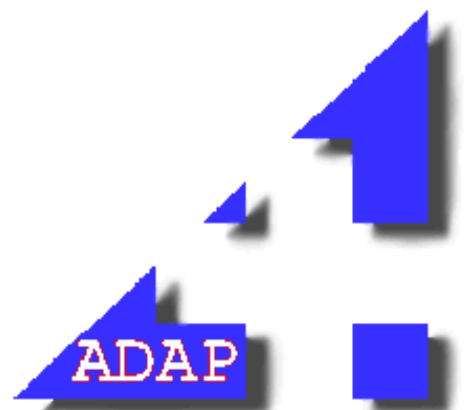


**NEW YORK STATE
DEPARTMENT OF HEALTH
AIDS INSTITUTE**

**UNINSURED CARE PROGRAMS
HOME CARE PROVIDER MANUAL**

**Uninsured Care Programs
Empire Station
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NEW YORK STATE DEPARTMENT OF HEALTH AIDS INSTITUTE

UNINSURED CARE PROGRAMS PROVIDER MANUAL FOR HOME CARE

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NEW YORK STATE DEPARTMENT OF HEALTH AIDS INSTITUTE

UNINSURED CARE PROGRAMS PROVIDER MANUAL FOR HOME CARE

A. PURPOSE OF HOMECARE SERVICES

To assist uninsured or underinsured persons living with HIV/AIDS obtain necessary home medical care and treatments, the AIDS Institute/New York State Department of Health has implemented a reimbursement pool that pays for home care services.

The Uninsured Care Programs provide enrolled home care agencies, hospice, and adult day health care providers with reimbursement for pre-approved home care services, up to a lifetime limit of \$30,000 per participant. This initiative is funded through a partnership between New York State and the planning councils of the New York City, Long Island, Lower Hudson and Dutchess County Regions.

B. PROVIDER ELIGIBILITY

All Home Care Agencies or Adult Day Health Care providers which are licensed or certified with the New York State Department of Health Bureau of Long Term Care are encouraged to enroll in the Uninsured Care Programs' Home Care Program.

Types of agencies which are eligible to enroll:

- Adult Day Health Care (ADHC) – (medical model only)
- AIDS Home Care Programs (AHCP)
- Certified Home Health Agencies (CHHA)
- Hospice
- Licensed Home Care Service Agencies (LHCSA)
- Long Term Home Health Care Programs (LTHHCP)

In addition to meeting the requirements outlined in this manual, home care agencies/providers must meet the record-keeping requirements for their particular type of facility outlined in regulations of the New York State Department of Health.

Please note that for the Uninsured Care Program's purposes, records must be maintained for six years from date of payment. To find out more about Provider enrollment call the Uninsured Care Programs Administration Department at (518-459-1641).

C. POPULATION TO BE SERVED – CLIENT ELIGIBILITY

The UCP's Home Care program will pay for services provided to HIV-infected New York State residents who are uninsured or under-insured for home care services and who meet established eligibility criteria. Applicants who have partial insurance or limitations on their insurance will be eligible. The agency applying for service reimbursement will be responsible for the coordination of benefits with insurance companies.

CLIENT ELIGIBILITY

1. Residency - New York State
2. Medical - HIV infection, chronic medical dependency and home health care ordered by a physician
3. Financial
 - Income for a household of one \$44,000 per year; \$59,200 for two and \$74,400 for three or more.
 - Liquid Assets less than \$25,000
 - Uninsured or Underinsured – meeting established program criteria

When home care applications are made for participants already enrolled in ADAP (AIDS Drug Assistance Program), ADAP Plus (Primary Care coverage), and/or APIC (ADAP Plus Insurance Continuation), Client Services staff review the eligibility file and residence information included in the homecare application. Such reviews often generate Missing Information Letters (MILs) requesting updated residence, income, assets, and insurance information from the applicant. Failure to provide the missing information may prompt an interruption in program services. As applicants are often coming out of the hospital and or in acute medical distress, Uninsured Care Programs' Client Services staff seek out hospital social workers, community case managers, family members and/or home care agency staff for assistance in providing the requested updates.

D. CLIENT ENROLLMENT PROCESS

- Applicants may apply to any of the Uninsured Care Programs by providing proof of residency, income and assets. A medical application, verifying HIV infection and indicating medical/disease status, completed by a physician, physician assistant, or nurse practitioner is required. (see Attachments A and B for examples of these forms).
- Once standard eligibility requirements are met, an additional application process must be completed for home care services.
 1. Physicians, Discharge planners or Home care providers must prepare an **AI485** Home Health Certification and Plan of Treatment (Attachment C), specifically indicating the types, level and hours of home assistance required.

(* Note: Although Home Care Services may be started without a Physicians signature, payment will not be made without receipt of the A1485, complete with Physicians signature.)

2. All home care services are pre-certified by Client Services staff at the Uninsured Care Program for a specific period not to exceed two months.
3. A **Nursing Assessment** (Attachment D) must accompany the Home Health Certification and Plan of Treatment (AI485).
4. If any Durable Medical Equipment or supply items are required, an **AI3615** (Prior Approval Request Form) must be submitted. (Attachment E).

