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GENERAL LETTER NO. 16-J-30

ISSUED BY: Bureau of Child Welfare and Community Services
Division of Adult, Children and Family Services

SUBJECT: Employees' Manual, Title 16, Chapter J, ***IN-HOME HEALTH-RELATED CARE SERVICES***, Contents (page 1), revised; and pages 1 through 30, revised.

Summary

Chapter 16-J is revised to enter the In-Home Health-Related Care program into the ISIS system. These changes impact how payments are made to clients or their payee. Services, payments, and providers will now be entered into the ISIS system.

Effective Date

Immediately.

Material Superseded

This material replaces the following pages from Employees' Manual, Title 16, Chapter J:

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Contents (page 1)	April 17, 2009
1, 2	October 17, 2008
3	October 22, 2010
4	October 17, 2008
5	November 18, 2011
6-14	October 17, 2008
15, 16	April 17, 2009
17	October 22, 2010
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23-31	October 17, 2008
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Additional Information

Refer questions about this general letter to your area service administrator.

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Chapter Overview

In-home health-related care is a State Supplementary Assistance program to:

- ◆ Provide health care in the home
- ◆ Prevent out-of-home placement
- ◆ Preserve independent self-care

This program provides health care to a person, of any age, in the person's own home. The person must require health care due to a mental or physical challenge. The services are approved by a physician and supervised by a registered nurse.

The state supplements the person's income to allow the person to pay for the needed services. The state does not purchase the services directly. The cost of the services must be below a specified limit but above what the person is determined able to pay.

Legal Basis

Iowa Code Chapter 217 governs the establishment, purposes, and general duties of the Department of Human Services.

Iowa Code Chapter 249 provides that State Supplementary Assistance payments may be made to an eligible person receiving "nursing care in the person's own home, certified by a physician as being required, so long as the cost of the nursing care does not exceed standards established by the Department."

Iowa Administrative Code 441, Chapter 177, "In-Home Health-Related Care," establishes the rules for the program. Chapters 50, 51, and 52 establish the rules for application, eligibility, and payment for State Supplementary Assistance.

Chapter Organization

This chapter provides direction regarding the in-home health-related care (IHHC) program in relation to:

- ◆ [Determining eligibility](#)
- ◆ [Planning services](#)
- ◆ [Requesting certification](#)
- ◆ [Processing payments](#)
- ◆ [Monitoring and changing services](#)
- ◆ [Termination of services](#)

List of Requirements

Legal reference: 441 IAC 177 and 441 IAC 50

Application and Assessment

Medical Eligibility

- ◆ Person must be under a physician's care.
- ◆ Care must be supervised by a registered nurse.
- ◆ Person must require health care or personal care.

Financial Eligibility (Determined by income maintenance (IM) worker)

- ◆ Person's income must be under the current Supplemental Security Income (SSI) standard plus the current maximum IHHRC payment.
- ◆ DHS service worker or designee helps the client complete form 470-2927 or 470-2927(S), *Health Services Application*, if the client requests assistance. The Income Maintenance (IM) worker may provide this form to the client or the client can print it from the DHS web page.
- ◆ Send the completed application to the IM worker in the local DHS office. Upon receipt the IM will then pend the case in ISIS.

NOTE: The signed application form in the IM case file serves as the application for both medical and service components of the program. A copy of the application is not required to be kept in the DHS service case file.

NOTE: At each step in the approval process the DHS service worker will have ISIS milestones to answer.

- ◆ If the person's income is below the SSI benefit amount, refer the person to apply for SSI. (The person is eligible for IHHRC when IM is notified of the person's SSI eligibility.)

Opening Case

- ◆ Have the client sign form 470-3951 or 470-3951(S), *Authorization to Obtain or Release Health Care Information*, for the supervising registered nurse and the client's physician.
- ◆ Provide the *Physician's Report*, form 470-0673, to the client.
- ◆ Send signed form 470-3951 or 470-3951(S) to the supervising registered nurse with a request for the physician's plan of care and the nurse's provider instructions.
- ◆ Have the provider sign form 470-3951 or 470-3951(S), *Authorization to Obtain or Release Health Care Information*, for the provider's health care provider.
- ◆ Give a copy of signed form 470-3951 or 470-3951(S) to the provider along with form 470-0672, *Provider Health Assessment*, which must be completed by the provider's physician, advanced registered nurse practitioner, or a physician assistant working under the direction of a physician to certify the provider's ability to provide assistance.

Approval

- ◆ Receive physician's plan of care and health provider instructions from the supervising registered nurse.
- ◆ Receive completed *Provider Health Assessment* from the provider.
- ◆ The provider must have a valid Medicaid provider number. Before entering provider demographic information, search ISIS to determine if the provider has a Medicaid provider number. If the provider does not have a traditional provider number, ISIS will generate a non-traditional provider number upon entry of all required fields.
- ◆ Complete form 470-0636, *Provider Agreement*, with the client and the provider.
- ◆ The client must complete the W-9 form.
- ◆ Scan the W-9 form in and email to InHomeHealthDemographic@dhs.state.ia.us

Approval (Cont.)

