GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Senior Deputy Director/Medicaid Director **Transmittal # 16-20**

TO: Home Health Agencies

FROM: Claudia Schlosberg, J.D.
Senior Deputy Director and State Medicaid Director

DATE: June 20, 2016

SUBJECT: **Personal Care Assistance Claims Edit information and Denied Claims Instructions to Home Health Agencies**

The following transmittal provides instructions to Home Health Agencies (HHAs) on how to investigate claims for Personal Care Assistance (PCA) services that are denied by the Department of Health Care Finance (DHCF), and steps HHAs should take based on the results of their investigation.

DHCF is continuing efforts to reduce fraud, waste and abuse in the Personal Care Assistance Services program. Effective August 1, 2015, DHCF implemented a new edit in MMIS to deny all claims delivered by any personal care aide for delivering more than 16 hours of service in a single day. As a result, DHCF may deny claims submitted by more than one HHA for services delivered by the same aide on a single day.

DHCF implemented this edit because a review of our Medicaid claims data revealed a significant number of personal care aides who are submitting time sheets for 16 hours or more on a single day are working for multiple agencies. When combined, these personal care aides are causing claims to be submitted that total 24 hours or more on a single day. DHCF is implementing this edit to provide HHAs with an opportunity to investigate these claims. Working together, we can ensure that only legitimate claims for services rendered are paid. This transmittal explains DHCF's expectations regarding how HHAs should respond to denied claims and how DHCF will process claims, once an investigation is completed.

If a claim is denied or voided because the aide's hours exceeded 16 hours for a date of service, the HHA should initiate their own investigation into the validity of the services provided by the aide to the beneficiary being served by the agency. Next, the HHA should:

- Initiate an investigation to determine if the aide provided the services, and document the results of the investigation. The investigation should include, but is not limited to:
    - Interviewing the aide about other agencies he/she may work with and the hours they work with the other agency(ies).
    - If the aide provides information about the other agency(ies), consider speaking with the other agency(ies) to validate the time being reported by the aide.
    - Interviewing the beneficiary and family members to confirm that the aide is on site for the time reported on the timesheet.
    - Doing periodic unannounced visits to ensure that the aide is with the beneficiary during scheduled hours.
    - If there are multiple beneficiaries in the home, the aide cannot bill eight hours for beneficiary A and eight hours for beneficiary B.

- If the HHA determines that services were provided, the agency should:
    - Submit an appeal to Xerox with supporting documentation including the aide's timesheet and a summary of the agency's investigative report.
    - Provide an attestation certifying that the services were provided.

  Xerox will process these appeals within 21 days of receipt. It is important to note that if all agencies resubmit their claims, the claims will deny again and the process will restart from the beginning.

- If the HHA determines that services were not provided, the agency should:
    - Provide DHCF's Division of Program Integrity with the results of its investigation, including the aide's timesheets and a summary of the agency's investigative report; and
    - Take disciplinary action against the aide and report the aide to the Board of Nursing (See transmittal #16-13).

Questions regarding this policy should be directed to Donald Shearer, Director, Health Care Operations Administration, Department of Health Care Finance, by calling 202-698-2007, or submitting an email to donald.shearer@dc.gov.