256B.0651 HOME CARE SERVICES.

Subdivision 1. **Definitions.** (a) "Activities of daily living" includes eating, toileting, grooming, dressing, bathing, transferring, mobility, and positioning.

(b) "Assessment" means a review and evaluation of a recipient's need for home care services conducted in person. Assessments for home health agency services shall be conducted by a home health agency nurse. Assessments for medical assistance home care services for developmental disability and alternative care services for developmentally disabled home and community-based waivered recipients may be conducted by the county public health nurse to ensure coordination and avoid duplication. Assessments must be completed on forms provided by the commissioner within 30 days of a request for home care services by a recipient or responsible party.

(c) "Home care services" means a health service, determined by the commissioner as medically necessary, that is ordered by a physician and documented in a service plan that is reviewed by the physician at least once every 60 days for the provision of home health services, or private duty nursing, or at least once every 365 days for personal care. Home care services are provided to the recipient at the recipient's residence that is a place other than a hospital or long-term care facility or as specified in section 256B.0625.

(d) "Medically necessary" has the meaning given in Minnesota Rules, parts 9505.0170 to 9505.0475.

(e) "Telehomecare" means the use of telecommunications technology by a home health care professional to deliver home health care services, within the professional's scope of practice, to a patient located at a site other than the site where the practitioner is located.

Subd. 2. **Services covered.** Home care services covered under this section and sections 256B.0653 to 256B.0656 include:

(1) nursing services under section 256B.0625, subdivision 6a;

(2) private duty nursing services under section 256B.0625, subdivision 7;

(3) home health services under section 256B.0625, subdivision 6a;

(4) personal care assistant services under section 256B.0625, subdivision 19a;

(5) supervision of personal care assistant services provided by a qualified professional under section 256B.0625, subdivision 19a;

(6) qualified professional of personal care assistant services under the fiscal intermediary option as specified in section 256B.0655, subdivision 7;

(7) face-to-face assessments by county public health nurses for services under section 256B.0625, subdivision 19a; and

(8) service updates and review of temporary increases for personal care assistant services by the county public health nurse for services under section 256B.0625, subdivision 19a.

Subd. 3. **Noncovered home care services.** The following home care services are not eligible for payment under medical assistance:

(1) skilled nurse visits for the sole purpose of supervision of the home health aide;

(2) a skilled nursing visit:

(i) only for the purpose of monitoring medication compliance with an established medication program for a recipient; or

(ii) to administer or assist with medication administration, including injections, prefilling syringes for injections, or oral medication set-up of an adult recipient, when as determined and documented by the registered nurse, the need can be met by an available pharmacy or the recipient is physically and mentally able to self-administer or prefill a medication;

(3) home care services to a recipient who is eligible for covered services under the Medicare program or any other insurance held by the recipient;

(4) services to other members of the recipient's household;

(5) a visit made by a skilled nurse solely to train other home health agency workers;

(6) any home care service included in the daily rate of the community-based residential facility where the recipient is residing;

(7) nursing and rehabilitation therapy services that are reasonably accessible to a recipient outside the recipient's place of residence, excluding the assessment, counseling and education, and personal assistant care;

(8) any home health agency service, excluding personal care assistant services and private duty nursing services, which are performed in a place other than the recipient's residence; and

(9) Medicare evaluation or administrative nursing visits on dual-eligible recipients that do not qualify for Medicare visit billing.

Subd. 4. **Prior authorization; exceptions.** All home care services above the limits in subdivision 11 must receive the commissioner's prior authorization, except when:

(1) the home care services were required to treat an emergency medical condition that if not immediately treated could cause a recipient serious physical or mental disability, continuation

of severe pain, or death. The provider must request retroactive authorization no later than five working days after giving the initial service. The provider must be able to substantiate the emergency by documentation such as reports, notes, and admission or discharge histories;

(2) the home care services were provided on or after the date on which the recipient's eligibility began, but before the date on which the recipient was notified that the case was opened. Authorization will be considered if the request is submitted by the provider within 20 working days of the date the recipient was notified that the case was opened;

(3) a third-party payor for home care services has denied or adjusted a payment. Authorization requests must be submitted by the provider within 20 working days of the notice of denial or adjustment. A copy of the notice must be included with the request;

(4) the commissioner has determined that a county or state human services agency has made an error; or

(5) the professional nurse determines an immediate need for up to 40 skilled nursing or home health aide visits per calendar year and submits a request for authorization within 20 working days of the initial service date, and medical assistance is determined to be the appropriate payer.

Subd. 5. **Retroactive authorization.** A request for retroactive authorization will be evaluated according to the same criteria applied to prior authorization requests.

Subd. 6. **Prior authorization.** The commissioner, or the commissioner's designee, shall review the assessment, service update, request for temporary services, request for flexible use option, service plan, and any additional information that is submitted. The commissioner shall, within 30 days after receiving a complete request, assessment, and service plan, authorize home care services as follows:

(a) **Home health services.** All home health services provided by a home health aide must be prior authorized by the commissioner or the commissioner's designee. Prior authorization must be based on medical necessity and cost-effectiveness when compared with other care options. When home health services are used in combination with personal care and private duty nursing, the cost of all home care services shall be considered for cost-effectiveness. The commissioner shall limit home health aide visits to no more than one visit each per day. The commissioner, or the commissioner's designee, may authorize up to two skilled nurse visits per day.

