



GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance
441 4th Street Northwest, Suite 900 South
Washington, DC 20001

Department of Health Care Finance Informational Bulletin

DATE: April 22, 2020
FROM: Ieisha Gray
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SUBJECT: **Sixth COVID-19 Update for Long Term Care Providers**

News since our last bulletin:

- The Centers for Medicare and Medicaid Services (CMS) approved the District's Appendix K authorizing temporary and emergency changes to policy, procedure, and payment during the public health emergency (PHE). As a result, DHCF has issued an array of guidance documents:
 - Rate transmittals (which will be issued 4/22/2020) to provide guidance on any adjustments to billing and reimbursement for long-term services and supports during the PHE, including for **home health agencies (HHAs), adult day health programs (ADHPs), nursing facilities (NFs), and intermediate care facilities (ICFs)**.
 - Formal announcement 4/22/2020 of CMS approval of the Appendix K and a summary of the changes effectuated by this approval.
 - The attached *Home- and Community-Based Services Billing and Documentation Guidelines*, issued by DHCF's Long Term Care Administration, which provides more-detailed guidance to case management agencies (CMAs), ADHPs, HHAs, and EPD waiver providers more generally. **All home and community-based providers must read and adhere to this guidance.** LTCA will answer questions from all provider types during the monthly provider meeting, held by Webex, on 4/23.

Join the monthly provider meeting Thursday 4/23 via Webex using the following information:

- **Meeting link:** <https://dcnet.webex.com/dcnet/j.php?MTID=m8398fd4df9c3a8689c816b047be5bf16>
- **Meeting number:** 477 724 079
- **Password:** isHBwWdZ227
- **OR join by phone:** 1-650-479-3208 Call-in number (US/Canada); access code: 477 724 079

The meeting will cover Medicaid eligibility topics (as scheduled) and COVID-related policy guidance.

Important reminders:

- **Preservation of Medicaid eligibility.** DHCF and DHS have issued yearlong extensions to all Medicaid enrollees typically required to actively recertify their eligibility in the Medicaid program, including waiver enrollees. Case managers must complete and submit application packets for all waiver renewals. Liberty continues to process and complete all assessments and attestations and one must be completed prior to the completion and submission of the LTC application, as is standard practice. Case managers must complete, review and submit all person-centered service plans (PCSPs) once the application submission is complete.

- **Staff or beneficiary COVID infections.** If a staff member, beneficiary, or beneficiary's household member tests positive for COVID infection, please contact DC Health immediately for guidance.

Additional resources you should consult include

- DC Health [Guidance for Healthcare Personnel Monitoring, Restriction and Return to Work](#)
- DC Health guidance for patients and home health aides about [home quarantine](#)
- DC Health guidance about [testing, testing sites & testing priorities](#)
- **For aides exposed or infected who may be employed by multiple agencies,**
 - Correspond closely with other agencies when staff have been exposed or infected.
 - Inform DHCF; as a last resort, DHCF can examine claims records to identify other agencies with which the aide may be affiliated.

As always, we extend our thanks for your continued partnership and commitment to the care and safety of District residents in these challenging and unprecedented circumstances. We will continue to be in touch with updated information as it becomes available. Please continue to take good care of yourselves as well.

COVID-19 Public Health Emergency (PHE): Home- and Community-Based Services Billing and Documentation Guidelines for Services Delivered Under Temporary Policy & Procedural Arrangements

Document purpose

This document describes allowable service delivery arrangements, required case documentation, and billing practices that are temporarily in effect during the COVID-19 public health emergency (PHE) for the home- and community-based services reimbursed by Medicaid in the District of Columbia. All guidance in this document is subject to change, particularly in respect to updated federal and local District laws, including emergency orders issued or amended by the federal or District governments. The DC Department of Health Care Finance (DHCF) developed and will update this document.

General information and recommendations

Medicaid home- and community-based services reimbursed by the Medicaid program include personal care aide (PCA) services authorized under the Medicaid State Plan; 1915(i) adult day health program (ADHP) services; all services delivered under the 1915(c) home- and community-based services (HCBS) Waiver for the Elderly and Physically Disabled (EPD Waiver); and other in-home services and supports delivered by home health agencies.