Upon determination of eligibility for home care services, the home care provider will receive a pre-authorization letter detailing the participant's identification number, certification period, care plan authorization number, specific services and rates, as well as any Durable Medical Equipment which has been approved. The participant will be sent an ADAP/ ADAP Plus Identification Card indicating approval for homecare reimbursement and a letter listing the name of the pre-approved home care agency, the services approved, and the remaining home care benefits. If the ADAP/ ADAP Plus card indicates approval for ADAP and/or ADAP Plus the participant may use the card to obtain primary care services or medications from an enrolled provider.

E. MEDICAID

Individuals enrolled in Medicaid are not eligible for any of the Uninsured Care Programs. Individuals awaiting Medicaid eligibility determination are eligible. The program will interface with Medicaid to prevent duplication of enrollment and billing. The program will seek, at eligibility determination and at recertification periods, to identify individuals who are potentially eligible for Medicaid and encourage them to apply for Medicaid. Home Care Providers, whose skilled nursing service rates/services include assistance in applying for benefits, are required to identify and encourage Medicaid application for potentially eligible clients.

Due to the \$30,000 lifetime cap for HIV Uninsured Care Programs home care benefits, it is imperative that participants pursue Medicaid when applicable. It is the responsibility of the home care agency to assist with the Medicaid application process. Cobra case management agencies may be able to assist with Medicaid applications as well. Home care providers can call HIV Uninsured Care Program hotline staff at (800) 542-2437 to obtain names and telephone numbers of participating agencies in their area.

F. MEDICAID SPENDDOWN DIRECT

In an effort to reduce expenses and expedite service provision, a process called Medicaid Spenddown Direct billing was established for Medicaid enrolled home care agencies to directly bill the program for services provided to participants with a Medicaid Spenddown.

Traditionally, individuals with disability income (SSD) and low assets may be eligible for a Medicaid Spenddown; which refers to the amount of income the client makes over the allowable income level for Medicaid eligibility. Normally the client must incur this monthly dollar amount and provide proof in order for him/her to be eligible for active Medicaid. The HIV Uninsured Care Program is authorized to pay the spenddown or surplus amount for eligible participants, qualifying them for full Medicaid. The majority of spenddowns are met via pharmacy payments through the ADAP portion of the HIV Uninsured Care Programs. However, alternative health related payments, including Medicare premiums and insurance premiums may also be utilized to meet an individual's monthly Spenddown.

If Spenddowns cannot be met via the options listed above, providers who are actively enrolled with Medicaid and have enrolled as a Medicaid Spenddown direct provider with the Uninsured Care Programs may collect the participant's monthly Medicaid Spenddown amount directly from the HIV Uninsured Care Programs provided the cost of the monthly services exceed the monthly Spenddown amount.

To exercise Medicaid Spenddown Direct an agency would (see attached F):

- Verify they (the agency) are currently active with NYS Medicaid and eligible to directly collect the Medicaid Spenddown amount from a Medicaid Spenddown eligible individual for services provided.
- Send an informal "Notice of Intent of Home Care Services" (faxed request for homecare on letterhead, including: statement regarding request for Medicaid Spenddown Direct, participant name, ADAP ID #, Start of Care, and current Spenddown amount).
- If spenddown information is different from our records, a Notice of Decision or updated Medicaid Spenddown information will be requested.
- If approved the home care agency will receive a Medicaid Spenddown Direct letter
- **No AI485, Nursing Assessment or recertification is needed for Medicaid Spenddown Direct approval.**

G. REIMBURSABLE SERVICES UNDER HOME CARE PROGRAM

The services that are reimbursable by the Uninsured Care Programs under the HIV Home Care Program include:

Skilled Nursing Visits Home Health Services Personal Care Services Homemaker Services	}	When justified as a medical necessity in the supporting documentation. Applicant must also be considered "homebound" in that they need supervision when leaving their home.
Intravenous Therapy Administration & Supplies		
Durable Medical Equipment (Including Oxygen and Supplies)*		
Adult Day Treatment (Medical Model)		
Nutritional counseling (Maximum of 12 annually)**		
Physical Therapy (limited to 3 lifetime visits)		

*The applicant must meet the home care criteria and be approved for home care services to receive DME. The Uninsured Care Programs cannot cover DME alone.

**Agencies other than AIDS Home Care Programs and Long Term Home Health Care Programs must provide the license number and name of the Certified Nutritionist or the Registration Number and name of the Registered Dietician in order to be eligible for pre-certification of Nutritional Counseling Services.

EXCLUSIONS FROM HOMECARE COVERAGE (HOMECARE SERVICES FOR WHICH PAYMENT IS NOT ALLOWED)

In an effort to contain costs and provide an incentive for enrollment in Medicaid, certain restrictions have been placed on payments to Providers. As a general reference, the following is a list of services that do not qualify for payment:

- Medications/Pharmacy (covered under ADAP)
- Medication adherence/compliance only
- Transportation Services (either for the participant or Home Health Care Worker)
- Substance Abuse & Alcoholism Services(Methadone Maintenance)
- Case Management/Social Work
- Mental Health Nursing Visits
- Speech Therapy
- Occupational Therapy
- Respiratory Therapy
- TPN or PPN (Administration only is covered)
- In-Patient Services
- Orthotics/Prosthetics

In addition to those services specifically excluded, payment will not be made for medical care and services:

- Which are medically unnecessary
- Which are rendered outside of the participant's certification period
- Which are fraudulently claimed

- Which represent abuse or overuse
- Which are provided only because of the participant's personal preference
- Which are rendered in the absence of authorization from the Program
- Which have already been rejected or disallowed by the HIV Uninsured Care Program when the rejection was based upon findings that the services or supplies provided:
 - Were not medically necessary
 - Were fraudulently claimed
 - Represented abuse or overuse
 - Were inappropriate
 - Were provided outside of New York State

Providers must offer the same quality of service to Home Care Program participants that they commonly extend to the general public.

