

Chapter 24-A

Home Care Services

Covered Services

1. Home health aide (HHA)
2. Private duty nurse (PDN)
3. Rehabilitation therapies (occupational therapy, physical therapy, respiratory therapy, and speech therapy)
4. Skilled nurse visit (SNV)

Prior authorization is required for the following:

1. All HHA services – **not required for Minnesota Senior Care Plus (MSC+), Minnesota Senior Health Options (MSHO)*, and Special Needs BasicCare (SNBC)****
2. All PDN services – **not required for MSC+ and MSHO** (For SNBC: not covered by PrimeWest Health, but may be covered by the Minnesota Department of Human Services [DHS])
3. SNVs above nine visits per member, per calendar year – **not required for MSC+, MSHO, and SNBC**
4. Rehabilitation therapies above nine visits per member, per calendar year – **not required for MSC+, MSHO, and SNBC**
5. All tele-home-care visits – **required for all**

Information about the authorization requirements and process can be found at the end of this chapter in the section titled *Information for All PrimeWest Health Home Care Providers*.

Eligible Providers

1. Home health agency
2. PDN agency
3. Registered nurse
4. Licensed practical nurse

Provider requirements: Medicare-certified, Class A-licensed home health agencies enrolled with PrimeWest Health.

Qualifying Services

Qualifying services must be all of the following:

1. Provided to an eligible member
2. Medically necessary
3. Physician-ordered services provided to PrimeWest Health members in their own residence, that is other than a hospital, nursing facility (NF), or intermediate care facility (ICF)
4. Documented in a written care plan, which is reviewed by the member's physician at least once every 60 days for home health agency or PDN services, or at least once every 365 days for personal care services

*PrimeWest Health's name for this program is PrimeWest Senior Health Complete (HMO SNP)

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Plan of Care

The care plan is a written description of professional nursing services needed by the member as assessed to maintain and/or restore optimal health.

The orders or plan of care must do all of the following:

1. Specify the disciplines providing care
2. Specify the frequency and duration of all services
3. Demonstrate the need for the services and be supported by all pertinent diagnoses
4. Include recipient's functional level, medications, treatments, and clinical summary
5. Be individualized based on recipient needs
6. Have realistic goals
7. Subsequent plans of care must show recipient response to services and progress since the previous plan was developed
8. Changes to the plan of care are expected if the recipient is not achieving expected care outcomes

Home Health Aide (HHA) Services

HHA services are medically oriented tasks required to maintain the member's health or to facilitate treatment of an illness or injury. Services must be ordered by a physician and have professional supervision provided by a Medicare-certified agency.

Eligible Recipients

Recipients must be eligible for services under one of the following programs:

1. Medical Assistance
2. MinnesotaCare: Expanded Benefit Set (pregnant women and children under age 21), Basic, Basic Plus, Basic Plus One, and Basic Plus Two
3. Waivered service programs, including Elderly Waiver (EW), Developmentally Disabled (DD), Community Alternative Care (CAC), Community Alternatives for Disabled Individuals (CADI), and Traumatic Brain Injury (TBI).

Description of HHA Services

1. Assisting with personal cares such as bathing, dressing, grooming, feeding, toileting, routine catheter and colostomy care, ambulating, and transfers or positioning
2. Simple dressing changes that do not require the skills of a licensed nurse
3. Assisting with medications that are ordinarily self-administered and do not require the skill of a licensed nurse to be provided safely and effectively
4. Assisting with activities that are directly supportive of skilled therapy services but do not require the skill of a therapist to be safely and effectively performed, such as routine maintenance exercises
5. Routine care of prosthetic and orthotic devices
6. Incidental household services necessary to the provision of one of the above health related services

HHA visits for the sole purpose of providing household tasks, transportation, companionship, or socialization are **not covered**.

HHA services are normally paid on a per visit basis at a maximum of one HHA visit per day. As a waiver program service, HHA services may sometimes be authorized as approved units of service.

Authorization information/process can be found in section titled *Information for All PrimeWest Home Health Care Providers*.

Non-Covered Services

1. HHA visits for the sole purpose of providing household tasks, transportation, companionship, or socialization
2. Services that are not medically necessary
3. Services provided in a hospital, NF, or ICF
4. More than one HHA visit per day

Private Duty Nursing (PDN) Services

Definition

Private duty nursing (PDN) services are nursing services ordered by a physician for a member whose illness, injury, or physical or mental condition requires more individual and continuous care by a registered nurse (RN) or licensed practical nurse (LPN) than can be provided in a single or twice daily skilled nurse visit and requires greater skill than an HHA or Personal Care Assistant (PCA) can provide.

Professional nursing care is based on an assessment of the member's medical/health care needs. This service includes ongoing professional nursing observation, monitoring, intervention, and evaluation providing the continuity, intensity, and length of time required maintaining or restoring optimal health. Professional nursing is defined in the Minnesota Nurse Practice Act. PDN services have been designated as either "Regular" or "Complex."

Complex PDN Care is care provided to members who are either ventilator-dependent **or** who require an "intensive level of care."