(b) **Ventilator-dependent recipients.** If the recipient is ventilator-dependent, the monthly medical assistance authorization for home care services shall not exceed what the commissioner would pay for care at the highest cost hospital designated as a long-term hospital under the Medicare program. For purposes of this paragraph, home care services means all services

provided in the home that would be included in the payment for care at the long-term hospital. "Ventilator-dependent" means an individual who receives mechanical ventilation for life support at least six hours per day and is expected to be or has been dependent for at least 30 consecutive days.

Subd. 7. **Prior authorization; time limits.** The commissioner or the commissioner's designee shall determine the time period for which a prior authorization shall be effective and, if flexible use has been requested, whether to allow the flexible use option. If the recipient continues to require home care services beyond the duration of the prior authorization, the home care provider must request a new prior authorization. A personal care provider agency must request a new personal care assistant services assessment, or service update if allowed, at least 60 days prior to the end of the current prior authorization time period. The request for the assessment must be made on a form approved by the commissioner. Under no circumstances, other than the exceptions in subdivision 4, shall a prior authorization be valid prior to the date the commissioner receives the request or for more than 12 months. A recipient who appeals a reduction in previously authorized home care services may continue previously authorized services, other than temporary services under subdivision 8, pending an appeal under section 256.045. The commissioner must provide a detailed explanation of why the authorized services are reduced in amount from those requested by the home care provider.

Subd. 8. **Prior authorization requests; temporary services.** The agency nurse, the independently enrolled private duty nurse, or county public health nurse may request a temporary authorization for home care services by telephone. The commissioner may approve a temporary level of home care services based on the assessment, and service or care plan information, and primary payer coverage determination information as required. Authorization for a temporary level of home care services including nurse supervision is limited to the time specified by the commissioner, but shall not exceed 45 days, unless extended because the county public health nurse has not completed the required assessment and service plan, or the commissioner's determination has not been made. The level of services authorized under this provision shall have no bearing on a future prior authorization.

Subd. 9. **Prior authorization for foster care setting.** Home care services provided in an adult or child foster care setting must receive prior authorization by the department according to the limits established in subdivision 11.

The commissioner may not authorize:

(1) home care services that are the responsibility of the foster care provider under the terms of the foster care placement agreement and administrative rules;

(2) personal care assistant services when the foster care license holder is also the personal care provider or personal care assistant unless the recipient can direct the recipient's own care, or case management is provided as required in section 256B.0625, subdivision 19a;

(3) personal care assistant services when the responsible party is an employee of, or under contract with, or has any direct or indirect financial relationship with the personal care provider or personal care assistant, unless case management is provided as required in section 256B.0625, subdivision 19a; or

(4) personal care assistant and private duty nursing services when the number of foster care residents is greater than four unless the county responsible for the recipient's foster placement made the placement prior to April 1, 1992, requests that personal care assistant and private duty nursing services be provided, and case management is provided as required in section 256B.0625, subdivision 19a.

Subd. 10. **Limitation on payments.** Medical assistance payments for home care services shall be limited according to subdivisions 4 to 12 and sections 256B.0654, subdivision 2, and 256B.0655, subdivisions 3 and 4.

Subd. 11. **Limits on services without prior authorization.** A recipient may receive the following home care services during a calendar year:

(1) up to two face-to-face assessments to determine a recipient's need for personal care assistant services;

(2) one service update done to determine a recipient's need for personal care assistant services; and

(3) up to nine skilled nurse visits.

Subd. 12. **Approval of home care services.** The commissioner or the commissioner's designee shall determine the medical necessity of home care services, the level of caregiver according to subdivision 2, and the institutional comparison according to subdivisions 4 to 12 and sections 256B.0654, subdivision 2, and 256B.0655, subdivisions 3 and 4, the cost-effectiveness of services, and the amount, scope, and duration of home care services reimbursable by medical assistance, based on the assessment, primary payer coverage determination information as required, the service plan, the recipient's age, the cost of services, the recipient's medical condition, and diagnosis or disability. The commissioner may publish additional criteria for determining medical necessity according to section 256B.04.

Subd. 13. **Recovery of excessive payments.** The commissioner shall seek monetary recovery from providers of payments made for services which exceed the limits established in

this section and sections 256B.0653 to 256B.0656. This subdivision does not apply to services provided to a recipient at the previously authorized level pending an appeal under section 256.045, subdivision 10.

History: *1986 c 444; 1990 c 568 art 3 s 51; 1991 c 292 art 7 s 12,25; 1992 c 391 s 3-6; 1992 c 464 art 2 s 1; 1992 c 513 art 7 s 50; 1Sp1993 c 1 art 5 s 51-53; 1995 c 207 art 6 s 52-55; 1996 c 451 art 5 s 17-20; 1997 c 203 art 4 s 28,29; 3Sp1997 c 3 s 9; 1998 c 407 art 4 s 29-31; 1999 c 245 art 4 s 50-58; 2000 c 474 s 8-11; 1Sp2001 c 9 art 3 s 29-41; 2002 c 375 art 2 s 17; 2002 c 379 art 1 s 113; 2003 c 15 art 1 s 33; 1Sp2003 c 14 art 3 s 26-28; 2005 c 10 art 1 s 49,50; 2005 c 56 s 1; 1Sp2005 c 4 art 7 s 15-19; 2007 c 147 art 7 s 8*