H. REIMBURSEMENT

The Uninsured Care Programs will use the established Medicaid and New York State Department of Health rate schedules and coding for payment of covered services to simplify billing and ensure consistency. Home Care Providers will submit claims on the Uninsured Care Program Claim Form (Attachment G) or standard UB92 or HCFA 1500. The establishment of electronic HIPAA compliant homecare billing is in process. Providers will be notified when the Uninsured Care Program is ready to accept electronic billing.

All billing must include provider ID number, participant ID number, date(s) of service and services billed, care plan number, and certification period. The provider should ensure that the services and disciplines listed on the claim form **exactly** match the services and disciplines listed on the letter of authorization.

- The HIV Uninsured Care Programs will not reimburse claims submitted in excess of 90 days of the date of service.
- All reimbursement is paid at either the agency Medicaid rate or the regional rate currently on file with the HIV Uninsured Care Programs. No retroactive rate adjustments are processed. It is the responsibility of the home care agency/provider to submit Medicaid rate changes to the HIV Uninsured Care Programs.
- The total of any approved services not billed to or reimbursed by the HIV Uninsured Care Programs, either due to late claim submissions or non-delivery of services, will be reapplied to the participant's available home care benefit balance.
- Acceptance of payment from the HIV Uninsured Care Programs implies agreement by the home care provider to accept fee paid as payment in full. Home care agencies may not bill participants for balances incurred as a result of rate or service definition discrepancies between the provider and the HIV Uninsured Care Programs.
- The HIV Uninsured Care Programs does not reimburse DME vendors. Payment for requested DME equipment is made directly to the home care agency based on Medicaid rates. Updated average DME rates have been established for some recurring non standard DME items. Vendors who only provide DME are not eligible to enroll as homecare providers with the HIV Uninsured Care Programs. The home care agency is responsible for arranging services through a local DME vendor, submitting all prior approval documentation and ensuring required supplies or equipment have been delivered to adequately provide required home care services. Home care providers are required to both bill for and reimburse as appropriate the DME vendor in a timely manner.
- No co-payment will be charged to participants.

I. COORDINATION OF INSURANCE BENEFITS

If a participant has third-party insurance coverage, he/she is required to inform the home care agency and the Uninsured Care Programs of that coverage. Home care agencies/providers are responsible for maximizing private health insurance benefits prior to billing the HIV Uninsured Care Programs. The HIV Uninsured Care Programs Home Care Program can be used to supplement existing home care benefits, if those benefits are insufficient to meet the health care needs of the patient. **It is the responsibility of the home care agency to coordinate benefits and bill insurance carriers as appropriate.** The HIV Uninsured Care Program should **always** be the payer of last resort. Written confirmation of home health care benefits will be required before services can be authorized by the HIV Uninsured Care Programs.

Some third party health insurers have preferred provider restrictions or other limitations. If a participant's health insurer requires a specific homecare agency, supplemental reimbursement will not be approved unless the agency is a participating provider with the Uninsured Care Programs.

Private health insurance policies often have specific annual limitations. As January 1st approaches, home care agencies should investigate a participant's private health insurance benefits. Exhausted benefits may be reinstated with the new calendar year.

The Uninsured Care programs do not cover private health insurance co-payments for home care. Additionally, the program will not cover outstanding account balances that are incurred as a result of partial payments by private insurance companies.

J. MEDICARE

The HIV Uninsured Care Program may not be billed for Medicare covered services for which the provider agrees not to charge a beneficiary under the terms of their Medicare provider agreement or for services for which the beneficiary cannot be held liable by the provider under existing Medicare regulations.

Approvals for home care services for participants with Medicare are usually made to a certified agency (CHHA), Long-term homehealth care program (LTHHCP), or Hospice. However, licensed agencies may be preferable if the services requested are custodial or otherwise not covered by Medicare. The HUCP can be used to supplement Medicare home care benefits.

Home care services will not be approved for the sole purpose of covering a DME item not covered by Medicare.

K. CARE RENDERED AS A RESULT OF AN ACCIDENT OR INJURY

Worker's Compensation benefits include all necessary medical care arising from job-related injury or illness. Therefore, no Home Care Program payments will be made for services covered by Worker's Compensation. In case of work-related injuries or illness, providers and participants may obtain information from the nearest Worker's Compensation Board Office or the participant's employer. In the case of injuries resulting from an accident, medical payments may be available from Worker's Compensation, auto or homeowner's liability insurance policies, etc.

L. UTILIZATION REVIEW, RECORD KEEPING, AUDIT AND CLAIM REVIEW

Record-Keeping Requirements

Federal Law and State Regulations require Providers to maintain financial and health records necessary to fully disclose the extent of services, care, and supplies provided to Home Care Program participants. Providers must furnish information regarding any payment claimed to authorized officials upon request of the New York State Department of Health.