1. **Ventilator Dependent** – A member is considered ventilator-dependent when mechanical ventilation for life support is needed for at least six hours per day and the person is expected to be or has been dependent for at least 30 consecutive days.
2. **Intensive Level of Care** – A member has medical needs that meet intensive level of care when the doctor's orders require complex nursing assessments and interventions that are in response to life-threatening episodes of instability. The interventions would be needed immediately based on either anticipated or unanticipated changes in the member's health status.

Regular PDN Care is nursing provided to a member who is not ventilator-dependent and does not require an intensive level of care.

1. Regular PDN assessments and interventions are needed for a member who is considered stable but has episodes of instability that are not immediately life threatening. Nursing observation, monitoring, and assessment are needed to determine appropriate interventions that maintain or improve the member's health status.

Other information

1. Effective August 1, 2010, if a home care provider determines it is unable to continue providing care to a member, the provider must notify the member, responsible party, and PrimeWest Health at least 30 days before terminating services and assist the member in transitioning to another home care provider. If the termination is a result of sanctions on the provider, the provider must give each recipient a copy of the home care bill of rights at least 30 days before terminating services. ([Ch 352, art 1, sec 8](#))
2. PDN services are for members who need more individual and continuous skilled nursing care than can be provided in a skilled nurse visit and the care is outside the scope of services that can be provided by an HHA or PCA.
3. PDN services are provided under a plan of care or service plan approved by the physician that specifies the level of care that the nurse is qualified to provide.

4. PDN services are ordered by the member's physician with updates as required.
5. Members authorized to receive PDN services in their home may use approved hours outside of their home during hours when normal life activities take them outside of their home.
6. PDN services must be provided by an RN or LPN who is not the member's legal guardian or related to the member as the spouse, parent, or foster care provider of a member who is under age 18 unless a hardship waiver is approved.

PDN Relative Hardship Waiver

The PDN Relative Hardship Waiver allows certain relatives to receive reimbursement for providing services to a PrimeWest Health member. The relative must be currently licensed in the State of Minnesota as an RN or LPN employed by a PDN Agency enrolled with PrimeWest Health and is:

1. The parent of a member;
2. The spouse of a member; or
3. A non-corporate legal guardian of a member.

In order to qualify for a PDN Relative Hardship Waiver, at least one of the following criteria must be met:

1. The relative resigns from a full-time or part-time job to provide PDN for the member
2. The relative goes from a full-time to a part-time job with less compensation to provide PDN for the member
3. The relative takes a leave of absence without pay to provide PDN for the member
4. Because of labor conditions, intermittent hours of care needed, or special language needs, the relative is needed in order to provide an adequate number of qualified PDNs to meet the member's needs

In the case of a PDN Relative Hardship Waiver, the provider agency is responsible for the following:

1. Receiving the request from the member/responsible party
2. Obtaining the relative's signature
3. Completing the PDN Hardship Waiver Application request form ([DHS-4109](#))
4. Ensuring the accuracy of the information
5. Submitting the form ([DHS-4109](#)) along with supporting documentation to the [Disability Services Division \(DSD\)](#)

Please note:

1. Provision of paid service does not preclude the parent, spouse, or guardian from his/her obligations for non-reimbursed family responsibilities of emergency backup caregiver and primary caregiver. The provision of these services is not legally required of the parent, spouse, or legal guardian. Services provided by a parent, spouse, or guardian cannot be used in lieu of nursing services covered and available under liable third-party payers including Medicare.
2. Paid hours of service provided by the parent, spouse, or guardian must be included in the member's care plan. Hours authorized for the parent, spouse, or guardian may not exceed 50 percent of the total approved nursing hours or eight hours per day, whichever is less, up to a maximum of 40 hours per week.
3. A parent, spouse, or guardian may not be paid to provide PDN if he/she fails to pass a criminal background check or if the home health agency, the waiver case manager, or the physician determines that the care provided by the parent, spouse, or guardian is unsafe.
4. The review process is 30 days. Written notice will be issued upon a decision. The provider must keep this notice in the recipient's file. The hardship waiver will be approved from the date received forward. If the hardship waiver is denied an explanation will be provided.
5. PDN services may not be reimbursed if the nurse is the foster care provider of a person who is under the age of 18 years.

Eligible Recipients

1. Medical Assistance recipients
2. MinnesotaCare recipients who are under age 21 or pregnant women
3. Waiver program recipients including CAC, CADI, TBI, and EW

NOTE: Non-pregnant adult MinnesotaCare recipients are not eligible for PDN services.

Eligible Providers of PDN Services

1. Enrolled home health agency
2. Enrolled PDN Class A-licensed agency
3. Enrolled independent RN
4. Enrolled independent LPN with a Class A license from the Minnesota Department of Health (MDH)

Authorization Requirements

Ongoing requirements for PDN authorization and documentation:

1. All PDN services require prior authorization.
2. PDN services require a physician order prior to initiating service.
3. Review/approval of the service plan by the member's physician is required every 60 days; or less if the authorization is approved by PrimeWest for fewer than 60 days depending on the member's individual condition.
4. Signed orders must be on file in the member's chart at the provider agency's office.
5. The orders or plan of care must do all of the following:
 - a. Specify the disciplines providing care
 - b. Specify the frequency and duration of all services
 - c. Demonstrate the need for the services and be supported by all pertinent diagnoses
 - d. Include recipient's functional level, medications, treatments, and clinical summary
 - e. Be individualized based on recipient needs
 - f. Have realistic goals
 - g. Subsequent plans of care must show recipient response to services and progress since the previous plan was developed
 - h. Changes to the plan of care are expected if the recipient is not achieving expected care outcomes

Authorization information/process in section titled *Information for All PrimeWest Health Home Care Providers*.

