

# COMMUNITY HEALTH WORKER

## ELIGIBLE PROVIDERS

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In order to receive payment, all eligible servicing and billing provider's National Provider Identifiers (NPI) must be enrolled with South Dakota Medicaid. Servicing providers acting as a locum tenen provider must enroll in South Dakota Medicaid and be listed on the claim form. Please refer to the [provider enrollment chart](#) for additional details on enrollment eligibility and supporting documentation requirement.

South Dakota Medicaid has a streamlined enrollment process for ordering, referring, and attending physicians that may require no action on the part of the provider as submission of claims constitutes agreement to the South Dakota Medicaid Provider Agreement.

South Dakota Medicaid does not enroll individual community health workers (CHW). A community health worker (CHW) agency is required to be enrolled with South Dakota Medicaid to be reimbursed for services.

Individual CHWs must be employed and supervised by an enrolled CHW agency. CHW agencies must complete a supplemental provider agreement addendum and submit their written policies and procedures outlined in the supplemental agreement addendum as part of the provider enrollment process.

The staff training policy must identify a process to certify that the individual has completed the Indian Health Service Community Health Representative basic training or a CHW program approved by the South Dakota Board of Technical Education, the South Dakota Board of Regents, or a CHW training program approved by the State. The agency will ensure that each CHW receives a minimum of 6 hours of training annually thereafter.

The staff training policy must include identification of the processes and timelines for new staff orientation and annual staff training. The new employee orientation must occur before the employee enters an individual's home unsupervised.

The agency must conduct fingerprint-based criminal background check (FCBC) or other State approved background check to screen for abuse, neglect, and exploitation for all employees hired to work in homes of individuals. The supplemental agreement includes the fitness criteria used to determine whether the background check is deemed to have been passed or failed. The agency must routinely check the Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and System for Award Management (SAM) to ensure that new hires and current employees are not excluded from participating.

## ELIGIBLE RECIPIENTS

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Providers are responsible for checking a recipient's Medicaid ID card and verifying eligibility before providing services. Eligibility can be verified using South Dakota Medicaid's [online portal](#).

The following recipients are eligible for medically necessary services covered in accordance with the limitations described in this chapter:

Coverage Type	Coverage Limitations
Medicaid/CHIP Full Coverage	Medically necessary services covered in accordance with the limitations described in this chapter.
Medicaid – Pregnancy Related Postpartum Care Only (47)	Coverage restricted to family planning and postpartum care only.
Medicaid – Pregnancy Related Coverage Only (77)	Coverage restricted to pregnancy related services only including medical issues that can harm the life of the mother or baby.
Unborn Children Prenatal Care Program (79)	Coverage restricted to pregnancy related services only including medical issues that can harm the life of the mother or baby.

Refer to the [Recipient Eligibility](#) manual for additional information regarding eligibility including information regarding limited coverage aid categories.

## COVERED SERVICES AND LIMITS

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### General Coverage Principles

Providers should refer to the [General Coverage Principles](#) manual for basic coverage requirements all services must meet. These coverage requirements include:

- The provider must be properly enrolled;
- Services must be medically necessary;
- The recipient must be eligible; and
- If applicable, the service must be prior authorized.

The manual also includes non-discrimination requirements providers must abide by.

### CHW Covered Services

CHW services are a preventive health service to prevent disease, disability, and other health conditions or their progression for individuals with a chronic condition or at risk for a chronic condition who are unable to self-manage the condition or for individuals with a documented barrier that is affecting the individual's health.

The following are examples of qualifying conditions:

- Asthma;
- Cancer;
- COPD;
- Depression;
- Diabetes;
- Heart Disease;
- Hypercholesterolemia;

- Hypertension;
- Mental Health Conditions;
- Musculoskeletal and neck/back disorders;
- Obesity;
- Pre-Diabetes;
- High Risk Pregnancy;
- Substance Use Disorder;
- Tobacco use; and
- Use of multiple medications (6 or more classes of drugs).

Barriers must be based on a risk assessment or prior health care experiences with the individual. The following are examples of barriers affecting an individual's health that could result in CHW services being necessary:

- Geographic distance from health services results in inability to attend medical appointment or pick-up prescriptions;
- Lack of phone results in the individual going to the emergency department instead of scheduling a medical appointment; or
- Cultural/language communication barriers results in the individual not following a medical professional's recommendation.

### **Physician or Other Licensed Practitioner Order**

Community health worker services must be ordered by a physician, physician assistant, nurse practitioners, or a certified nurse midwife. The service must be ordered or referred by the recipient's primary care provider or health home if applicable.