Home Care agencies providing services must keep medical records on each participant to whom care is rendered. The minimum content of the participant record **MUST** include:

- Participant identification (name, sex, age, etc.);
- Conditions or reasons for which care is provided;
- Nature and full description of services provided;
- Type of services ordered;
- The dates of service provided and ordered
- Nursing notes
- Home Health Aide, Personal Care Aide, or Homemaker site certification sheets if these services were provided

The maintenance and furnishing of information relative to care included on a HIV Uninsured Care Home Care claim is a basic condition for participation in the program. For audit purposes, records on participants must be maintained and be available to authorized HIV Uninsured Care Program officials for six years following the date of payment. Failure to conform with these requirements may affect payment and may jeopardize a Provider's eligibility to continue enrollment with the program.

Unacceptable Practice

An unacceptable practice is conduct by a person which conflicts with any of the policies, standards or procedures of the State of New York or Federal statute or regulation which relates to the quality of care, services and supplies or the fiscal integrity of the Program. Examples of unacceptable practices include, but are not limited to the following:

- knowingly making a claim for an improper amount or for unfurnished, inappropriate or unnecessary care, services or supplies;
- practicing a profession fraudulently beyond its authorized scope, including the rendering of care, services or supplies while one's license to practice is suspended or revoked;
- failing to maintain records necessary to fully disclose the extent of the care, services or supplies furnished;
- submitting bills or accepting payment for care, services or supplies rendered by a person suspended or disqualified from participating in Home Care Program; soliciting, receiving, offering or agreeing to make any payment for the purpose of influencing a Home Care Program participant to either utilize or refrain from utilizing any particular source of care, services or supplies; and
- knowingly demanding or collecting any compensation in addition to claims paid by the Program.

Audit and Claim Review

- A. Providers shall be subject to audit by the Department of Health, Health Research, Inc. or its designees. With respect to such audits, the provider may be required:
1. to reimburse the department for overpayments discovered by audits; and
 2. to pay restitution for any direct or indirect monetary damage to the program resulting from their improperly or inappropriately furnishing covered services.
- B. The Department of Health may conduct audits and claim reviews, and investigate potential fraud or abuse in a provider's conduct.
- C. The Department of Health or Health Research, Inc. may pay or deny claims, or delay claims for audit review.
- D. When audit findings indicate that a provider has provided covered services in a manner which may be inconsistent with regulations governing the program, or with established standards for quality, or in an otherwise unauthorized manner, the Department of Health may summarily suspend a provider's participation in the program and/or payment of all claims submitted and all future claims may be delayed or suspended. When claims are delayed or suspended, a notice of withholding payment or recoupment shall be sent to the provider by the department. This notice shall inform the provider that within 30 days he/she may request in writing an administrative review of the audit determination before a designee of the Department of Health. The review must occur and a decision rendered within a reasonable time after a request for recoupment is warranted, or if no request for review is made by the provider within the 30 days provided, the department shall continue to recoup or withhold funds pursuant to the audit determination.

Where investigation indicates evidence of abuse by a provider, the provider may be fined, suspended, restricted or terminated from the program.

Audits and Recovery of Overpayments

- (a) Recovery of overpayments shall be made only upon a determination by the Department of Health that such overpayments have been made, and recovery shall be made of all money paid to the provider to which it has no lawful right or entitlement.
- (b) Recovery of overpayments pursuant to this subject shall not preclude the Department of Health, Health Research or any other authorized governmental body or agency from taking any other action with respect to the provider, including auditing or reviewing other payments, or claims for payment for the same or similar periods, imposing program sanctions, or taking any other action authorized by law.
- (c) The Department of Health or Health Research, Inc. may utilize any lawful means to recover overpayments, including civil lawsuit, participation in a proceeding in bankruptcy, common law set-on, or such other actions or proceedings authorized or recognized by law.
- (d) All fiscal and statistical records and reports of providers and all covered services which are used for the purpose of establishing the provider's right to payment under the program and any underlying books, records, documentation which formed the basis for such fiscal and statistical records and reports shall be subject to audit. All underlying books, records and documentation including all

covered services provided shall be kept and maintained by the provider for a period of not less than six years from the date of completion of such reports, or the date upon which the fiscal and statistical records were required to be filed, whichever is later, or the date the service was provided.

- (e) All claims made under the program shall be subject to audit by the Department of Health, Health Research, Inc. and its agents or designees, for a period of six years from the date of service, this limitation shall not apply to situations in which fraud may be involved or where the provider or an agent thereof prevents or obstructs the performance of an audit pursuant to this Part.

Fraud

Examples of fraud include when a person knowingly:

- Makes a false statement or representation which enables any person to obtain medical services to which he/she is not entitled;
- Presents for payment any false claim for furnishing services or merchandise; Submits false information for the purpose of obtaining greater compensation than that to which he/she is legally entitled;
- Submits false information for the purpose of obtaining authorization for the provision of services or merchandise.

M. PARTICIPANT'S RIGHT TO REFUSE MEDICAL CARE

Federal and State Laws and Regulations provide for Program participants to reject any recommended medical procedure of health care or services and prohibits any coercion to accept such recommended health care. This includes the right to reject care on the grounds of religious beliefs.

N. CESSATION OF SERVICES

Home care agencies are asked to complete the "Cessation of Home Care Services" form (Attachment H) when services are completed or another paysource (i.e. Medicaid) is being billed.

If recertification is not received within 2-3 weeks of the end date of previous homecare certification you will receive a Home Care Termination letter from the Uninsured Care Program.