Shared PDN Services

This option allows two members/recipients to share PDN services in the same setting at the same time from the same PDN. All regulations pertaining to PDN services also apply to the shared care option.

A setting includes:

1. The home or licensed foster care home of one of the recipients;
2. Outside the home or foster care home of one of the recipients when normal life activities take the recipients outside the home;
3. A child care program licensed under [MS 245A](#), or operated by a local school district or private school;
or
4. An adult day care service licensed under [MS 245A](#).

PDNs Providing Shared Care

Services cannot be provided to two individuals in separate apartments in the same building, to other non-PDN recipients in the setting, or replace or supplement required staff at licensed facilities.

Shared care must be arranged through PrimeWest Health. The PDN agency must contact PrimeWest Health for instructions on accessing shared care.

Authorization Requirements

A member, or a member's legal representative, may select the shared care option at **any time** during the authorization period by contacting the PDN agency. Together with the member's physician and the PDN agency staff, the member (or the legal representative) will determine the following:

1. Whether shared care is an appropriate option based upon the needs and preferences of the member; and
2. The number of shared care units that will be part of the overall authorization of PDN services. A shared care arrangement does not reduce the total number of service units authorized for the member. The use of authorized service units should be divided between the shared care option and 1:1 services.

The member (or the member's legal representative) and the PDN agency will approve:

1. The other recipient who is sharing the PDN services. This decision must be based on the ages of the recipients, their compatibility, and the ability to coordinate their care needs; and
2. The arrangement and the setting for the shared services.

PDN agency responsibilities: Shared care requires prior authorization. To request authorization for shared services, the PDN agency must do the following:

1. Complete the Medical Assistance (MA) PDN Home Care Assessment, include the number of shared hours and the number of 1:1 hours on page 4 of the Assessment, and submit the Assessment to PrimeWest Health
2. Submit the Service Agreement via ITS software or mail a paper copy to PrimeWest Health

Instructions for completing the Service Agreement (DHS-3070): On a separate line item, enter the procedure code, rate, and total number of units for 1:1 PDN services. On a separate line item, enter the procedure code, rate, and total number of units for shared (1:2) PDN services.

Both 1:1 and 1:2 PDN services use the same procedure codes. To authorize 1:2 services, a modifier and shared care indicator must be used. For the shared PDN line item, enter the following:

1. "52" in the Modifier 1 (MOD1) field;
2. "Y" in the Shared Care (SHR) indicator; and
3. "5" in the Frequency (FREQ) field on Screen 2 in the ITS.

Waiver program recipients: The county case manager follows the same criteria and process to determine whether the shared care option is an appropriate and safe alternative for a member on a waiver. If the member chooses the shared care option, document the number of shared PDN service units on the member's waiver care plan and calculate the cost of shared care into the overall cost of service plan. Use MA home care procedure codes for PDN services to the fullest extent possible (for all medically necessary nursing services) before using extended PDN codes on waiver service agreements.

Documentation Requirements

Include a copy of each of the following in the member's chart when service is shared PDN:

1. A signed consent form by each recipient/legal representative
2. Permission for the agency to schedule shared care up to the maximum hours chosen by the member
3. Any use of services outside the member's home

4. Permission to place the member's name in the chart of the other shared recipient
5. How the needs of both recipients are appropriately and safely being met
6. Where the shared services will be provided
7. Ongoing monitoring and evaluation of the shared services by the PDN
8. Emergency response backup plans to the member's illness/absence or PDN's illness/absence
9. Additional training, if needed, for the PDN to provide care to two recipients
10. The names of each recipient receiving shared PDN services
11. The starting and ending times the recipients received shared PDN
12. Routine nursing documentation such as changes in the member's condition/any problems due to sharing services

Changing or Discontinuing Shared PDN

The member or legal representative must notify the provider in writing if the member chooses to make a change in his/her shared care. Changes include the following:

1. The number of authorized units the member wishes to share
2. Discontinuing participation in shared care
3. Changing providers

The written revocation or change must be maintained in the member's file.

When services are changed or discontinued, the current provider must mail or fax the completed [Home Care Fax Form](#) to PrimeWest Health indicating the change in the number of authorized shared care or the last date of shared PDN services and the total number of units to be designated for shared care.

PrimeWest Health will transfer shared care authorizations on the same service agreement. PrimeWest Health reserves the right to request a copy of the PDN assessment tool from the new provider agency at the time services are transferred or requested.