### **Care Plan**

Services must be delivered according to a care plan. The care plan must be written by the ordering provider or a qualified healthcare professional supervised by the ordering provider. The care plan must be finalized prior to CHW services being rendered. The ordering provider must specify the condition that the service is being ordered for and the duration of the service. An order may not exceed a period of one year. The plan must meet the following requirements:

- The plan must be relevant to the condition;
- Include a list of other healthcare professionals providing treatment for the condition or barrier;
- Contain written objectives which specifically address the recipient's condition or barrier affecting their health;
- List the specific services required for meeting the written objectives; and
- Include the frequency and duration of CHW services (not to exceed the provider's order) to be provided to meet the care plans objectives.

### **Care Plan Review**

The ordering provider must review the recipient's care plan at least semiannually with the first review completed no later than six months from the effective date of the initial care plan. The ordering provider must determine if progress is being made toward the written objective and whether services are still

medically necessary. If there is a significant change in the recipient's condition, providers should consider amending or discharging from the care plan. The ordering provider and the CHW agency must communicate regarding changes or amendments to the care plan.

### **Covered Services**

CHW Services must be related to a medical intervention outlined in the individual's care plan. Service must be provided face-to-face (including via telemedicine) with the recipient. Services are only allowed to be provided in a home or community setting with the exception of a CHW attending a medical appointment with a recipient and group services that take place in a meeting room of a medical setting. The care plan must be finalized prior to CHW services being rendered. Covered services include:

- Health system navigation and resource coordination including helping a recipient find Medicaid providers to receive a covered service, helping a recipient make an appointment for a Medicaid covered service, arranging transportation to a medical appointment, attending an appointment with the recipient for a covered medical service, and helping a recipient find other relevant community resources such as support groups.
- Health promotion and coaching including providing information or education to recipients that makes positive contributions to their health status such as cessation of tobacco use, reduction in the misuse of alcohol or drugs, improvement in nutrition, improvement of physical fitness, family planning, control of stress, pregnancy and infant care including prevention of fetal alcohol syndrome.
- Health education to teach or promote methods and measures that have been proven effective in avoiding illness and/or lessening its effects such as immunizations, control of high blood pressure, control of sexually transmittable disease, prevention and control of diabetes, control of toxic agents, occupational safety and health, and accident prevention. The content of the education must be consistent with established or recognized healthcare standards.

Services may be provided to the parent or legal guardian of a recipient 18 or younger if the service is for the direct benefit of the recipient, in accordance with the recipient's needs and care plan objectives, and for the purpose of addressing the diagnosis identified in the care plan.

### **Individual and Group Services**

Services may be provided to an individual recipient or a group of recipients. The group may consist of Medicaid recipients and non-Medicaid recipients. The group may not be larger than 8 individuals. CHW agencies may only bill South Dakota Medicaid for Medicaid recipients in the group with an active care plan. If the group consists of non-Medicaid recipients, South Dakota Medicaid must not be billed at a rate higher than other group participants are billed at. If the CHW agency does not charge other group members, South Dakota Medicaid must not be billed.

When services are provided to a single recipient that is a child and one or more parents or legal guardians is present the service is considered an individual service. If services are provided to more than one Medicaid recipient at the same time, they must be billed using the applicable group CPT code.

## NON-COVERED SERVICES

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### General Non-Covered Services

Providers should refer to [ARSD 67:16:01:08](#) or the [General Coverage Principles](#) manual for a general list of services that are not covered by South Dakota Medicaid.

Noncovered services include, but are not limited to:

- Advocacy on behalf of the recipient;
- Case management/care management;
- Child care;
- Chore services including shopping and cooking;
- Companion services;
- Covered services provided in a clinic or medical facility setting except for attending a medical appointment;
- Employment services;
- Helping a recipient enroll in government programs or insurance;
- Interpreter services;
- Missed or broken appointments;
- Medication, medical equipment, or medical supply delivery;
- Personal Care services/homemaker services;
- Respite care;
- Services not listed in the recipient's care plan;
- Services provided prior to the recipient's care plan being finalized;
- Services provided to non-Medicaid patients.
- Services that duplicate another covered Medicaid service;
- Services that the require licensure;
- Socialization;
- Transporting the recipient; and
- Travel time.

CHWs may provide non-covered services at their discretion if appropriate; however, these services must not be billed to South Dakota Medicaid. CHW agencies may not charge recipients for non-covered services.

## DOCUMENTATION REQUIREMENTS

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### General Requirements

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least 6 years after the last date a claim was paid or denied. Please refer to the [Documentation and Record Keeping](#) manual for additional requirements.

### **CHW Documentation**

Each service provided by a CHW agency must be documented. Services that are not documented are considered to have not occurred and are subject to recoupment of payment in the event of an audit.