If your patient is hospitalized for more than seven days during a certification period and home care services are interrupted, a new AI485 and Nursing Assessment will need to be submitted to reinstate authorization for home care services through the Uninsured Care Programs.

O. CONTACT INFORMATION AND INQUIRIES

All information, material requests or correspondence should be directed to:

**UNINSURED CARE PROGRAM
EMPIRE STATION
P.O. BOX 2052
ALBANY, NY 12220-0052
or call: 1-800-542-2437**

APPENDIX C
NEW YORK STATE DEPARTMENT OF HEALTH UNINSURED CARE PROGRAMS HOME CARE

**INSTRUCTIONS FOR COMPLETING HOME HEALTH CERTIFICATION
AND PLAN OF TREATMENT
(AI485 & AI487)**

The AIDS Institute AI485 and 487 forms will be used to meet the requirements for the Physician's Home Health Plan of Treatment and Home Health Certification and recertification.

All components of the form must be completed, signed and dated by the physician. Unsigned forms will be accepted to initiate services. If an order is received unsigned, the Uninsured Care Program requests the signed order within 30 days of original submission. **No claims will be paid until signed orders are received.**

Agency-specific 485 forms, usually computer generated, may be accepted if previewed and approved by Uninsured Care Programs' Client Services staff. Please note the use of the AI485 and 487 forms differ from HCFA 485 because only information specific to the Uninsured Care Program-Home Care is needed.

An addendum (AI 487) can be used to continue care plan information, to report changes in the treatment plan, or to request additional services. Supplemental orders requesting additions to the care plan must be submitted by the home care agency for prior-approval. All AI 487 forms require a physician's signature for payment and should include medical justification for any service change request.

The following definitions and directions correspond to the item numbers on the AI485 form:

- 1.) **Patients HI Claim No.:** Enter the participant's ADAP ID number or social security number
- 2.) **SOC Date:** Enter the six-digit month, day and year on which home health services began (e.g. MMDDYY = 010101). The start-of-care date is the first billable visit. This date remains the same on subsequent plans of treatment until the patient is discharged. Home care may be suspended and later resumed under the same start of care date.
- 3.) **Certification Period:** Enter the two six-digit month, day and year dates, (e.g. MMDDYY = 010101-030101), which identify the period covered by the Physician's Plan of Care. The "From" date for the initial certification must match the start-of-care date. The "To" date can be up to, but never exceed, two calendar months later or 60 days.

The approval period dates may not always match the certification period dates. Length of approval is based on the patient's financial status on file with the ADAP program. In general, patients who appear to meet the Medicaid eligibility requirements are approved for 30 days only. It is expected that these patients will transition to Medicaid as quickly as possible.

NOTE: Any increase or addition of services requires submission of supplemental orders (AI487), dated and signed by the physician, including justification specific to the patient's medical condition.

- 4.) **Medical Record No.:** Enter your agencies internal medical record number.
- 5.) **Provider No.:** Enter your home care provider number as assigned by the HIV Uninsured Care Program (7 digit number beginning with four 0's). **This is not the Medicaid or license number.**

- 6.) **Patient's Name and Address:** Enter patient's last name, first name and middle initial followed by the street address, city, state and zip code.
- 7.) **Provider's Name and Address:** Enter organization name, street address, city, state and zip code. The "provider" is defined as the home care agency providing services. It is not the medical facility or physician name. Please include site-specific telephone and fax numbers. This is a required field.
- 8.) **Date of Birth:** Enter the six-digit date for month, day and year (e.g. MMDDYY, 012363).
- 9.) **Sex:** Check the appropriate box.
- 10.) **Medications:** Enter all medications ordered by the physician, including the dosage, frequency and route of administration for each.

This is a required field. Applications forwarded without this information will be delayed.

Enter intravenous therapy ordered by the physician including the medication, dosage, frequency, route of administration, solution (type, volume and rate) and other drugs needed for procedure (e.g. heparin).

Use the addendum AI-487 for medications and solutions when additional space is needed.

- NOTE: Total or partial parenteral nutrition is not reimbursable

- 11.) **ICD-9-CM Code and Principle Diagnosis:** The principle diagnosis is the diagnosis most related to the current plan of treatment. It may or may not be related to the patient's most recent hospital stay, but it must relate to the services rendered. If more than one diagnosis is treated concurrently, enter the diagnosis that represents the most acute condition and requires the most intensive services.

Enter the appropriate ICD-9-CM code for HIV Immunodeficiency Virus (HIV) Infection with specified conditions or enter an indicator condition for Clinical/Symptomatic HIV illness in the space provided. The principle diagnosis may change on subsequent forms only if the patient develops an acute condition or an exacerbation of a secondary diagnosis requiring intensive services different than those on the established plan of care.

The date is always represented by six digits (MMDDYY); if the exact day is not known, use 00. The date of onset is specific to the medical reason for home health care services. If the condition is chronic, use the date of exacerbation. Use one or the other, not both. Always use the latest date.