- ◆ Enter the service plan and client participation in ISIS.
- ◆ Answer milestones in ISIS to approve the service plan.
- ◆ IM will determine the financial eligibility and issue a medical card.
- ◆ Explain billing procedures, responsibilities, and limitations of the program to the client and provider.
- ◆ Discuss termination procedures and time limits with the client and the provider.
- ◆ Write the case plan using the *Individual Client Case Plan*.
- ◆ Submit copies of *Provider Agreement*, and a copy of the case plan, including health care plan, to service area manager (or designee) for approval and certification.
- ◆ When the service area manager (or designee) returns the signed *Provider Agreement*, file one copy in the DHS service file and mail copies to the client and provider, along with form 470-0602, *Notice of Decision: Services*, approving service. Clarify who will receive the client participation, the amount, and the type of service.
- ◆ Before sending copies of the *Provider Agreement* to the client and provider, use black marker pen to delete the client's Social Security number.
- ◆ Give each provider an adequate supply of form 470-0648, *Statements of Services Rendered*, and self-addressed stamped envelopes to mail to the assigned DHS service worker.

Case Maintenance

Monthly Billing

- ◆ Upon receipt of form 470-0648, *Statement of Services Rendered*, from the client complete form 470-0020, *Purchase of Service Provider Invoice*. Enter the invoice information in ISIS.
- ◆ Attach *Statement of Services Rendered* to the printed invoice page from ISIS and place in the service case file.

Case Review

Bimonthly Review

- ◆ The physician reviews the need for continued in-home health care services and provides a written recertification of the continuing appropriateness of the care plan every 60 days.
- ◆ The supervising registered nurse obtains an updated physician's plan of care, and reviews the nursing plan with both the provider and DHS service worker. A copy of the updated physician's plan of care should be provided to the DHS service worker. A copy of the nursing plan should be provided to both the DHS service worker and the provider.

Semiannual Review

Review the entire care plan at least once every six months. Document this review in the narrative.

Annual Review

- ◆ Review and reassess all eligibility factors by conducting a home visit once per year, minimum, and completing all paperwork requirements.
- ◆ Assist the client in completing form 470-3118 or 470-3118(S), *Medicaid Review*, if needed. The IM worker sends this form to the client when it is time for the review.
- ◆ Remind the client to obtain the required annual physician's physical examination. Provide form 470-0673, *Physician's Report*, to the client.
- ◆ Have the client sign a current form 470-3951, *Authorization to Obtain or Release Health Care Information*, for the supervising registered nurse.
- ◆ Request a copy of updated health care plan and physician's report from the nurse.
- ◆ Have the provider sign a current form 470-3951, *Authorization to Obtain or Release Health Care Information*.
- ◆ Obtain a new *Provider Health Assessment*, form 470-0672, from provider.
- ◆ Complete a new *Provider Agreement*, form 470-0636.

Annual Review (Cont.)

- ◆ Complete ISIS milestones for annual review.
- ◆ Send *Notice of Decision: Services*, form 470-0602 or 470-0602(S), clarifying how much client participation is paid to each provider for which service.
- ◆ Notify the supervising registered nurse of any changes.
- ◆ If the provider changes, terminate the *Provider Agreement* and complete the required steps for approving a case.
- ◆ Notify the IM worker of any changes either by email or entries in ISIS, such as case termination and note reason.

Determining Eligibility

Legal reference: 441 IAC 177.4(249)

A person must meet the following requirements to be eligible for in-home health-related care:

- ◆ The person must be eligible for SSI in every respect except income, and
- ◆ The person must be certified by a physician as needing specific health care services and those services can be provided in the person's own home, and
- ◆ The person requires and is receiving qualified health care services. "Qualified health care services" are health care services supervised by a registered nurse and approved by a physician.
- ◆ The person must be living in the person's own home.

NOTE: "Own home" means a person's house, apartment, or other living arrangement intended for single or family residential use. A person is considered to be living in the person's own home even though the person may be sharing the household of another. Such arrangements may be temporary or permanent and may be established for the purpose of providing health care.

Instructions for determining eligibility are divided into four sections:

- ◆ [Communicating with income maintenance](#)
- ◆ [Taking applications](#)
- ◆ [Pending applications](#)
- ◆ [Assessing services needs](#)

Communicating with Income Maintenance

Use the comment section in ISIS to communicate with the IM worker as to what is happening in the case. Examples of communication may include notice of service eligibility, payments issued, and case closure.

Communication may also include the use of email to inform the IM worker of such things as:

- ◆ The client's living arrangements have changed.
- ◆ The client has died.
- ◆ The client is no longer receiving the service.

Examples of times when the IM worker would use ISIS to communicate with the DHS service worker:

- ◆ The amount of client participation on a new case has been determined.
- ◆ The client becomes eligible to receive Medicaid.
- ◆ The client's income has increased or decreased.
- ◆ The client participation has increased or decreased.
- ◆ The client's address has changed.
- ◆ The client is financially ineligible for services.

Taking Applications

Legal reference: 441 IAC 177.4(10)

The client, or a responsible person acting on behalf of the client, shall apply for services at the local office of the Department. The initial application can be submitted to either the Department social worker or the IM worker.