Billing Requirements

The process for billing shared PDN is the same as billing for 1:1 care with the following modification:

1. Use a separate line item to bill the shared (1:2) PDN units; and
2. Enter a "52" on the Modifier 1 field.

Complex reimbursement rates: A complex care reimbursement rate is available only when the recipient is receiving 1:1 PDN services. A complex care rate is not available when the recipient is receiving shared (1:2) PDN services. This means that a recipient can share PDN services if he/she is authorized complex care, but the agency will only receive the complex rate during the hours the recipient is receiving the 1:1 services

Rehabilitation Therapies

1. Occupational Therapy (OT) Procedure Code S9129
2. Certified Occupational Therapy Assistant Code S9129 TF modifier
3. Physical Therapy (PT) Procedure Code S9131
4. Physical Therapy Assistant (PTA) Procedure Code S9131 TF modifier
5. Respiratory Therapy (RT) Procedure Code S5181
6. Speech Therapy (ST) Procedure Code S9128

Coverage

Rehabilitation therapy procedure codes are daily, per visit codes, with the exception of respiratory therapy, which may be provided more than once per day.

Eligible Recipients

1. MinnesotaCare recipients and Medical Assistance recipients. To receive payment for rehabilitation therapy, the services must be all of the following:
 - a. Provided in the recipient's home
 - b. Ordered by a physician
 - c. Appropriate to meet the recipient's needs
 - d. Specified in the plan of care
 - e. Medically necessary
2. To qualify for payment, services must be provided to an eligible recipient who is confined to the home or for whom it takes "considerable effort" to depart.
3. Provided to the member whose functional status is expected to progress toward or achieve the goals specified in the member's plan of care within a 60-day period or less time if the authorization is granted for less than 60 days depending on the member's individual condition. (If the service is a Medicare-covered service and is provided to a member who is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare.)
4. Rehabilitation services cannot be covered when the member can reasonably access these services outside his/her residence, excluding the assessment, counseling, and education. A member who leaves the home at will, or a parent who could easily transport the child, must obtain these services at the rehabilitation center and will not be eligible for home care therapies.

Authorization Requirements

Prior authorization is needed for rehabilitation therapies when more than nine visits are needed in a calendar year.

Providers are required to document the following in the member's record and provide this information to PrimeWest Health when requesting an authorization:

1. All evaluations
2. Services provided including:
 - a. Date, type, and length of each service provided
 - b. The name and title of the person(s) providing each service
3. A statement every 30 days by the therapist indicating the nature, scope, duration, and intensity of the therapy are appropriate to the medical condition
4. Client progress and goals
5. Discharge plans

Eligible Providers

Therapists must be employed by a Medicare-certified Home Health Agency enrolled with PrimeWest Health. Services may be provided by the following:

1. Licensed Physical Therapist
2. Registered Occupational Therapist
3. Certified Occupational Therapy Assistant*
4. Physical Therapy Assistant*
5. Respiratory Therapist (RT)

6. Speech Therapist (ST)

*When services are provided by an assistant and the licensed or registered therapist is not on the premises (the member's home), the services are billed with a TF modifier, and the payment will be at 65 percent of the therapist's rate. The licensed PT or registered OT must provide in-person direction to the assistant at least every sixth visit. When a home visit is made jointly by the therapist and assistant, the provider may bill only for the therapist's visit. Providers may not bill for both the PT and PTA (or the OT and COTA) when a joint home visit is made.

Covered Services

Rehabilitation therapy services are daily, per visit codes, with the exception of Respiratory Therapy (RT), which may be provided more than once per day for services provided in the member's home. All therapies must be specified in the member's plan of care.

The following home care therapy services are not subject to the outpatient rehabilitative service thresholds:

Code	Type of Therapy
S9129 TF	Certified Occupational Therapy Assistant (COTA) services
S9129	Occupational Therapy (OT)
S9131	Physical Therapy (PT)
S9131 TF	Physical Therapy Assistant (PTA) services
S5181	Respiratory Therapy (RT)
S9128	Speech Therapy (ST)

If the service is a Medicare-covered service and is provided to a member who is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare.

Therapy Classifications

Therapies must be classified as to whether they are restorative or specialized maintenance.

Restorative therapy is a health service that is:

1. Specified in the member's plan of care;
2. Ordered by a physician; and
3. Designed to restore the member's functional status to a level consistent with the member's physical or mental limitations.

Specialized maintenance therapy is a health service that:

1. Is specified in the member's plan of care;
2. Is ordered by a physician;
3. Is necessary for maintaining a member's functional status at a level consistent with the member's physical or mental limitations; and
4. May include treatments in addition to rehabilitative nursing services.

Non-covered Services

1. Rehabilitation services in the home when the member can reasonably access these services outside his/her residence, or to a member who can leave at will
2. Rehabilitation provided to a child who could easily be transported by a parent/guardian to a rehab center

Billing

1. When services are provided by an assistant and the licensed or registered therapist is not on the premises, the services are billed with a modifier, and the payment will be at 65 percent of the therapist's rate. The licensed PT or registered OT must provide in-person direction to the assistant at least every sixth visit.
2. When a home visit is made jointly by the therapist and assistant, the provider may bill only for the therapist's visit. Providers may not bill for both the PT and PTA (or the OT and COTA) when a joint home visit is made.
3. When billing for specialized maintenance therapies, use the XC modifier on your claim form to differentiate these services. Home care therapy services are not subject to the one-time rehabilitative service thresholds.