- 12.) **Surgical Procedure, Date, ICD-9-CM Code:** Enter the surgical procedure relevant to care rendered (e.g. insertion Hickman/Broviac). If a surgical procedure was not performed or is not relevant to the plan of care enter N/A.
- 13.) **Other Pertinent Diagnoses: Date of Onset/Exacerbation, ICD-9-CM:** Enter all pertinent diagnoses, both narrative and ICD-9-CM codes, relevant to the care rendered. Other pertinent diagnoses are all conditions that coexisted at the time the plan of care was established or which developed subsequently. Exclude diagnoses that have no bearing on this plan of care. These diagnoses can be changed to reflect changes in the patient's condition. In listing the diagnoses, place them in order to

reflect the seriousness of the patient's condition and to justify the disciplines and services provided. If there are more than four pertinent diagnoses, use the addendum AI 487 form to list them.

- 14.) **DME and Supplies:** Enter the item(s) of durable medical equipment (DME) and intravenous surgical supplies ordered by the physician for which reimbursement under the HIV Home Care Uninsured Program will be requested.

NOTE:

- All DME/Infusion supplies must be itemized on an AI 3615 form. Prior-authorization will be made only for those items coded and priced on an AI 3615 form regardless of whether or not they are listed on the AI485. Please refer to the specific instructions for completing the AI 3615-Prior Approval Request Form.
- Only DME and supplies covered by Medicaid are reimbursable under the HIV Home Care Uninsured Fund. (Please refer to Medicaid Management Information System (MMIS) Provider Manual for Durable Medical Equipment).

- 15.) **Safety Measures:** Enter the physician's instructions for safety measures.

- 16.) **Nutritional Requirements:** Enter the physician's order for the diet. This includes specific therapeutic diets and/or specific dietary requirements. Record fluid needs or restrictions. If more space is needed use the AI487 form. The entry in this field must support requests for nutritional assessments and/or consultations at home. Patients who are not prescribed special diets, or who do not present with nutritional needs will not be approved for nutritional visits.

- 17.) **Allergies:** Enter medication to which the patient is allergic and other allergies the patient experiences (i.e. foods, adhesive tape, iodine). No known allergies may be an appropriate response.

- 18A.) **Functional Limitations:** Check all items which describe the patient's current limitations as assessed by the physician and you.

NOTE: Reimbursement is limited to patients who are medically or chronically dependent, defined as:

- **Medically dependent:** The patient requires the use of home care services to prevent or compensate for serious deterioration of physical health or cognitive functioning related to HIV infection. Long term care or repeated acute care episodes are avoided if home care services are provided.
- **Chronically dependent:** Due to physical or cognitive impairment from HIV infection, the patient is incapable of independently performing at least two of the following activities of daily living: bathing, dressing, toileting, transferring, or eating.

The functional limitation section must be used to document this dependence.

- 18b.) **Activities Permitted:** Check the activities which the physician allows and/or for which physician's orders are present.

NOTE: If you check "Other" under either the "Functional Limitations" or "Activities Permitted" category, provide a narrative explanation on the AI487 form. This will be needed in all cases to document medical or chronic dependence.

- 19.) **Mental Status:** Check the block(s) most appropriate to describe the patient's mental status. If you check "Other," specify the condition.
- 20.) **Prognosis:** Check the box which specifies the most appropriate prognosis for the patient: poor, guarded, fair, good or excellent.
- 21.) **Orders for Discipline and Treatments:** Specify the frequency and the expected duration of the visits for each discipline ordered. A discipline may be one or more of the following: Skilled Nursing (SNV), Physical Therapy (PTV), Home Health Aide (HHA), Personal Care Aide (PCA), Homemaker (HMK), Housekeeper, or Nutritionist (N1010, N1020).

Frequency denotes the number of visits per discipline to be provided, stated in days, weeks, or months.

Duration identifies the length of time the services are to be provided, stated in hours, days, weeks, or months.

Orders must include all disciplines and treatments, even if they are not reimbursable.

EXAMPLE OF PHYSICIAN'S ORDERS: Certification Period is 010101 to 030101.

SNV - Monitor vital signs, assess and observe effects of medications, side effects and any changes, assess wound healing, supervise HHA. QW x 8 weeks.

HHA - Provide personal care: assist with bathing, ambulation, transfer and exercises. 3 days x 4 hours x 8 weeks.

NOTE: The following services **are** reimbursable under the Home Care Uninsured Program:

- Homemaker, home health aide, personal care aide, skilled nursing
- Physical therapy is limited to 3 visits per lifetime.
- Nutritional counseling and assessment is limited to 12 visits per year
- Home intravenous therapy, including nursing visits and infusion equipment and supplies. Drugs for infusion must be billed electronically by an enrolled pharmacy through the participant's ADAP enrollment. Infusion companies who are not enrolled as an ADAP pharmacy provider will be unable to bill for infusion drugs.
- Durable medical equipment (limited).

NOTE: The following services **are not** reimbursable under the Uninsured Care Programs-Home Care Program.

- Speech Therapy (ST)
- Occupational Therapy (OT)
- Medical Social Worker (MSW)
- Respiratory Therapist (RT)
- Mental Health Nursing Visits

- 22.) **Goals/Rehabilitation Potential and Discharge Plans:** Enter the information which reflects the physician's description of achievable goals and the patient's ability to meet them as well as plans for care after discharge.

EXAMPLES OF GOALS:

- Encourage ambulation with walker.
- Improve nutritional intake and weight gain.
- Increase patient's knowledge and independence to self-administer IV medication.

Discharge Plans - Address where or how the patient will be cared for when home care services are provided.