If received by a DHS service worker, review the demographic information for accuracy and forward the application to income maintenance.

Form 470-2927 or 470-2927(S), *Health Services Application*, is the application for both medical and service components of the in-home health-related care program. Keep the signed application in the IM case file. It is not required that a copy of the *Health Services Application* be kept in the DHS service case file.

NOTE: The *Health Services Application* serves the purpose of the *Application for All Social Services*, form 470-0615 or 470-0615(S). It is not necessary for the client to sign the *Application for All Social Services* also.

A Department IM worker is responsible for determining financial eligibility. The DHS service worker will receive notice from the IM worker as to whether the client is initially financially eligible and if client participation is required in ISIS.

If the client's income is above SSI standards, the IM worker determines the amount of countable income and resources based on policies in [6-B](#), [Resources](#), and [8-E](#), [INCOME POLICIES FOR SSI-RELATED COVERAGE GROUPS](#).

Countable income may be from any source: Veterans Administration, Railroad Retirement, Social Security, pension, interest, farm, etc.

If income is below SSI standards and the client is not receiving SSI, it is essential that the client, the client's legal representative, or a responsible party immediately complete an application at the Social Security Administration office, so SSI eligibility can be established. (Application for other benefits is an eligibility factor for State Supplementary Assistance.)

Pending Applications

Legal reference: 441 IAC 177.4(10)

Complete the eligibility determination within 30 days from the date of the application, unless one or more of the following conditions exist:

- ◆ An application for Supplemental Security Income (SSI) benefits is pending.
- ◆ The receipt of information, which is beyond the control of the client or the Department, has not yet been received.
- ◆ A disability determination is pending.
- ◆ Form 470-0636, *Provider Agreement*, has not yet been received.

NOTE: Communicate any delays due to the above reasons to IM by email.

EXCEPTION: The 30-day time frame can be extended to 60 days if a provider cannot be located within 60 days from the date of application.

The client may reapply when a provider is located.

Assessing Service Needs

Legal reference: 441 IAC 177.4(1); 441 IAC 177.4(2)

In-home health-related care can be provided only when other existing programs cannot meet the client's needs. A person cannot receive the same service from in-home health-related care and another Medicaid program at the same time. A person who is eligible for more than one Medicaid program that can provide the same service must select the most cost-effective program to meet the client's needs. The DHS service worker is responsible for determining if the needed services can be met through programs other than in-home health-related care.

1. Make an initial assessment of the client's physical and emotional health care needs and protective needs, based on all available information including information from other professionals (e.g., physician, public health nurse) and the completed *Service Worker Comprehensive Assessment*, form 470-5044.
2. Make the initial determination that the client's needs can be met by an in-home program, and cannot be adequately met by other community programs, including:
 - ◆ Homemaker-health aide program
 - ◆ Visiting nurse services
 - ◆ Chore service
 - ◆ Medicaid waiver programs
 - ◆ Service organizations
 - ◆ County-funded programs
3. Consult the physician or arrange for the supervising registered nurse to consult the physician to determine the health care needs of the client. The physician must make the determination of whether or not the client needs the service and whether or not the client's health care needs can be met with this service.
4. Consult with supervising registered nurse regarding the personal, nursing, and medical care required by the client, the qualifications of the provider, and the amount of supervision the nurse will provide.

5. Assist the client and family with obtaining the necessary health care services, as stated in the health care plan. The identified health care services can include a registered nurse, licensed practical nurse, homemaker-home health aide, or volunteers (family or otherwise) to be trained by a professional, either from another agency or private providers.
6. Help the client inform these persons about how the program will operate, including payment procedures, and provide overall coordination of the health care services with other services being provided to the client, e.g., chore service, mobile meals, homemaker, etc.
7. If the client is being transferred from a hospital or nursing facility, obtain a transfer form describing the client's current care plan, to be provided to the registered nurse supervising the in-home care plan.

Planning Services

This section covers the actions necessary to move from the service assessment to a plan for using the in-home health care program to meet the client's assessed needs. It is organized in the following parts:

- ◆ [Available services](#)
- ◆ [Health care plan](#)
- ◆ [Case plan](#)
- ◆ [Determining amount of supplementation](#)
- ◆ [Qualifications of service providers](#)
- ◆ [Determining reasonable charges](#)
- ◆ [Agreements for service](#)

Available Services

Legal reference: 441 IAC 177.3(249)

The in-home health-related care program includes both skilled and personal care services, as follows:

- ◆ Skilled services which are necessary for the client may include, but are not limited to:
 - Gavage feedings (tube feeding of person unable to eat solid food).
 - Intravenous therapy administered only by a registered nurse.
 - Intramuscular injections, if they are required more than once or twice a week (excluding diabetes).
 - Catheterizations, including continuing care of in dwelling catheters with supervision of irrigations and changing of Foley catheter when required.
 - Inhalation therapy.
 - Care of decubiti and other ulcerated areas (requires noting and reporting to physician).
 - Rehabilitation services, which include, but are not limited to: bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, teaching the activities of daily living, respiratory care and breathing programs, remotivation, and behavior modification.
 - Tracheotomy care.
 - Colostomy care, until the person is capable of maintaining the colostomy personally.
 - Care of uncontrolled types of medical conditions, including brittle diabetes and terminal conditions.
 - Post-surgical nursing care for short time periods, primarily for persons with complications following surgery, or with the need for frequent dressing changes.
 - Monitoring medications when there is a need for close supervision of medications because of fluctuating physical or mental conditions, such as hypertensives, digitalis preparations, or narcotics.
 - Need for therapeutic diets. Evaluation of diet at frequent intervals.
 - Recording and reporting change in vital signs to the attending physician.