Skilled Nurse Visits (SNVs)

Definition

Skilled nurse visits (SNVs): Intermittent home visits to initiate and complete professional nursing tasks based on a member whose illness, injury, or physical or mental condition creates a need for service as assessed to maintain or restore optimal health. Visits are made by a registered nurse (RN) or licensed practical nurse (LPN), employed by a Medicare-certified home health agency, under the supervision of an RN, and provided under a plan of care or service plan that specifies a level of care which the nurse is qualified to provide.

Eligible Recipients

1. Medical Assistance recipients
2. MinnesotaCare Expanded Benefit Set (children under age 21, and pregnant women)
3. MinnesotaCare Basic, Basic Plus, Basic Plus One, or Basic Plus Two coverage

Eligible Providers

Medicare certified, Class A Licensed home health agencies enrolled with PrimeWest Health.

Prior Authorization Requirements

Two visits per day can be authorized. If the necessary medical services are more complex and require more time than can be performed in a single or twice daily skilled nurse visit, PDN services is an appropriate option.

1. Skilled nurse services above nine visits per member, per calendar year require prior authorization. (No authorization is required for MSC+ and MSHO members.)
2. All Tele-Home-Care SNVs must be prior authorized.
3. Waiver recipients require prior authorization from the county case manager.

Prior authorization cannot begin before the date PrimeWest Health receives the complete service agreement request with all corresponding documentation. Refer to *Information for All PrimeWest Health Home Care Providers* later in this chapter for authorization process.

Covered Skilled Nursing Services

1. An SNV is made according to the member's written plan of care or service plan, ordered by the physician, and is an accepted standard of medical and nursing practice in accordance with the Minnesota Nurse Practice Act. Equipment and supplies that are usual and customary to completing an SNV are not billable (e.g., stethoscope, nail clippers, sphygmomanometer, alcohol wipes, etc.).
2. Intermittent home visits to initiate and complete professional nursing tasks based on a recipient's need for service as assessed to maintain or restore optimal health. Visits are made by an RN or LPN employed by a Medicare-certified home health agency, under the supervision of an RN. If the necessary medical services are more complex and require more time than can be performed in a single or twice daily SNV, PDN services are an appropriate option.
3. Observation, assessment, and evaluation of a person's physical or mental health status. These may be covered when the likelihood of a change in condition requires skilled nursing personnel to identify and evaluate the need for possible modification of treatment or initiation of additional medical procedures until the member's treatment regiment is stabilized.
4. A procedure that requires substantial and specialized nursing skill such as administration of intravenous therapy, intra-muscular injections, and procedures, such as sterile catheter insertion or sterile wound cares.
5. Teaching and training that requires the skills of a nurse. Examples could include: teaching self-administration of injectable medications or a complex range of medications, teaching a newly diagnosed diabetic person or caregiver on all aspects of diabetic management, teaching self-catheterization or bowel and/or bladder training.
6. Postpartum visits to new mothers and their newborn infants if the mother and her newborn are discharged early from the hospital. Early discharge means less than 48 hours following a vaginal delivery or less than 96 hours following a Caesarian section. Post-delivery care includes a minimum of one home visit by a licensed RN. The RN must provide parent education, assistance, and training in breast and bottle-feeding and conduct any necessary and appropriate clinical tests. The licensed RN must make the home visit within four days following hospital discharge. A separate plan of care is needed for the mother and newborn.
7. Community health nursing visits provided by a public health agency or home health agency for the sole purpose of maternal, child, and adult health promotion are covered when an authorized skilled nursing service is provided at the same visit.
8. Two visits per day can be authorized when necessary.
9. Tele-home-care visits. Coverage of tele-home-care is limited to two visits per day, and all of the visits must be prior authorized.
10. Venipuncture from a peripheral site. The Home Health provider can submit a request for prior authorization if he/she has determined and documented the following:
 - a. That there is not an available lab service that can visit the member's home to obtain the venipuncture from the peripheral site
 - b. That there is not a service reasonably available to the member outside of his/her place of residence
 - c. The member no longer qualifies for Medicare Part A skilled nurse services

Non-covered SNVs

Home visits:

1. Usual and customary equipment and supplies that are necessary to complete an SNV (e.g., stethoscope, nail clippers, sphygmomanometer, alcohol wipes, etc.)
2. Home visits made for the sole purpose of supervising an HHA or PCA. However, supervision may be done during an SNV that qualified for payment.
3. Home visits made for the sole purpose of monitoring medication compliance with an established medication program for a member.
4. Home visits made for the sole purpose of monitoring a member's overall physical status, when the member's physical status has not changed and the person is considered stable.

5. Home visits made to set up or administer oral medications; pre-fill injections, such as insulin syringes for an adult member when the need can be met by an available pharmacy; or the member is physically and mentally able to self-administer or pre-fill a medication; or if the activity can be delegated to a family member or HHA.
6. Home visits when the sole purpose of the visit is to train other home health agency workers.
7. Home visits when the visit is performed in a place other than the member's residence.
8. Home visits made for Medicare evaluation or administrative nursing visits required by Medicare but not qualifying as an SNV. (These visits are an administrative expense for the Medicare-certified agency and cannot be billed to PrimeWest Health.)
9. Home visits by a licensed RN who makes an SNV but is employed by a PCPO or non-Medicare PDN agency.
10. A communication between the home care nurse and member that consists solely of a telephone conversation, facsimile, or electronic mail or a consultation between two health care practitioners is not considered a tele-home-care visit

ICF/DD SNVs

PrimeWest Health may authorize SNVs for fewer than 90 days for a recipient residing in an ICF/DD to prevent admission to a hospital or nursing facility, if the ICF/DD is not required to provide the nursing services. The home health agency must obtain prior authorization.