During the COVID-19 PHE, CMS has authorized the District's Medicaid program to waive certain program requirements; alter reimbursement rates; and preserve or extend program eligibility and certain services. These flexibilities include:

- Waiver of physician/APRN signature on POF requesting initial assessment and reassessments for all individuals (waiver enrollees or applicants, state plan Medicaid enrollees, and all others)
- Conduct of long-term care assessments through remote, web-based or telephonic means
- Waiver of physical beneficiary signature on LTC applications for EPD waiver renewals, PCSP documentation, plans of care, and other forms
- Extension of Medicaid eligibility for up to twelve months from the previously established eligibility end date
- Conduct of person-centered service planning, monthly visits, and any other care coordination visits by case managers, Services My Way (SMW) support brokers, and home health agencies' supervisory nursing staff through HIPAA-compliant remote, web-based or telephonic means
- Payment flexibilities for personal care aide services facilitating additional staffing, overtime pay and other mechanisms to address potential workforce shortages
- Payment flexibilities for ADHPs to facilitate conduct of some ADHP services through HIPAA-compliant remote, web-based or telephonic means, or to pay retainer payments when services cannot be rendered

In addition to altering standard policies and procedures temporarily during the PHE, DHCF reminds providers of the imperative to comply with public health guidance from DC Health. Helpful resources include the following:

- DC Health [Guidance for Healthcare Personnel Monitoring, Restriction and Return to Work](#)
- DC Health [case examples for PPE use](#)
- DC Health guidance on [conservation of PPE](#)
- DC Health guidance for patients and home health aides about [home quarantine](#)
- DC Health guidance about [testing, testing sites & testing priorities](#)

All Health Notices can be found on DC Health's website at <https://dchealth.dc.gov/page/health-notices>.

Provider-specific information

For **case management services**, turn to page 2.

For **home health agencies**, including guidance regarding PCA services, turn to page 3.

For **adult day health program services**, turn to page 5.

**COVID-19 Public Health Emergency (PHE):
Home- and Community-Based Services Billing and Documentation Guidelines
for Services Delivered Under Temporary Policy & Procedural Arrangements**

Case management services in the EPD Waiver

- *Suitable delivery arrangements during the PHE*
 - Case management services may be delivered in person if all parties agree to meeting in person, all parties exercise standard social distancing precautions or use personal protective equipment (PPE), and if all parties are without symptoms of infection, known to be COVID-negative, or known to be recovered. For purposes of this guidance, these are described as “in-person CM services.”
 - Case management services may be delivered remotely, by telephonic or web-based means, to accommodate symptomatic beneficiaries or family members, in accordance with beneficiary preferences, or to prevent asymptomatic transmission of infection. For purposes of this guidance, these are described as “remote CM services.”
 - Case management services should not be delivered on-site through a barrier, such as a door or window, even if this modality is agreeable to the beneficiary and his or her family members or representatives and if all parties comply with social distancing guidelines issued by DC Health and the Centers for Disease Control and Prevention (CDC). This is due to the non-private nature of such an exchange. Should health care providers wish to complete “wellness checks” through this means, that is acceptable and encouraged, but should be limited to fairly minimal exchange of information that does not pose risk of needless PHI exposure.

- *Documentation of services during the PHE*
 - Due to the potential for exclusively remote case management services during the PHE, beneficiary signatures are not required on PCSP documentation, including the provider choice form; long-term care applications; or other forms ordinarily requiring their signature. This provision is in place during the PHE only.
 - Given the waiver of beneficiary signature, case managers must document beneficiary assent and approval for such items through different means. DHCF will accept the following forms of beneficiary assent for any beneficiary signature ordinarily required by local or federal policy:
 - Written agreement from the beneficiary by email or US mail
 - An attestation of the beneficiary’s assent recorded by agency staff through dated and time-stamped entry in DC Care Connect (including using the e-signature area to document verbal consent)
 - Existing minimum standards for documentation of monthly case manager visits, PCSP planning meetings, and all other CM contact with beneficiaries remain in place. Case managers are required to over-document given the reduced face-to-face exchange of information, and evidence in DC Care Connect will serve as justification for billing and reimbursement for services delivered during the PHE. As always, CMs are required to:
 - Document monthly visits in the monthly visit notes, as well as note any more significant changes, events, or conversations in the beneficiary’s Case Notes;
 - Document PCSP quarterly reviews conducted to evaluate personal goals, services, and the individual’s health and safety;
 - Upload attachments of note, such as wellness checklists or other case management or care coordination tools used during remote patient monitoring and support;
 - Employ best practices and routine procedures for reporting, documenting, investigating and resolving incidents, including health services or hospitalizations related to COVID infection.

- *Billing for services delivered under alternate modalities during PHE*
 - Case management agencies should bill for monthly case management using procedure code T1023 as normal and under their existing authorizations, but **must** also **indicate Place of Service Code 02 (telehealth) for any month in which all services were conducted remotely**. Beneficiary assent to the monthly visit and other remote contact should be documented regardless of the mode of delivery; it can be documented as indicated above or in person with a signature.