- ◆ Personal care services may include, but are not limited to:
 - Supervision on a 24-hour basis for physical or emotional needs. This may include the use of volunteers or non-paid family, as well as the service provider, but only the cost of the health care provider will be included.
 - Helping client with bath, shampoo, and oral hygiene.
 - Helping client with toileting.
 - Helping client in and out of bed and with ambulation.
 - Helping client to reestablish activities of daily living.
 - Assisting with oral medications.
 - Performing incidental household services that are essential to the client's health care at home and are necessary to prevent or postpone facility care.

Other technical procedures may be assigned at the discretion of the supervising registered nurse, based on evaluation of the training, experience, and ability of the provider.

Health Care Plan

Legal reference: 441 IAC 177.6(249), 441 IAC 177.10(249)

The supervising registered nurse completes the health care plan (also known as care plan) with the physician's approval. Include the specific types of services required, the method of providing those services, and the expected duration of the services in the health care plan.

The supervising registered nurse is responsible for assuring that the medical records in the health care plan include the following items whenever appropriate:

- ◆ Transfer forms
- ◆ Physician's certification and orders
- ◆ Progress notes
- ◆ Drug administration records
- ◆ Treatment records
- ◆ Incident reports
- ◆ Emergency instructions

The supervising registered nurse will obtain from the client's physician either the physician's plan of treatment or the *Physician's Report*, form 470-0673, found in [16-J-Appendix](#). Include the physician's certification that the client's health care needs can be met adequately in an in-home setting, the specific types of service required, the method of providing those services, and the expected duration of services in the health care plan.

Give a copy of the health care plan to the provider to follow. Provide a copy of the health care plan to be kept in the client's home as well. Other medical records shall be located in the supervising registered nurse's case file. Keep a copy of the physician's plan of services in the DHS service case file. (The physician's plan of services can be the *Physician's Report* form.)

The Department may review medical records related to the In-Home Health Care program.

The supervising registered nurse will complete written instructions for dealing with emergency situations. Include the instructions in the health care plan and maintain them in the client's home in the service record. The emergency instructions will include:

- ◆ The name and telephone number of the client's:
 - Physician.
 - Nurse.
 - Family members or other significant person.
 - DHS service worker.
- ◆ Information as to which hospital to use.
- ◆ Information as to ambulance service or other emergency transportation to use.

Individual Client Case Plan

Legal reference: 441 IAC 130.7(234)

Develop an individual client case plan using the *Individual Client Case Plan*. Include in the plan:

- ◆ **Assessment:** Include a summary of the client's current home situation, informal supports, need for services, and other services the client is currently receiving.
- ◆ **Income Information:** Source of income.
- ◆ **Goals:** List the goals of the plan.
- ◆ **Objectives:** List the objectives of the plan.

- ◆ **Specific Services:** List the services the client will be receiving through the In-Home Health-Related Care (IHHRC) program and any other formal and informal services that the client is receiving.
- ◆ **Responsibilities:** List the responsibilities of the client, provider, and the DHS service worker.
- ◆ **Reassessment/Termination:** Note if this is a reassessment or termination. If reassessment, update the information above. If termination, explain the reason for termination.

The health care plan is only part of the total assessment of the person's need for services. The individual client case plan should include a comprehensive outline of all service needs and plans for meeting those needs. When preparing the plan, take into consideration:

- ◆ Whether needed services can be met through existing programs including, but not limited to:
 - Homemaker-home health aide programs
 - Visiting nurse services
 - Medicaid waiver programs
 - Service organizations
 - County-funded programs
- ◆ That the cost of service paid for under this program cannot exceed the base SSI allowance plus the service cost.

NOTE: The DHS service worker is responsible for determining if the needed services can be met through programs other than in-home health-related care. Do not use this program in place of valid referrals for homemaker, a waiver service, etc.

Amount of Supplementation

Legal reference: 441 IAC 51.2(249)

The DHS service worker determines the person's services and the cost of those services. The IM worker determines financial eligibility and the amount of client participation in the service cost. When the IM worker has transmitted that information to the DHS service worker through ISIS, the maximum dollar amount per month the client is eligible to receive through this program can be determined.

The amount of supplementation is the difference between the cost of the service and the amount of client participation, up to the current maximum cost per month for each person needing care. The costs must be justified by the service plan.

The current maximum payment per month is \$480.55.

The IM worker determines eligibility based on the family's gross income. After eligibility is determined, all other income available to the client is considered in determining client participation, with applicable disregards. Some of these disregards are:

- ◆ The amount of the basic SSI income standard for an individual or a couple living in their own home and for any dependents:
 - For an individual \$733.00
 - For a couple \$1,100.00
 - For each dependent, add \$367.00
- ◆ When income is earned, \$65 plus one-half of the remainder.
- ◆ Diversion for established unmet medical needs of the client, the spouse, and any dependents.