A skilled nurse may be authorized for venipuncture if none of the above conditions can be met. Authorization requests must include full documentation in a clinical update on a CMS 485 or CMS 486.

Tele-home-Care

1. A tele-home-care visit is an SNV that is made via live, interactive audiovisual technology between the home care nurse and the member. It can also be augmented by utilizing store- and-forward technologies, which is a technology that does not occur in real time via synchronous transmission and does not require a face-to-face encounter with the member for all, or part of, any such tele-home-care visit.
2. T 1030-GT is the code for home tele-health face-to-face "live" (SNV).
3. A communication between the home care nurse and member that consists solely of a telephone conversation, facsimile, or electronic mail or a consultation between two health care practitioners is not considered a tele-home-care visit.
4. Coverage of tele-home-care is limited to one visit per week no more than four times per month, and authorization is required for all visits.
5. Home health for peripheral only (weight, pulse, oximetry, etc.) use the code 99091 (the code 99091 can be billed four times within the month [i.e., once per week]).
6. Bill using Code E1399-52 for equipment used for peripheral tele-home care visit.

Combination PCA and Other Home Care Services

PCA combinations are Service Authorizations that include one or more of the following PrimeWest Health fee-for-services: SNV, HHA, and/or PDN, along with PCA services. Home care services must be medically necessary and cost effective. The home care rating determines the maximum dollar amount that can be authorized for all home care services. See PDN and PCA decision trees for further information.

PCA Hardship Waiver

The need to apply for the PCA Hardship Waiver to provide PCA services has been repealed. Parents of adult recipients and adult children or siblings of a recipient may now provide PCA services to a family member

without applying for a PCA Hardship Waiver, if they meet the criteria to work as a PCA.

The following family members may **not** serve as the PCA:

1. Spouse
2. Parent of a minor child
3. The responsible party

Home Care and Hospice Election

The hospice benefit:

1. Is a comprehensive package of services offering palliative care support to terminally ill individuals and their families
2. Is designed to supplement the care provided by primary care givers such as family (as the patient defines family), friends, and neighbors
3. Is NOT intended to replace the supportive services provided by primary caregivers
4. Is NOT intended to duplicate health services or supports that relate to a pre-existing condition
 - a. Example: A home care service or supply is required for a condition **unrelated** to the terminal condition (e.g. quadriplegia, schizophrenia, cerebral palsy) and does not supplant or duplicate the covered hospice benefit
5. Is NOT intended to cover medical needs that arise during the period of the hospice benefit that are unrelated to the terminal illness

Generally, the determination about whether a service duplicates a hospice benefit service will be made as part of the hospice provider's general responsibility to provide care coordination. The hospice care coordinator assumes the lead responsibility for collaborating with the county case manager, home care agency, physician, or other providers providing the services that are outside of the hospice benefit.

For further information and details about the hospice benefit, see [Hospice Services](#), Chapter 28.

Individualized Educational Plan (IEP)

Refer to [Children's Services](#), Chapter 9, for additional information regarding IEP Services. Covered IEP services include nursing services, PCA services, physical therapy, occupational therapy, speech language pathology, mental health services, special transportation, and assistive technology devices.

The child may also be receiving these services through MA and/or a home and community based services waiver. When services are provided through the school, they are considered IEP services and billed as such. IEP services are not considered or billed as home care, therapy, or waiver services.

Coordination of IEP services and home care services are assessed on a 24-hour non-school day.

A parent/guardian may choose to use authorized home care or waiver services in the school rather than have the school bill for the education plan service.

1. Services must be listed in the child's IEP/IFSP/IIP; and
2. Permission must be given by the parent/guardian in the care plan and retained by the provider in his/her records.

The education plan services do not count against the prior authorization cap for home care services, will not be counted against the waiver cap or affect the amount of services available under the waiver, and are not counted against DHS service limitations or thresholds for therapies. The education plan team and the home care provider or waiver case manager are responsible to coordinate and not duplicate services.

Non-Covered Services

1. Services that are not ordered by the member's physician
2. Services that are not specified in the member's service plan or care plan
3. Services provided without authorization from DHS when required
4. Services that have already been paid by Medicare, health plans, health insurance policies, or any other liable third party at more than the MHCP allowable amount
5. PDN or PCA services provided to non-pregnant MinnesotaCare members
6. Services to other members of the member's household
7. Home care services included in the daily rate of a community-based residential facility where the member is residing
8. Services that are the responsibility of the foster care provider under the terms of the foster care placement agreement and administrative rules
9. Services provided when the number of foster care residents is greater than four (unless the county responsible for the member's foster placement made, prior to April 1, 1992, requests that home care service be provided, and county or state case management is provided)

Information for All PrimeWest Health Home Care Providers – Service Agreement Quick Reference Guide

Use this Quick Reference Guide to obtain Service Authorizations in a timely and productive manner.