**COVID-19 Public Health Emergency (PHE):
Home- and Community-Based Services Billing and Documentation Guidelines
for Services Delivered Under Temporary Policy & Procedural Arrangements**

All home health services, including Personal Care Aide and respite services, under state plan and waiver authority

- *Suitable delivery arrangements during the PHE*
 - Hands-on care must be delivered in person. This includes personal care aide services, nursing services requiring person-to-person contact (e.g., hands-on wound care, injections), and therapeutic services requiring person-to-person contact (e.g., physical therapies requiring therapist manipulation). For the purposes of this guidance, these are described as “in-person hands-on care.” All direct care staff must comply with DC Health and CDC standards of universal precautions during the PHE. DC Health’s library of Health Notices can be viewed and downloaded here: <https://dchealth.dc.gov/page/health-notice>.
 - Nursing or therapeutic visits overseeing personal care services (supervisory nurse visits), providing care coordination to home health agency patients, providing clinical nursing care or advice, or providing therapeutic guidance to a patient may be delivered in person if all persons are asymptomatic, known to be COVID-negative, or known to be recovered. For purposes of this guidance, these are described as “in-person home health services.”
 - Such nursing or therapeutic visits described immediately above may be delivered remotely, by telephonic or web-based means, to accommodate symptomatic beneficiaries or family members, in accordance with beneficiary preferences, or to prevent asymptomatic transmission of infection. For purposes of this guidance, these are described as “remote home health services.”
 - No home health agency services should be delivered on-site through a barrier, such as a door or window, even if this modality is agreeable to the beneficiary and his or her family members or representatives and if all parties comply with social distancing guidelines issued by DC Health and the Centers for Disease Control and Prevention (CDC). This is due to the non-private nature of such an exchange. Should health care providers wish to complete “wellness checks” through this means, that is acceptable and encouraged, but should be limited to fairly minimal exchange of information that does not pose risk of needless PHI exposure.
- *Documentation of services during the PHE*
 - Due to the potential for exclusively remote home health services during the PHE, beneficiary signatures are not required on plans of care, nursing visit documentation, or forms ordinarily requiring their signature. This provision is in place during the PHE only and applies only to remote services. For in-person hands-on care or any other in-person home health services, all required beneficiary signatures remain required.
 - For remote home health services, nurses and other HHA staff must document beneficiary assent and approval for such items through different means. DHCF will accept the following forms of beneficiary assent for any beneficiary signature ordinarily required by local or federal policy:
 - Written agreement from the beneficiary by email or US mail
 - An attestation of the beneficiary’s assent recorded by agency staff through dated and time-stamped entry in DC Care Connect
 - Existing minimum standards for documentation of monthly supervisory nurse visits, PCA timesheets, plans of care, service planning, and other HHA staff contact with beneficiaries remain in place. Agencies are required to over-document given the reduced face-to-face exchange of information. Documentation in DC Care Connect will serve as justification for billing and reimbursement of services delivered during the PHE, and HHAs should copy information from their own systems into DC Care Connect to avoid duplicative work. HHAs and their staff are encouraged to:
 - Document monthly supervisory nurse visits, as well as note any more significant changes, events, or conversations in the beneficiary’s Case Notes;
 - Document care coordination and other efforts to manage and support the individual’s health and safety;
 - Upload attachments of note, such as wellness checklists or other patient monitoring or care coordination tools used during remote patient monitoring and support;