- 23.) **Verbal Start of Care and Nurse's Signature and Date:** This verifies that a nurse spoke to the patient's primary care physician and received verbal orders to start care, modify care or continue care at recertification. This is signed by the nurse who received the verbal orders or by the nurse responsible for completion of the form. If the nurse who received the orders does not prepare the AI485, then the orders must be transcribed to a form, signed and dated by her and retained in a provider file.

The verbal start-of-care date must precede the start-of care date in item 2.

Enter N/A if the physician has signed and dated the AI485 on or before the SOC or recertification date, or has submitted a written order to start, modify or continue care on a document other than the AI485.

- 24.) **Physician's Name and Address:** Print clearly the physician's name and address. The primary care physician is the physician who establishes the plan of care and who certifies and recertifies the medical necessity of the visits and services.
- 25.) **Date HHA Received Signed POT:** Enter the date you received the signed plan of treatment (POT) from the primary care physician. Enter N/A if item 27 date is completed.
- 26.) **Physician Certification:** Check whether this is an initial certification or a recertification.
- 27.) **Attending Physician's Signature and Date Signed:** The primary care physician signs and dates the plan of treatment/certification prior to your submitting the claim. Unsigned forms will be accepted in order to initiate services. No claims will be paid prior to receipt of signed forms. Rubber signature stamps are not acceptable. The form may be signed by another physician who is authorized by the primary care physician to care for the patient in his/her absence. Signatures from other medical professionals are not acceptable. A physician must sign this form.

APPENDIX D
NEW YORK STATE DEPARTMENT OF HEALTH UNINSURED CARE PROGRAMS HOME CARE

INSTRUCTIONS FOR COMPLETING THREE PAGE NURSING ASSESSMENT

- 1) A nursing assessment must be submitted with all new applications and with each recertification thereafter.
- 2) The nursing assessment should be completed no more than two weeks prior to application.
- 3) A nurse or other licensed health care professional must sign and complete the nursing assessment. Instruments completed by social workers, case managers, or discharge planners (unless an RN) will not be accepted.
- 4) It is extremely important that the nursing assessment accurately reflects the service needs of the patient. An entry must be made for each question. It is acceptable to enter NOT APPLICABLE when appropriate. Inaccurate and incomplete nursing assessments that do not support the level of service requested on the AI 485 will delay the approval process. Home care services will be denied if the nursing assessment does not reflect a patient who is homebound and medically or chronically dependent due to HIV-related physical or cognitive impairments.
- 5) With the exception of patients receiving home infusion therapies, all patients must be homebound to receive approval for home care services. If you check "NO" for this question on the Nursing Assessment (page 3), then you must provide separate justification for home care services. An applicant/participant must be homebound in the sense that he/she can not leave home unsupervised or unescorted.
- 6) Please refer to the overview section of this manual for specifics regarding home care insurance benefits, Medicare, and Medicaid. It is expected that the home care agency will utilize private insurance benefits and Medicare whenever possible. Written verification of home care benefits or denials may be requested prior to HUCP approval. The insurance and Medicaid eligibility questions on page three of the Nursing Assessment must be completed.

APPENDIX E
NEW YORK STATE DEPARTMENT OF HEALTH UNINSURED CARE PROGRAMS HOME CARE

**INSTRUCTIONS FOR COMPLETING THE DME
PRIOR APPROVAL REQUEST FORM (AI 3615)**

Prior approval is required before the purchase or rental of any durable medical equipment. Durable medical equipment is defined as; devices and equipment, other than prosthetic or orthotic appliances, which have been ordered by a qualified practitioner in the treatment of a specific medical condition and which have all of the following characteristics:

- The item can withstand repeated use for a protracted period of time.
- The use is primarily and customarily for medical purposes.
- They are generally not useful to a person in the absence of illness or injury.
- The item is usually not fitted, designed, or fashioned for a particular individual's use.
- If equipment is intended for use by only one patient, it may be custom made or customized.

All Prior Approval Requests will be evaluated for medical necessity, cost, appropriateness and relation to program goals. All information provided on this form is kept STRICTLY CONFIDENTIAL.

The following details the steps to complete the Prior Approval Request Form. Please follow the instructions closely, as mistakes will result in a return of the request to your agency for further information.

1. **Participant Name:** Print the last name, followed by the first name and middle initial of the participant. Use the patient name as it appears on the Patient Enrollment Form submitted by the home health agency.
2. **Certification Period:** Enter the certification period as it appears on the AI 485 Home Health Certification and Plan of Treatment.
3. **ADAP ID Number/ Care Plan Number:** Enter participant's ADAP ID number or care plan number, if known.
4. **Sex:** Check the appropriate box.
5. **Date of Birth:** Enter the participant's birthday in the MMDDYY format.
6. **Home Care Agency Name:** Enter the name of the home care agency that will be providing care to the patient. This agency is responsible for obtaining prior authorization and billing for all supplies. **DME vendors can not bill directly.**
7. **Home Care Agency Address:** Enter the address of the branch office assigned the case.
8. **Home Care agency telephone and fax numbers:** Enter the telephone and fax numbers of the branch office assigned the case.