Getting Started

1. Obtain all health insurance coverage information.
2. Verify member eligibility; see [Billing Policy](#), Chapter 4.
3. If the recipient is eligible for a waiver, contact the recipient's county case manager or lead agency.
4. If the recipient is PrimeWest Health eligible without a waiver, follow the process outlined in the Quick Reference section.

Bill Medicare and other insurance before billing PrimeWest Health.

Authorization Guidelines

Request prior authorization for all of the following:

1. All HHA services (MSC+, MSHO, and SNBC members excluded)
2. All PDN services (MSC+ and MSHO members excluded)
3. SNVs, rehabilitation therapy visits above nine visits per recipient, per calendar year for MA (MSC+, MSHO, and SNBC members excluded)
4. All tele-home-care visits
5. More than two face-to-face PCA assessment visits conducted by the county PHN, per recipient, per calendar year
6. More than one service update assessment visit by the county PHN per recipient, per calendar year
7. All PCA services and supervision of PCA services (MSC+ and MSHO members excluded)

Prior authorization requests for SNV, HHA, Rehabilitation Therapies, and PDN are submitted directly to PrimeWest Health by the provider agency.

The county PHN under contract with the county must submit the prior authorization requests for PCA services to PrimeWest Health at:

Fax: **1-866-431-0804** (toll free)

Mail: PrimeWest Health
2209 Jefferson St, Ste 101
Alexandria, MN 56308

Review the [Service Authorization](#) immediately for content and comments. Line item dates may differ from header dates. If you are unclear about comments or have questions about the authorization, contact the PrimeWest Health Provider Contact Center at **1-866-431-0802** (toll free).

Exceptions to Retroactive Prior Authorization

PrimeWest Health will consider retroactive authorization requests only in the following cases:

1. **Emergency Service Provision:** The home care service(s) were required to treat an emergency medical condition that, if not immediately treated, could cause a recipient serious physical or mental disability, continuation of severe pain, or death. Substantiate the emergency by documentation such as reports, notes, and admission or discharge history.
 - a. **SNV, HHA, Rehabilitation Therapy, and PDN:** Submit retroactive authorization request within five working days of providing the initial service by submitting the [Home Care Fax Form](#) to **1-866-431-0804** (toll free).
 - b. **PCA:** Contact the county PHN to request retroactive authorization within five working days of providing the initial service.
2. **Retroactive Eligibility:** Home care services were provided on or after the PrimeWest Health recipient's eligibility **begin** date, but before the date the recipient was notified that his/her case opened.
 - a. **SNV, HHA, Rehabilitation Therapy, and PDN:** Submit retroactive authorization request within 20 working days of the date the recipient was notified that the case was opened with the required documentation for a long-term authorization (refer to the appropriate home care service policy section) and a copy of the notice of eligibility.
 - b. **PCA:** Contact the county PHN to request retroactive authorization within 20 working days of the date the recipient was notified that the case was opened.
3. **Third Party Payer:** A third party payer for home care services denied or paid the claim.
 - a. **SNV, HHA, Rehabilitation Therapy, and PDN:** Submit retroactive authorization request within 20 working days of the notice of denial or payment with the required documentation for a long-term authorization (refer to the appropriate home care service policy section) and a copy of the third party payer's notice.
 - b. **PCA:** Contact the county PHN to request retroactive authorization within 20 working days of the notice of denial or payment.
4. **Administrative Error:** The local county agency or PrimeWest Health made an error.
 - a. **SNV, HHA, Rehabilitation Therapy, and PDN:** Submit required documentation for a long-term authorization (refer to the appropriate home care service policy section) and include a statement that specifies which agency made the error, what the error was, and when it occurred. If a county agency made the error, include supporting documentation from that agency.
 - b. **PCA:** Submit the request to the county PHN.
5. **Medical Need:** The professional nurse determines an immediate medical need for up to 40 skilled nursing or HHA visits per calendar year. Exceptions to prior authorization requests are evaluated according to the same criteria applied to prior authorization requests.

PrimeWest Health **cannot** authorize waiver services requested by a home care provider (refer to Waiver section).

Face-to-face Assessments

The county PHN may conduct up to two face-to-face assessments per recipient per calendar year without prior authorization when:

1. A recipient is requesting PCA services for the first time;
2. A recipient's condition changes significantly;
3. PCA services change(s) is needed; or
4. A recipient is using PCA Choice.

The county PHN or certified PHN under contract with the county must do the following:

1. Complete the assessment within 30 days of request
2. Conduct all assessments for PCA services
3. Conduct service updates and temporary service increase requests for PCA services
4. Provide information about options available in the PCA program
5. Develop a service plan appropriate to the recipient's needs
6. Recommend and provide referral information about other services as appropriate
7. Assist the recipient in identifying the most appropriate professional (if selected) to supervise the PCA
8. Recommend the necessary amount of PCA services and supervision of PCA services (if selected) to PrimeWest Health, including requests for temporary Service Authorizations and temporary service increases from PrimeWest Health
9. Provide the recipient or responsible party with a list of enrolled PCPOs and PCA Choice providers, if requested

A county PHN agency that is also a provider of PCA services cannot conduct assessments for its own PCA recipients. These county agencies must contract with:

1. Another PHN agency; or
2. An independent certified PHN:
 - a. not employed by or under contract with the county agency; or
 - b. not under contract with an enrolled PCPO to conduct the assessment and reassessments.