- Employ best practices and routine procedures for reporting, documenting, investigating and resolving incidents, including services or hospitalizations related to COVID infection.
- *Billing for services delivered under alternate modalities during PHE*
 - All in-person hands-on care and in-person home health services should be billed according to standard procedure coding and under existing authorizations as is routine, except in the event of staffing for a quarantined or COVID-positive beneficiary, emergency staffing, or overtime pay (for more information, see the following section).
 - All skilled services conducted remotely (including supervisory nurse visits for personal care services) should be billed according to existing procedure code-modifier combinations, but the documentation of same in DC Care connect **must** indicate that the services were rendered telephonically or by web.
- *Billing for personal care aide and skilled nursing services under emergency staffing pay, quarantine or overtime pay*
 - **Overtime pay** may be paid to aides or nurses (LPN or RN) who work in excess of 40 hours per week for the same agency.
 - **Quarantine pay** may be paid to aides or nurses delivering hands-on care to COVID-positive and quarantined individuals. **Quarantine overtime pay** may be paid to aides or nurses delivering hands-on care to COVID-positive and quarantined individuals.
 - **The above rates will require prior authorization and will be paid for claims billed using the appropriate HCPCS procedure code-modifier combinations:**
 - **T1019-CR:** PCA services (state plan or waiver) at an overtime rate (\$32 per hour)
 - **T1019-CR-U1:** PCA services (state plan or waiver) for a quarantined or COVID+ beneficiary (\$32 per hour)
 - **T1019-CR-U2:** PCA services (state plan or waiver) for a quarantined or COVID+ beneficiary at an overtime rate (\$48 per hour)
 - **G0299-TD-CR:** RN skilled visit at overtime rate (\$90 per hour)
 - **G0300-TE-CR:** LPN skilled visit at overtime rate (\$75 per hour)
 - **G0299-TD-CR:** RN skilled visit for a quarantined or COVID+ beneficiary (\$90 per hour)
 - **G0300-TE-CR:** LPN skilled visit for a quarantined or COVID+ beneficiary (\$75 per hour)
 - **G0299-TD-CR:** RN skilled visit at overtime rate for a quarantined or COVID+ beneficiary (\$135 per hour)
 - **G0300-TE-CR:** LPN skilled visit at overtime rate for a quarantined or COVID+ beneficiary (\$112.50 per hour)
 - Quarantine pay, overtime pay, and quarantine overtime pay authorizations will be issued either directly by DHCF staff or through amendment of a waiver beneficiary's PCSP. In order to obtain these emergency authorizations, HHAs should document COVID exposure or infection and HHA response as follows:
 - Notify Epidemiology at DC Health by calling 202-576-1117
 - Document infection and any related health services (e.g., hospital admission) in DC Care Connect Incident Management; please select "Other" as incident type and note "COVID-19 exposure / infection" in the comments
 - Collaborate with CM for waiver beneficiaries to amend service delivery arrangements as appropriate
 - Emergency staffing pay may be paid to home health agencies required to pay the costs of higher wages to temporary workers hired from ~~nurse~~ staffing agencies to supplant sick or quarantined aides assigned to a beneficiary. For hours worked by such staff, services should be billed according to standard procedure coding and under existing authorizations. The following steps **must** be taken in order to be reimbursed for marginal costs incurred:
 - The staffing agency's NPI must be entered in "Other NPI 1" on state plan claims.
 - The aide must have or obtain his or her own NPI. The HHA must enter the aide's NPI in "Other NPI 2" on state plan claims submitted. Waiver claims should be submitted as they normally are, with the contract aide's NPI entered on the claim. The aide does not have to enroll with DC Medicaid.
 - HHAs must submit documentation of marginal staffing costs incurred by paying contract staff via secure email or other HIPAA compliant means. Such documentation must include the claims impacted (e.g., by TCN), the prior authorization number, the amount due and the billing invoice from the staffing agency contracted.

**COVID-19 Public Health Emergency (PHE):
Home- and Community-Based Services Billing and Documentation Guidelines
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Adult day health program (ADHP) services under 1915(i) state plan and waiver authority

- *Suitable delivery arrangements during the PHE*
 - Adult day health program (ADHP) services under both 1915(i) state plan and waiver authorities may be delivered in person if all parties agree to meeting in person, all parties exercise standard social distancing precautions or use personal protective equipment (PPE), and if all parties are without symptoms of infection, known to be COVID-negative or to be recovered, and sites comply with existing DC Health guidance on social distancing and mass gatherings. For purposes of this guidance, these are described as “in-person ADHP services.”
 - ADHP services may be delivered remotely, by HIPAA-compliant telephonic or web-based means or by contact-free drop-off, to accommodate symptomatic beneficiaries or family members, in accordance with beneficiary preferences, to prevent congregate service delivery, to support remote assessment by DHCF’s assessment vendor Liberty Healthcare, or to prevent asymptomatic transmission of infection. For purposes of this guidance, these are described as “remote ADHP services.” These must be in alignment with the individual’s person-centered service plan and may include any of the following:
 - **Wellness checks** performed according to an established script or checklist, conducted by phone or another secure, HIPAA-compliant teleconferencing medium and documented according to the script or checklist
 - **Remote therapeutic activities** conducted individually or in groups by a licensed therapist and using a secure, HIPAA-compliant teleconferencing medium
 - **Remote nursing services** conducted individually by a licensed nurse by phone or a secure, HIPAA-compliant teleconferencing medium
 - **Meal or food delivery** to the beneficiary’s permanent or temporary residence
 - ADHP services should not be delivered on-site through a barrier, such as a door or window, even if this modality is agreeable to the beneficiary and his or her family members or representatives and if all parties comply with social distancing guidelines issued by DC Health and the Centers for Disease Control and Prevention (CDC). This is due to the non-private nature of such an exchange. Should health care providers wish to complete “wellness checks” through this means, that is acceptable and encouraged, but should be limited to fairly minimal exchange of information that does not pose risk of needless PHI exposure.
- *Documentation of services during the PHE*
 - Due to the significant alteration to ADHP operations in order to support their participants through the PHE, DHCF will require expanded documentation for services. The following describes these expanded requirements, which are required for each *day of service* for which such services are billed.
 - For remote ADHP-provided **wellness checks**, ADHPs must document the content of their contact with the beneficiary according to a checklist or script that DHCF reviews and approves, and this documentation must be uploaded in DC Care Connect. For simplicity, ADHPs may condense up to two calendar weeks’ worth of checklists into single documents for upload.
 - For remote **therapeutic activities**, ADHPs must document in their own records, and produce on DHCF’s request, a therapy summary that (1) describes the therapeutic activities conducted; (2) denotes the objectives of the therapeutic activities; (3) identifies the attendees of the session; (4) identifies the PCSP goals addressed by the session; (5) describes the modality used (e.g., Skype) and (6) identifies the licensed therapist leading the session and their clinical qualifications (e.g., licensed occupational therapist). For sessions conducted individually, this therapy summary should be included in the beneficiary’s record in DC Care Connect. No therapy summaries containing PHI for multiple beneficiaries should be uploaded in DC Care Connect.