9. **DME Vendor Name:** Enter the name of the DME vendor providing equipment or supplies. DME Vendors can not bill directly.
10. **DME Vendor Address:** Enter the address of the DME vendor listed above.
11. **Order Description/Medical Justification:** Enter a detailed description of the equipment prescribed and the reason for medical necessity. Medical necessity should include a description of the patient's functional status, the presence of existing equipment and caretaking arrangements, if any. Also, provide an estimation of the length of time the item will be required.
12. **Item Code:** This code indicates the equipment to be provided. Refer to the Durable Medical Equipment Procedure Codes listed in the Medicaid Management Information System (MMIS) Provider Manual. Leave the first 4 positions of this field blank. If the item ordered is not listed in the MMIS Provider Manual, please contact to your DME vendor.

The Uninsured Care Program has developed agency-specific coding for many IV supplies that are not listed in the MMIS Provider Manual. These "H" codes are available from Client Services staff upon request.
13. **Rental:** Enter an "X" in the appropriate box to indicate whether or not the equipment requested is to be rented.
14. **Description:** Enter the description which corresponds to the Item Code previously entered, as it appears in the MMIS Provider Manual for Durable Medical Equipment.
15. **Quantity Requested:** Enter the number of units being ordered. Please enter exact quantities. Do not refer to package units such as "one bag" or "one box." For example, "one box of tape" should be entered as 10 rolls of tape.
16. **Price per Item:** Please enter the Medicaid rate for each item. Do not enter the retail price as listed by the vendor. This field is mandatory for items without Medicaid Codes, as prices will need to be manually entered. For items with Medicaid Codes, the current Medicaid rate will be automatically applied.
17. **Total Amount Requested:** Enter the total dollar amount for each piece of equipment requested. The amount paid will be the price listed in the MMIS Provider Manual. If the equipment is a rental, enter the total rental price based on the length of the certification (one or two months).
18. **Action Code:** Leave blank.

APPENDIX F
NEW YORK STATE DEPARTMENT OF HEALTH UNINSURED CARE PROGRAMS HOME CARE

INSTRUCTIONS FOR COMPLETING CLAIM FORMS

A claim form is an itemized invoice of all services and/or supplies provided to an enrolled patient. Claim Forms must be submitted for reimbursement of eligible services or supplies under the Uninsured Care, Home Care Program. Claim Forms must be completed carefully, as errors will result in delay of reimbursement.

Please retain a copy of each completed Claim Form for your records.

The following instructions will assist you in completing the form:

PROVIDER INFORMATION:

1. **PROVIDER REGISTRATION NUMBER** - Enter your assigned Provider Registration Number as it appears on your Agency Enrollment Packet.
2. **PROVIDER NAME** - Enter your organization's name as it appears in your Agency Enrollment Packet.
3. **MMIS NUMBER** - Enter your organization's MMIS (Medicaid) number, if applicable, or your organization's license number.
4. **CARE PLAN AUTHORIZATION NUMBER** - Enter the Care Plan Number issued in the Patient Approval letter.
5. **CARE PLAN AUTHORIZATION PERIOD** - Enter the date(s) of the approved period as indicated in the Patient Approval letter. Please use the MM/DD/YY format when entering dates. For example, for service dates of January 1, 2001 through March 1, 2001, you would enter 01/01/01 – 03/01/01.
6. **SERVICE PERIOD** - Enter the date(s) for which services were provided to the patient, and are being billed on this claim. Please use the MM/DD/YY format when entering dates (see #5). The time period on the Claim Form should not exceed 30 days.

PATIENT INFORMATION:

1. **ADAP ID NUMBER** - Enter the participant's ADAP ID Number.
2. **NAME** - Enter the participant's last name first, first name and middle initial.
3. **SEX** - Please indicate with either M (male) or F (female).

SERVICE INFORMATION:

1. **DATE OF SERVICE** - Enter the date which the ordered supply or service was provided. Enter each date of service or supply (DME item) as a separate line. Continuation forms have been provided. Services listed on the claim forms must exactly match the services listed on the prior-approval/authorization letter. This is especially important for DME item codes and descriptions.

2. **SERVICE OR ITEM DESCRIPTION** - Provide a description of the service provided, the supplies purchased, or the equipment rented.
3. **MMIS ITEM CODE** - Enter the Medicaid Management Information System (MMIS) Procedure or Product Item Code for each item provided.
4. **PERSONNEL SERVICES HOURS/VISIT** - Enter the total number of nursing visits, or the total number of hours which paraprofessional services were provided during the service period.
5. **QUANTITY** - Enter the total number of units provided for each item supplied.
6. **UNIT CHARGE** - Enter the appropriate per unit rate for the service billed. CHHAs, LTHHCPs and Hospices will be reimbursed at the rate set by the Bureau of Long Term Care Reimbursement, NYSDOH. Reimbursement rates for LHCSAs are set by the Department of Social Services. Agencies may utilize agency-specific rates approved by their local area DSS if proper documentation is provided. Reimbursement rates on file with the Uninsured Care Programs are printed on the home care authorization letter. It is the responsibility of the agency to provide new or updated rates to the Uninsured Care Programs. There are no retroactive rate changes.
7. **TOTAL CHARGE** - Enter the total dollar amount for each service or item. This figure is determined by multiplying the quantity of each item or service by the unit charge. Total all charges on side 2 of the Claim Form.
8. **CERTIFICATION** - Each Claim Form must be dated and signed by an authorized representative of your organization. Only original signatures will be accepted.

ALL INFORMATION PROVIDED ON CLAIM FORMS IS STRICTLY CONFIDENTIAL