"Established unmet medical needs" include costs such as visits to physicians, prescription medicines, and related travel expenses needed on an ongoing basis and not covered by insurance or Medicaid. Insurance premiums and unmet past bills are not included.

Any income remaining after the disregards is applied toward service costs under this program before beginning supplementation. See [6-B, IN-HOME HEALTH-RELATED CARE](#), for a complete discussion of income eligibility and client participation policies for adults and children.

Then the potential supplementation is figured up to the maximum service cost.

1. Mr. A has unearned income (SS, VA, etc.) totaling \$847 per month and unmet medical needs of \$70 per month. He must pay the first \$56 of service $[(\$847 - \$70) - \$721]$. No supplementation is available to Mr. A if his total service need is \$56 or less.
2. Mr. and Mrs. B have unearned income (SS, VA, etc.) totaling \$1,371 per month, with no unmet medical needs. They must pay the first \$271 of service costs $(\$1,371 - \$1,100)$. No supplementation is available to Mr. and Mrs. B if their total service need is \$271 or less.
3. Mr. and Mrs. C have earned income of \$2,500 gross per month and unmet medical needs of \$50. Only Mr. C needs care. The first \$65 earned income is disregarded plus half of the remainder. The couple's adjusted monthly income is $\$1,217.50 [(\$2,500 - \$65) \div 2]$. They must pay the first \$67.50 of service $[(\$1,217.50 - \$50) - \$1,100]$. No supplementation is available to Mr. C if his total service need is \$67.50 or less.

If the first month of service for a person receiving in-home health-related care is less than a full month, there is no required client participation for that month. The program will pay for the actual days of service provided according to the agreed-upon rate.

Client participation can be split between more than one service and more than one provider. When developing the *Provider Agreement*, identify who will receive the client participation with the client and providers.

Once approved, in-home health-related care may be paid from the date of application or the date all eligibility requirements are met and qualified health care services are provided, whichever is later.

"Qualified health care services" are health care services supervised by a registered nurse and approved by a physician.

Qualifications of Service Providers

Legal reference: 441 IAC 177.5(249)

The primary responsibility for locating a provider is with the client or the client's family, however, the DHS service worker may assist if needed.

You may assist in locating a provider. However, the primary responsibility for locating a provider is with the client or the client's family.

All providers of service under this program must meet the following criteria:

- ◆ The provider shall be at least 18 years of age.
- ◆ The provider must have a valid Medicaid provider number.
- ◆ The provider shall obtain a health assessment report at the beginning of the service and annually thereafter. A physician, advanced registered nurse practitioner or physician assistant working under the direction of a physician shall complete form 470-0672, *Provider Health Assessment*.
- ◆ Providers shall have the training and experience necessary to carry out the health care plan. The registered nurse supervising the case plan approves the provider's training and experience. The Department assumes no liability for the actions of any of the providers, professional or nonprofessional.
- ◆ The provider may be related to the client, as long as the provider is not a member of the family. "Family" means:
 - Legal spouses (including common law) who reside in the same household.
 - Biological or adoptive parents and children (under 18) who reside in the same household.
 - An individual or a child who lives alone or who resides with a person or persons not legally responsible for the child's support.
- ◆ A temporary absence does not change the composition of the family. When adults other than spouses reside together, each is considered a separate family.

Reasonable Charges

Legal reference: 441 IAC 177.8(249)

Determine reasonable charges for payment of in-home health-related care service by:

- ◆ Prevailing (usual and customary) community standards for cost of similar services.
- ◆ Availability of service providers at no cost to the Department.

Agreements for Service

Legal reference: 441 IAC 177.9(249) and 177.4(9)

Ensure that the client and each provider of in-home health care negotiate a *Provider Agreement*, form 470-0636, as found in [16-J-Appendix](#) and Outlook, before provision of service. The *Provider Agreement* includes a statement of the work to be performed, the rate of payment in 15-minute increments, and the maximum monthly payment allowed. The distribution of client participation should also be identified at this time.

Discuss with providers (individuals and agencies) their responsibilities and liabilities, including discontinuance of payment upon termination of service.

The provider of services under this agreement is not considered an agent, employee, or servant of the state of Iowa, the Department of Human Services, or any of its employees. It is the provider's responsibility to determine employment status in regards to income tax and social security. Providers of service have no recourse to the Department to collect payments due as a result of this agreement.

Discuss the termination procedures and time limits with the client and the provider.

Each provider must have a valid Medicaid provider number in the ISIS system. Before entering provider demographic information search ISIS to determine if the provider has a Medicaid provider number. If the provider does not have a traditional provider number, ISIS will generate a non-traditional provider number upon entry of all required fields.

A client must have a separate *Provider Agreement* for each provider that the client is using. In such cases, each *Provider Agreement* will have a different number.

A provider that has more than one client must have a different *Provider Agreement* for each client. If the provider has more than one client, the provider will have the same provider number for each client.