- For remote **nursing services**, ADHPs must document in DC Care Connect a service summary that describes (1) the clinical activities conducted; (2) the objectives of the activities; (3) describes the modality used (e.g., Skype) and (4) identifies the licensed nurse leading the session and their clinical qualifications (e.g., BSN).
 - For **meal or food delivery**, ADHPs must document in DC Care Connect a service summary that describes (1) the content of the delivery; (2) special dietary needs or nutritional needs of the participant, if any; (3) the address to which food was delivered (if different from the address on file); and (4) identifies any gaps in food or nutritional needs of the beneficiary and potential solutions.
 - Due to the potential for exclusively remote ADHP services during the PHE, beneficiary signatures are not required on forms ordinarily requiring their signature. This provision is in place during the PHE only.
 - Given the waiver of beneficiary signature, ADHPs must document beneficiary assent and approval for such items through different means. DHCF will accept the following forms of beneficiary assent for any beneficiary signature ordinarily required by local or federal policy:
 - Written agreement from the beneficiary by email or US mail
 - An attestation of the beneficiary's assent recorded by agency staff through dated and time-stamped entry in DC Care Connect (including using the e-signature area to document verbal consent)
 - Existing minimum standards for documentation remain in place. ADHP staff are required to over-document given the reduced face-to-face exchange of information, and DC Care Connect will play an outsized role in care coordination and information exchange during the PHE. ADHPs are encouraged to:
 - Document all contact and conversations in the beneficiary's Case Notes;
 - Upload attachments of note, such as wellness checklists, service summaries, or other care coordination tools used during remote patient monitoring and support;
 - Employ best practices and routine procedures for reporting, documenting, investigating and resolving incidents, including health services or hospitalizations related to COVID infection.
- *Billing for services delivered under alternate modalities during PHE*
- For all in-person ADHP services, ADHPs may bill for services delivered Monday through Friday using their existing procedure code (S5100) and modifiers U1, U2, or U3 under current authorizations.
 - For all remote ADHP services, ADHPs may bill for daily services delivered Monday through Friday using their existing procedure code (S5100), modifier combinations, and Place of Service codes as follows:
 - **Remote wellness check ONLY:** S5100 with modifier CR (\$102 per diem)
 - Bill this for 1915(i) or 1915(c) services
 - **Indicate Place of Service Code 02 (telehealth)**
 - Does not require a new PA, but will only be authorized for individuals with prior claims for ADHP
 - **Remote wellness check PLUS any other remote ADHP services:** S5100 with modifiers U1 or U2 for 1915(i) services and modifier U3 for EPD waiver ADHP
 - **Indicate Place of Service Code 02 (telehealth)**
 - Relies on existing authorizations
- For any **dates of service on which no ADHP services were rendered to a beneficiary**, ADHPs may request payment of a retainer rate (\$34 per diem). ADHPs wishing to claim retainer payments must:
- Submit via secure email or other HIPAA-compliant means a list of beneficiaries and dates of service on days Monday through Friday for which no other claims can be submitted.
 - These lists should be submitted on a monthly basis after claims filing for the previous month has been completed.
 - These retainer payments will be disbursed via financial transactions after DHCF review and approval.