

**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**, go to page 2.

For **home health agencies**, including guidance regarding PCA services, go to page 4.

For **adult day health program services**, go to page 7.

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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.
 - Also effective only during the PHE, case managers are able to submit PCSPs for waiver beneficiaries prior to ESA processing of the LTC application. Ordinarily, the beneficiary’s certification date does not change until ESA processes the application; however, while eligibility extensions are being issued, eligibility is open and PCSPs can be submitted as soon as they are complete and reviewed internally at the CMA. Please complete and submit both the long-term care application and the PCSP as promptly as possible upon completion of the assessment. Case managers should not be waiting for ESA processing of long-term care applications to submit PCSPs to Comagine.
 - 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)
 - If services are delivered remotely, the provider must document the modality of service used to deliver the service (e.g. audio/visual, audio-only, etc.) and the patient’s telephone number, cellphone number, or other information on how communications were established with the patient based on the mode of communication used to deliver services.
 - 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.

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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.” Service delivery to beneficiaries that incorporates any remote home health services must remain in compliance with all other applicable District and federal regulations, including DC Health regulations related to supervision of home health care.
 - 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
 - If services are delivered remotely, the provider must document the modality of service used to deliver the service (e.g. audio/visual, audio-only, etc.) and the patient’s telephone number, cellphone number, or other

information on how communications were established with the patient based on the mode of communication used to deliver services.

- 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.
 - **Quarantine rates will require prior authorization and will be paid for claims billed using the appropriate HCPCS procedure code-modifier combinations:**
 - **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)
 - **Beginning in mid-July 2020, overtime PCA rates will no longer require prior authorization and will instead be validated using internal MMIS logic. These rates 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)

- Quarantine pay and quarantine overtime pay authorizations will continue to be issued directly by DHCF staff. 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
- To request quarantine-related authorizations, HHAs should complete the following steps:
 - DONs or other licensed clinical staff from the HHA must use the indicated attestation form to attest to the need for a specific PA (quarantine care or OT quarantine care) for a specific beneficiary and start date. HHAs should use their best estimate, based on existing scheduling mechanisms or protocols, to determine which beneficiary an aide serves will be covered by overtime hours.
 - Each beneficiary’s case will require its own form, and the form should be uploaded into DC Care Connect under Attachments: Others.
 - The request must then be submitted via ePPR. When submitting the request in the ePPR, HHAs must select “Prior Authorization” only in the check box selection and enter “COVID PA” in the comments. Completing these sections correctly will expedite processing.
 - LTC Operations staff will issue the PA, generally for a 14-day period, at the current services level based on the attestation.
 - LTCA staff will follow a “Follow Up Protocol” within 10 business days for each issued PA to review available data (MMIS, DCCC, CRISP) to confirm exposure / infection, incident documentation, PCSP updates, and that the case meets criteria for this authorization.
- In accordance with regulations and requirements implemented by DC Health in effect at the time of service, DC Medicaid home health agencies may have the flexibility to employ health care professionals licensed in other jurisdictions or as Certified Nursing Assistants (CNAs) to deliver Medicaid-reimbursable personal care aide services (PCA) in the absence of qualified District-certified home health aides. Providers must use other states’ license verification systems and verify the prospective hire currently works in home settings. Prior to billing for services rendered by such an employee, home health agencies must ensure the CNA possesses or acquires an NPI, that the CNA enrolls as a personal care aide in the PDMS and is affiliated to their agency, and must include this NPI on claims for services delivered by the CNA. DHCF will reimburse for services rendered by such health care professionals consistent with DC Health’s licensure standards at the time of service.
- Emergency staffing pay may be paid to home health agencies required to pay the costs of higher wages to temporary workers hired from 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.

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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 (1) agree to meeting in person; (2) use personal protective equipment (PPE) consistent with DC Health guidance; and (3) are without symptoms of infection, known to be COVID-negative or to be recovered; (4) comply with existing DC Health guidance on social distancing and group 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. A qualifying wellness check includes, but is not limited to, inquiries/reminders on the following:
 - Overall health status, including emotional well-being, need for care, and any signs or symptoms of illness
 - Meals, routines, and medication adherence
 - Social isolation and self-quarantine, including the availability/use of informal supports and access to groceries or emergency supplies
 - **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)
 - If services are delivered remotely, the provider must document the modality of service used to deliver the service (e.g. audio/visual, audio-only, etc.) and the patient's telephone number, cellphone number, or other information on how communications were established with the patient based on the mode of communication used to deliver services.
 - 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 in 15-minute increments delivered Monday through Friday using existing procedure code (S5100), modifiers, 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.