To change anything on a *Provider Agreement*, complete a new form and check "Amendment." See [Monitoring and Changing Services: Amending Agreement](#).

Requesting Certification

Legal reference: 441 IAC 177.4(5)

The service area manager (or designee) certifies the in-home health-related care service program by signing the *Provider Agreement*, form 470-0636. Send the following to the service area manager (or designee) for approval:

- ◆ A copy of the total *Individual Client Case Plan*, including the health care plan.
- ◆ Three copies of the *Provider Agreement*, form 470-0636.

A signed *Provider Agreement*, form 470-0636, returned to the assigned DHS service worker constitutes certification and approval for payment.

Distribute copies of the *Provider Agreement* to the client and the provider. Place the original in the DHS service case file.

When the agreement is approved, give each provider an adequate supply of form 470-0648, *Statement of Services Rendered*, with self-addressed stamped envelopes to mail to the assigned DHS service worker.

More information is included in the following sections:

- ◆ [Notification](#)
- ◆ [Denial of service](#)
- ◆ [Eligibility for Medicaid](#)

Notification

Legal reference: 441 IAC 7.7(1)

Notify the client of approval, denial, or termination of service and when changes occur, using form 470-0602, *Notice of Decision: Services*, located in [16-J-Appendix](#) or Outlook. For approvals the NOD can be generated by ISIS. Include in the *Notice of Decision: Services*:

- ◆ A statement of what action is being taken.
- ◆ The reasons for the intended action.
- ◆ The manual chapter number and subheading supporting the action, along with the Iowa Administrative Code reference.
- ◆ The amount of client participation, if any, and the distribution of client participation.

Information entered into ISIS will alert the IM worker to:

- ◆ The approval and certification of case plan.
- ◆ The maximum amount of payment approved.

Denial of Service

Legal reference: 441 IAC 51, 177

If the client is ineligible to receive State Supplementary Assistance because the income or resources exceed the program maximum limits, the IM worker will deny the application and sends form 470-0490, *Notice of Decision: Medical Assistance or State Supplementary Assistance*, to the client.

The DHS service worker will then deny the application and send form 470-0602, *Notice of Decision: Services*, stating that:

- ◆ The client is ineligible because the client participation exceeds the cost of care.
- ◆ The client does not need supplementation to meet the cost of care.
- ◆ The physician does not approve the in-home health care plan.
- ◆ An appropriate provider cannot be located within 60 days from the date of application.
- ◆ Other programs or services available in the community can meet the client's needs.

Eligibility for Medicaid

Legal reference: 441 IAC 75(9)

Most recipients of State Supplementary Assistance are eligible for Medicaid. (Medicaid has eligibility factors not common to SSI or State Supplementary Assistance.) The IM worker makes that determination. Eligibility is redetermined at least annually. When the client is eligible for Medicaid, the IM worker:

- ◆ Sends form, 470-0490, *Notice of Decision: Medical Assistance or State Supplementary Assistance*, to the client indicating the eligibility.
- ◆ Issues a *Medical Assistance Eligibility Card*. Medicaid eligibility begins the first day of the month when service begins.

A client who becomes eligible for Medicaid due to receipt of State Supplementary Assistance may be eligible for Medicaid retroactively for up to three months. To apply for retroactive assistance, the client informs the IM worker that there are unpaid bills. The IM worker determines retroactive eligibility.

NOTE: **Never** approve a client to receive in-home health-related care solely for the purpose of obtaining Medicaid coverage.

Processing Payments

Legal reference: 441 IAC 177.4(9)

ISIS is the computer system that provides the means to enter information from the *Provider Agreement* and the invoice to generate payment for in-home health related care services.

The provider and the client complete form 470-0648, *Statement of Services Rendered*, and submit it to the assigned DHS service worker.

The DHS service worker completes the invoice on ISIS for all in-home health-care providers that have submitted a signed *Statement of Services Rendered*. Complete only one invoice per month for each agreement.

Do **not** enter an invoice until **after** the month is over. The first day an invoice may be entered is the first day of the following month.

The client is the sole payee for payments made under this program. The client is responsible for making payment to the provider, except when either of the following circumstances applies:

- ◆ The client has a legally designated person to handle finances, such as a:
 - Conservator
 - Representative payee
 - Power of attorney
- ◆ One payment may be made to the provider on behalf of a client who dies or becomes incapacitated while receiving services.

After entering the invoice information on the ISIS system, attach the *Statement of Services Rendered* to the printed invoice screen from ISIS and file in the client's service file.

NOTE: To avoid potential payment issues enter all agreement information into ISIS at least two weeks before entering the invoice in ISIS.

Maintain the original invoices in the local office for the current fiscal year plus the next fiscal year. Invoices may then be sent to record storage for an additional nine years using reference # BUD 2-10-1, Accounts Payable Records. (*RECORDS MANAGEMENT MANUAL*, Records Retention and Disposition Schedule BUD.)