The following documentation must be maintained by the CHW agency:

- Type of service performed including whether it was an individual or group service;
- A summary of services provided including the objectives in the care plan the service is related to;
- Recipient receiving services;
- Number of group members if a group service was provided;
- Date of the service;
- Location of service delivery;
- Time the service begins and ends;
- Name of the individual providing the service; and
- CHW signature;

It is recommended that the CHW obtain a signed and dated statement/form from the recipient or their parent or legal guardian that indicates services were provided on that date.

Both the ordering provider and the CHW agency must keep record of a recipient's care plan. The ordering provider and CHW agency must also document when the care plan was reviewed.

## **REIMBURSEMENT AND CLAIM INSTRUCTIONS**

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### **Timely Filing**

South Dakota Medicaid must receive a provider's completed claim form within 6 months following the month the service was provided. Requests for reconsiderations will only be considered if they are received within the timely filing period or within 3 months of the date a claim was denied. The time limit may be waived or extended by South Dakota Medicaid in certain circumstances. Providers should refer to the [General Claim Guidance](#) manual for additional information.

### **Third-Party Liability**

Medicaid recipients may have one or more additional source of coverage for health services. South Dakota Medicaid is generally the payer of last resort, meaning Medicaid only pays for a service if there are no other liable third-party payers. Providers must pursue the availability of third-party payment sources and should use the Medicare Crossover or Third-Party Liability billing instructions when applicable. Providers should refer to the [General Claim Guidance](#) manual for additional information.

### **Reimbursement**

CHW agencies must bill for services at the provider's usual and customary rate. Covered services will be reimbursed at the lesser of the provider's usual and customary rate or the rate on the [Community Health Worker](#) fee schedule.

### **Claim Instructions**

CHW services must be billed on a CMS 1500 claim form. Please refer to the [Professional Services Billing Manual](#) for detailed claim form instructions.

CHW services may only be billed using one of the following CPT Codes:

- 98960 - Self-management education & training 1 patient - 30 minutes
- 98961 - Self-management education & training 2-4 patients - 30 minutes
- 98962 - Self-management education & training 5-8 patients - 30 minutes

Services are only billable if at least 16 minutes of service were provided. Providers must use the following table to determine if one or two units should be billed.

Unit	Time
1 Unit	16-45 Minutes of Service
2 Units	46 or More Minutes of Service

No more than 2 units of any combination of 98960, 98961, or 98962 are billable on a single date of service. A recipient is limited to 104 units of services in a plan year from July 1 to June 30. It is a fraudulent billing practice to list a date of service on the claim other than the date the service was rendered. A provider engaged in this practice may be subject to recoupment of payment, termination of the provider agreement, and referral to the Medicaid Fraud Control Unit in the Attorney General's Office.

The diagnosis code(s) included on the claim must relate to the medical reason for the recipient's care plan. The billing provider and servicing provider listed on the claim must be the CHW agency, not the individual CHW. Services may be billed on a monthly basis, but documentation must be for each date of service.

## DEFINITIONS

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1. "Telemedicine" - The use of an interactive telecommunications system to provide two-way, real-time, interactive communication between a provider and a Medicaid recipient across a distance.

## REFERENCES

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- [Administrative Rule of South Dakota \(ARSD\)](#)
- [South Dakota Medicaid State Plan](#)
- [Code of Federal Regulations](#)

## QUICK ANSWERS

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### 1. What is the difference between Community Health Worker services and Health Homes?

Health home services are provided in a clinic setting. Community health worker services are provided in a home or community setting with the exception of a CHW attending a medical appointment with the recipient. Group services may also take place in a meeting room of a medical setting.

### 2. Can services be provided via telemedicine?

Yes, services can be provided via telemedicine. Please refer to the [Professional Services Billing Manual](#) for additional information regarding telemedicine services.

**3. Can I provide more than two units a day?**

Yes, but only two units are reimbursable per day. A recipient may not be charged for services provided in excess of two units.

**4. Can a CHW agency bill a recipient for services not covered by South Dakota Medicaid?**

No, per the CHW supplemental addendum CHW agencies are not allowed to charge recipients for noncovered services.

**5. Can a CHW agency bill Medicaid or the recipient for transportation?**

No. If a CHW agency meets the standards to become a community transportation provider or a secure medical transportation provider, they can enroll with South Dakota Medicaid as that type of provider and provide covered transportation services. For transportation provider qualifications please refer to [ARSD Ch. 67:16:25](#).

**6. Is attending an appointment with a recipient a covered service?**

This is covered if the CHW services have been ordered for the recipient and this is specified as a service in the recipient's care plan. Like all other CHW services, this service is considered noncovered if provided prior to the care plan being finalized.