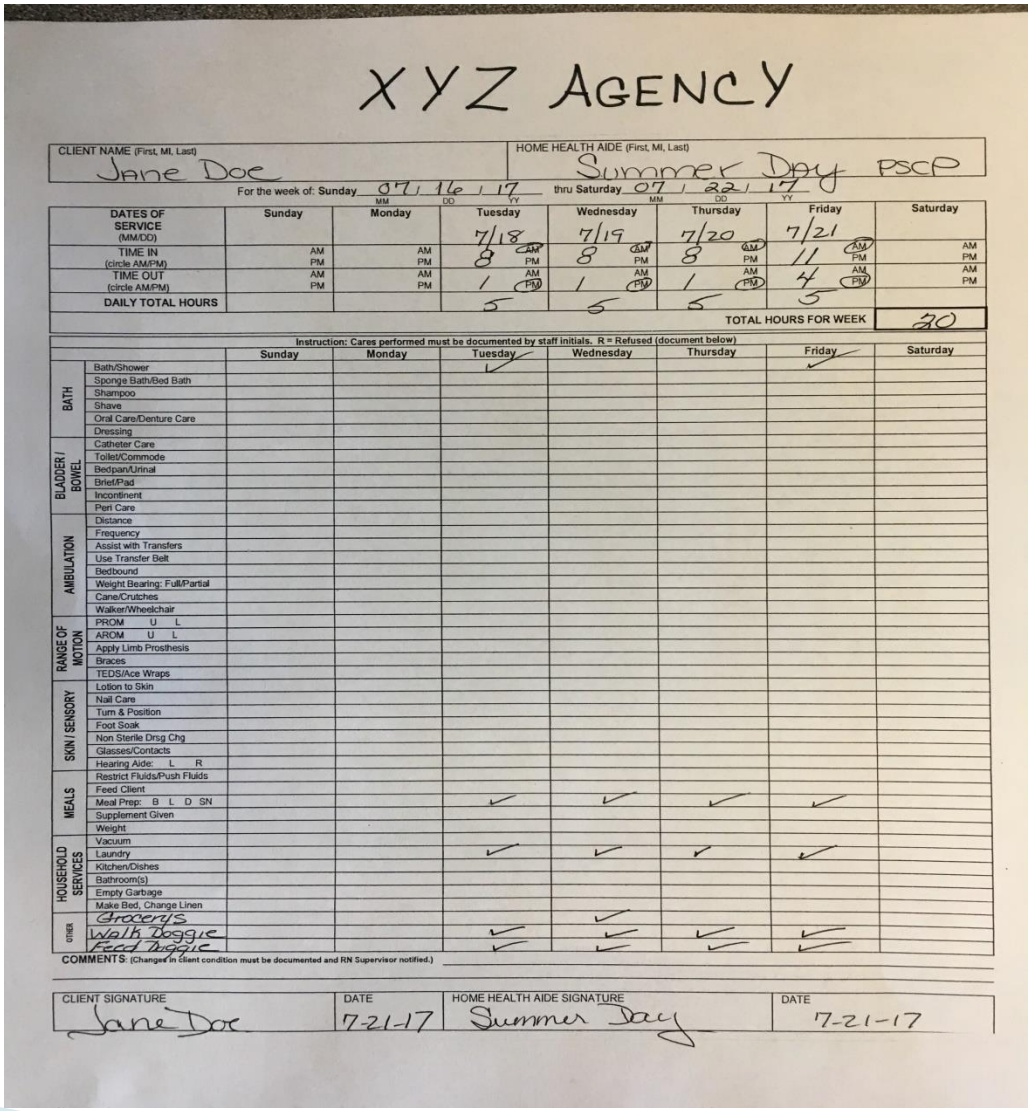
During a recent record review of Jane's personal care services it revealed in the PSCP care plan the following:

Jane has a dog as a service animal (Doggie)

Janes care plan indicates:

Assistance with service animal; PCSP to assist with Doggie, service dog as directed by Jane, may include feeding, hydration and walks for elimination.

Jane Doe ex 4 Time sheet



XYZ AGENCY

CLIENT NAME (First, MI, Last): Jane Doe

HOME HEALTH AIDE (First, MI, Last): Summer Day PSCP

For the week of: Sunday 07 / 16 / 17 (MM / DD / YY) thru Saturday 07 / 22 / 17 (MM / DD / YY)

DATES OF SERVICE (MM/DD)	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			7/18	7/19	7/20	7/21	
TIME IN (circle AM/PM)	AM / PM	AM / PM	8 AM / PM	8 AM / PM	8 AM / PM	11 AM / PM	AM / PM
TIME OUT (circle AM/PM)	AM / PM	AM / PM	1 AM / PM	1 AM / PM	1 AM / PM	4 AM / PM	AM / PM
DAILY TOTAL HOURS			5	5	5	5	
TOTAL HOURS FOR WEEK							20

Instruction: Cares performed must be documented by staff initials. R = Refused (document below)

		Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
BATH	Bath/Shower			✓			✓	
	Sponge Bath/Bed Bath							
	Shampoo							
	Shave							
	Oral Care/Denture Care							
	Dressing							
BLADDER / BOWEL	Catheter Care							
	Toilet/Commode							
	Bedpan/Urinal							
	Brief/Pad							
	Incontinent							
	Peri Care							
AMBULATION	Distance							
	Frequency							
	Assist with Transfers							
	Use Transfer Belt							
	Bedbound							
	Weight Bearing: Full/Partial							
	Cane/Crutches							
	Walker/Wheelchair							
RANGE OF MOTION	PROM U L							
	AROM U L							
	Apply Limb Prosthesis							
	Braces							
	TEDS/Ace Wraps							
SKIN / SENSORY	Lotion to Skin							
	Nail Care							
	Turn & Position							
	Foot Soak							
	Non Sterile Drsg Chg							
	Glasses/Contacts							
	Hearing Aide: L R							
MEALS	Restrict Fluids/Push Fluids							
	Feed Client							
	Meal Prep: B L D SN			✓	✓	✓	✓	
	Supplement Given							
	Weight							
HOUSEHOLD SERVICES	Vacuum							
	Laundry			✓	✓	✓	✓	
	Kitchen/Dishes							
	Bathroom(s)							
	Empty Garbage							
	Make Bed, Change Linen							
OTHER	Groceries				✓			
	Walk Doggie			✓	✓	✓	✓	
	Feed Doggie			✓	✓	✓	✓	

COMMENTS: (Changes in client condition must be documented and RN Supervisor notified.)

CLIENT SIGNATURE	DATE	HOME HEALTH AIDE SIGNATURE	DATE
Jane Doe	7-21-17	Summer Day	7-21-17

PET CARE

There is no reimbursement for Pet Care, to include; grooming, feeding, walking etc.

This includes Service Animals as well.

General Billing Manual - December 2018
Chapter 6.0 Non-Covered Services Pg. 6-2
Non-covered services include, but are not limited to: **Service and therapy animals**.

Exclusion of Providers

In section 4.10 of the General Billing Manual it indicates how providers should be performing checks.

-Exclusions are sanctions imposed by state or federal agencies prohibiting individuals, health care practices, corporations, and/or other entities from participating in Medicaid and Medicare programs.

-State and federal rules and regulations prohibit health care providers and entities from employing or entering into contracts with excluded individuals or entities to provide items or services to Medicaid members.

**Providers should check the Federal Department of Health and Human Services, Office of Inspector General's (OIG) web site at: https://exclusions.oig.hhs.gov that provides a searchable national database of all excluded individuals and entities.

This site is updated monthly and should be checked monthly for determining exclusion of current employees and contractors.

Exclusion of Providers (cont.)

New Hampshire Medicaid Provider Participation Agreement

- I acknowledge that I have an obligation to regularly screen **all** employees and contractors (utilizing the List of Excluded Individuals/Entities-LEIE-website at http://www.oig.hhs.gov/fraud/exclusions.asp and/or any other exclusion lists or instructions provided by NH Title XIX Program) to determine whether any of them have been excluded from participation in Federal health care programs, to report to Title XIX any exclusion information discovered, and I agree to comply with these obligations.

Exclusion of Providers (cont.)

What does this mean if a provider doesn't perform the checks?

Under certain circumstances, healthcare providers may be held financially liable for employing or contracting with excluded individuals or entities. In addition to full restitution, providers may be subject to Civil Monetary Penalties (CMP) of up to $10,000 for each item or service furnished by the excluded individual or entity.

All providers are urged to take precautionary measures to ensure that they are not employing or contracting with excluded individuals/entities.

Exclusion of Providers (cont.)

In order to avoid employing or contracting with an excluded individual or entity, it is recommended that providers:

- Check all potential employees or contractors via the OIG web site noted above;
- Include a question on all applications for employment asking whether the applicant **has ever** been excluded from participating in Medicaid and/or Medicare,
- Include a question on all applications for employment asking whether the applicant **is currently** excluded from participating in Medicaid and/or Medicare,
- Ask the applicant to produce documentation from the federal Department of Health and Human Services and/or any state departments, as applicable, that administer Medicaid Programs indicating the applicant's reinstatement into Medicaid and/or Medicare, if an applicant indicates that their exclusion has expired; and
- Institute an ongoing process to monthly verify that all current employees and contractors are not listed on the OIG exclusion database

Reminder

- Even though you may be billing electronically, as a Medicaid provider it is important to notify submit any change of address or contact information as soon as possible.
- Change of Provider Information Form can be found at: https://nhmmis.nh.gov/portals/wps/portal/DocumentsandForms

- Program Integrity also must be informed in writing if you are not going to be participating as a Medicaid provider any longer and include your ending date.

References

- CFI Provider Billing Manual
https://nhmmis.nh.gov/portals/wps/portal/EnterpriseHome

- CFI Administrative Rule He-E 801and He-E 805
http://www.gencourt.state.nh.us/rules/state_agencies/he-e800.html

- Preventing Medicaid Improper Payments for Personal Care Services booklet
https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/personal-care-services.html

- Change of Provider Information Form can be found at:
https://nhmmis.nh.gov/portals/wps/portal/DocumentsandForms

Questions?