The following sections provide additional information on:

- ◆ [Authorized reductions in payments](#)
- ◆ [Direct deposits](#)
- ◆ [Warrant returns](#)
- ◆ [Clients who have died or are incapacitated](#)

Authorized Payment Reduction

When the Department authorizes a payment reduction, have the provider and client complete the *Amendment to Provider Agreement*, form 470-1999, found in [16-J-Appendix](#). This will verify that the client and provider have been made aware that the payment will be reduced.

Direct Deposit

A client who wishes to have the in-home health-related care payment deposited directly into a bank account must complete an Electronic Funds Transfer (EFT) form authorizing direct deposit into the client's account. Submit the EFT authorization form to the Iowa Department of Administrative Services. A copy of the form is available on the DHS network. (Hoovr3s2: Payments: Payment Instructions & Forms: EFT Authorization.doc)

Warrant Returns

Any warrants returned to the Department's central office from the client will be kept in the Bureau of Purchasing, Payments, Receipts and Payroll until the DHS service worker can verify the address. When the address is verified, the Bureau will mail the warrant again.

If the warrant can not be delivered due to incorrect information on the *Provider Agreement*, ISIS detail screen or on I3, the DHS service worker should correct the information with an amendment to the agreement and notify the Bureau of Purchasing, Payments, Receipts and Payroll by mail or email (InHomeHealthDemographic@dhs.state.ia.us).

Notify the IM worker of the correct address information to be entered into IABC and uploaded into ISIS.

Client Has Died or Is Incapacitated

Legal reference: 441 IAC 177.4(9)

When a client dies or becomes incapacitated:

1. Complete an amended *Provider Agreement* reflecting the client's changed condition and listing the provider as the payee.
2. Change the client's name and address to the provider's name and address. Leave the provider's information. Change the social security number to the provider's social security number.
3. Complete a new W-9 with the provider's information. Keep a copy in the DHS service case file.

4. Submit the original statement of services rendered (signed by the provider), a completed provider invoice (indicating the clients changed condition listing the provider as the payee) on form number 470-0020, and the new W-9 form to the address below.

Department of Human Services
Bureau of Purchasing, Payments, Receipts and Payroll
1305 E. Walnut St.
Des Moines, Iowa 50319-0114

5. If a warrant was issued to the client, make a copy for the service file, then return the check to central office at the address:

Department of Human Services
Bureau of Purchasing, Payments, Receipts and Payroll
1305 E. Walnut St.
Des Moines, Iowa 50319-0114

NOTE: This is a one-time only procedure. If an incapacitated client will remain in the program, assist the client's family to have a person legally designated to handle the client's finances and become payee on behalf of the client.

Monitoring and Changing Services

Legal reference: 441 IAC 177.6(3) and 441 50.4(2)

The DHS service worker, physician, supervising registered nurse, or the provider may request a review of the care services at any time. While more frequent reviews may be held, at a minimum, a review of the continuing need for in-home health-related care services should occur at the following intervals:

◆ **At least every 60 days:**

- The physician shall review and recertify the appropriateness of the health care plan.
- The supervising registered nurse shall review the nursing plan.
- The supervising registered nurse shall provide an updated copy of the physician's health care plan or form [470-0673, *Physician's Report*](#), and the nursing plan of care to the provider and the DHS service worker.

- ◆ **At six months:** The DHS service worker shall review the entire health care plan (or *Physician's Report*) and nursing care plan at a minimum every six months. This can be completed by reviewing the service case file and either a face-to-face interview or phone contact with the provider and the supervising registered nurse involved with the care plan.
- ◆ **Annually:** Review the entire care plan annually.
 - Complete a new case plan annually.
 - A *Medicaid Review* form will be automatically sent to the client. This form serves the same function as the *Application for All Social Services*, form 470-0615 or 470-0615(S). Upon receipt of the *Medicaid Review* the form will be kept in the IM case file.
 - Have the provider complete a new *Provider Health Assessment*, form 470-0672.
 - Request an updated *Physician's Report*, form 470-0673, and nursing plan of care. File them in the DHS service case file.
 - Complete a new *Service Worker Comprehensive Assessment*, form 470-5044.
 - Update the *Provider Agreement*, form 470-0636, reviewing client participation payments.

Document each review in the narrative section of the DHS service case file.

Amending Agreement

To change anything on the *Provider Agreement*, form 470-0636, (other than client and provider name) fill out a new form, but check "amendment." Duties do not need to be repeated. The agreement number remains the same.

An amendment is required when there is a Department authorized reduction, client participation changes, or the client dies or becomes incapacitated.

An amendment cannot be used when there is a change regarding a client or a provider. There must be a new *Provider Agreement* when there is a new client or a new provider.

If a provider has more than one client, the provider must have a different *Provider Agreement* for every client. A client and a provider could each have more than one valid *Provider Agreement*. Each of the client's providers would have a different number. The provider's number would be the same for each client they serve.

When a client dies or becomes incapacitated while receiving services and the client is the payee, an amendment should be prepared listing the provider as payee. See [Client Has Died or Is Incapacitated](#).

The instructions are the same for each line item as those for the agreement. See [16-J-Appendix](#) for additional information.

If a change is made in the top section of the form, complete all items in both sections, enter the agreement number, and check "yes" for amendment.

The following items may be amended with no client or provider signature:

- ◆ Addresses and phone numbers.
- ◆ Incorrect social security number.
- ◆ Maximum per month DHS, if it is increased.
- ◆ Addition of or change in a payee.
- ◆ Unit cost, if increased.
- ◆ Termination date, if the client has requested termination, has died, or has entered a long-term care facility.

The following amendments require client and provider signatures:

- ◆ Decrease in unit cost.
- ◆ Decrease in maximum per month client.
- ◆ Change in client participation.
- ◆ Termination date that is adverse to the client. (Death or client move out of home does not require signature.)
- ◆ Renewal of agreement for the next time period. (List new beginning and termination dates.)

Send the agreement amendments to the service area manager (or designee) for signature. When the signed *Provider Agreement* is returned from the service area manager (or designee), enter the changes in ISIS.

Adding or Changing Providers

When a new provider begins:

1. Ensure that the provider has a valid Medicaid provider number.
2. Explain the billing procedures, responsibilities, and limitations of the program to the new provider.
3. Give the provider form 470-0672, *Provider Health Assessment*, to be completed by a physician, advanced registered nurse practitioner, or a physician assistant working under the direction of a physician.
4. Complete a *Provider Agreement*, form 470-0636, with the new provider and the client.
5. Submit three copies of the *Provider Agreement* to the service area manager (or designee) for approval.
6. When the service area manager (or designee) returns the three copies of the signed *Provider Agreement*, file the original copy and mail one each to the client and the provider. Before sending copies of the *Provider Agreement* to the client and provider, use a black marker pen to delete the client's social security number.
7. Give the new provider an adequate supply of form 470-0648, *Statement of Services Rendered*, and self-addressed stamped envelopes to mail to the assigned DHS service worker.
8. Notify the supervising registered nurse of the new provider and change the name of the provider on the case plan.

When a *Provider Agreement* is canceled before the expiration date:

1. End the service line for that provider in ISIS.
2. Complete a new *Provider Agreement*.
3. Enter new service line or lines in ISIS for the new provider.
4. Send a notice of decision to the client and the provider.
5. Send an ISIS-issued NOD to the client and the new provider.

To inactivate the provider in ISIS:

1. Manage nontraditional provider.
2. Enter provider number and then enter the Update button.
3. Change provider status to "other state termed."
4. Enter new enrollment status date.

Terminating Services

Legal reference: 441 IAC 177.11 (249)

Terminate in-home health-related care service under the following conditions:

- ◆ The client becomes sufficiently self-sustaining to remain in the client's own home with services that can be provided by other community supports or agencies.
- ◆ The physical or mental condition of the client requires more care than can be adequately provided by this program in the client's own home.
- ◆ Upon the request of the client or legal representative. If termination of the program would result in the client being unable to protect the client's own interests, provide assistance with making any necessary arrangements to ensure the client's needs will be met in a safe environment.
- ◆ The cost of care needed for the client exceeds the maximum established in the determination of the supplementation.
- ◆ When it is determined that other services can adequately meet the client's needs.
- ◆ A determination has been made that either the client or the provider has not met the terms of the *Provider Agreement*, form 470-0636.
- ◆ A *Notice of Decision* from income maintenance is issued that the client is no longer financially eligible.

The following sections give more information on:

- ◆ [When the client is absent from home for more than 15 days](#)
- ◆ [Termination procedures](#)
- ◆ [Appeals](#)

Client Absent From Home for More Than 15 Days

Allow the client to remain eligible and make payment for services for no more than 15 days in any calendar month when the client is absent from home for a temporary period. Do not authorize payment for over 15 days of continuous absence, whether or not the absence extends into a succeeding month or months.

When it is known that the out-of-home stay will exceed 15 days, tell the IM worker to send a termination notice to the client. Notify the supervising registered nurse and the provider.

Termination Procedures

To terminate IHHRC services, use the following procedures:

1. Notify the client of the termination on form 470-0602, *Notice of Decision: Services*, allowing timely and adequate notice except as described in [1-E, Dispensing With Timely Notice](#). **Always** send a copy to the IM worker so they can end the program request in ISIS.

EXCEPTION: When the IM worker has terminated IHHRC benefits due to the client no longer being financially eligible, **do not** send a *Notice of Decision*. The IM worker will send the DHS service worker a copy of the notice. That notice will serve as the notice of termination. Keep the notice of termination in the DHS service case file.

2. Notify the supervising registered nurse and the provider of the termination of service.
3. Continue payment during the ten-day notice period if service is provided during that time. For situations not requiring timely notice, payment shall be stopped immediately upon the date of the termination notice.

Appeals

Legal reference: 441 IAC 7.6(217)

Advise each applicant and recipient of the right to appeal any adverse action affecting the person's status. Assist in the filing process as needed.

If an appeal is received, immediately complete Part II of form 470-0487, *Appeal and Request for Hearing*. Send the written appeal, and a copy of the notice that the client is appealing to the Appeals Section within one day of receiving the appeal request.

Forward a summary and supporting documentation to the Appeals Section within 10 days of receiving the appeal request. Send a copy to the client and the client's representative, if any.

Follow the appeal processes outlined in Employees' Manual 1-E, [APPEALS AND HEARING](#).