An assessment must include the MA Health Status Assessment (DHS-3244), Home Care Service Plan (DHS-3244A), Payer Determination Form (DHS-3273), and any additional documentation as necessary to substantiate services.

Temporary or Long-Term Initial Authorization

Temporary requests are for services up to 45 days in length. Long-term initial authorization requests are for services that are expected to be provided for more than 45 days.

SNV, HHA, Rehabilitation Therapy, and PDN

To request initial authorization for HHA or PDN, complete and fax the [Home Care Fax Form](#) (DHS- 4074) along with supporting documentation (treatment plan, clinical summary, etc.) to PrimeWest Health before the first home visit. For initial authorization requests for SNV or rehabilitation therapy, complete the form and fax it along with supporting documentation (treatment plan, clinical summary, etc.) to PrimeWest Health by the ninth visit for the calendar year for each service.

Fax: **1-866-431-0804** (toll free)
Call: **1-866-431-0802** (toll free)
Mail: PrimeWest Health
2209 Jefferson St, Ste 101
Alexandria, MN 56308

Home Care Continuing Authorization

For temporary or long-term home care, if more services are needed than approved in the initial authorization, provide updated clinical information, goals, and treatment plan before the end of the authorization period or before the end of the visits approved, whichever runs out first. Fax updates to **1-866-431-0804** (toll free).

Changes in Medical Status or Primary Caregiver Availability

Changes in medical status include, but are not limited to, the following:

1. Change in health
2. Change in level of care
3. Addition of service(s)
4. Change in physician orders
5. Change in living arrangement (i.e., recent facility placement)
6. Change in primary caregiver's availability.

Changes are temporary (45 days or less) or long-term (up to 365/366 days). (PrimeWest Health cannot approve back-to-back temporary requests.) Documentation **must** support the requested change in service.

When a change in medical status exists, the provider must fax the following to PrimeWest Health at **1-866-431-0804** (toll free):

1. [Home Care Fax Form \(DHS-4074\)](#) or PrimeWest Health [Service Authorization](#) form
2. Updated Plan of Treatment (CMS 485 or DHS-4633 or any available)
3. Concise current clinical update (CMS 485, CMS 486 or DHS-4633 or any form available)
4. Completed MA PDN Assessment (DHS-4071A-ENG)

Combination of Services

PCA combinations are Service Authorizations that include PCA and one or more of the following:

1. SNV
2. HHA
3. PDN

Home care services must be medically necessary and cost effective. The home care rating determines the maximum dollar amount that can be authorized for all home care services. See PDN and PCA decision trees for further information.

Multiple Providers of Services

Service Authorization can be issued to more than one provider agency at the same time. Each provider agency must receive its own Service Authorization. Each provider agency can bill for the same type of service on the same day. Each agency must have an approved line item on the service agreement.

1. Daily codes (i.e., PDN and Rehabilitation Therapies) must be billed in consecutive date spans only, to avoid duplicative billing.
2. 15-minute codes may be billed by more than one provider, per date of service.

Each provider must submit the [Home Care Fax Form](#) (DHS-4074) or the [PrimeWest Health Authorization Form](#), indicating all of the following:

1. All provider names and numbers
2. Dates of service for each provider
3. The number of units to be used by each provider

Recipients using the PCA Choice Option cannot use more than one PCA Choice Provider or use a PCPO along with a PCA Choice Provider.

Change in Provider

A recipient may change services delivery from one provider to another provider.

Discontinuing Provider

To discontinue using a provider, fax the [Home Care Fax Form](#) (DHS-4074) or the [PrimeWest Health Authorization Form](#) to **1-866-431-0804** (toll free), with all of the following information:

1. Member ID #
2. Service agreement number being adjusted
3. Provider ID # of agency discontinuing services, last date of service with agency discontinuing services
4. Last date of service with agency discontinuing services
5. Total units to be transferred to the new agency

Initiating New Provider

To begin using a new provider, fax the [Home Care Fax Form](#) (DHS-4074) or the [PrimeWest Health Authorization Form](#) to **1-866-431-0804** (toll free) with all of the following information:

1. Member ID #
2. Service agreement number being adjusted (if available)
3. Provider ID # of agency beginning services
4. Date services will begin with the new agency

In the event the discontinuing provider does not submit the [Home Care Fax Form](#) release, the member, responsible party, or legal guardian must provide a signed written statement indicating the last date of service and the name of the new provider agency. Provide a copy to the provider agency terminating and initiating services.

Change in Living Arrangement

Admission to a Facility

When a recipient is admitted to a facility, the provider must submit the [Home Care Fax Form](#) (DHS-4074) or the [PrimeWest Health Authorization Form](#) to **1-866-431-0804** (toll free), indicating the following:

1. The last date service was provided
2. The total number of units provided up to that date

Discharge from a Facility to the Community

When a recipient is discharged from a facility into the community, the provider must submit the [Home Care Fax Form](#) (DHS-4074) or the [PrimeWest Health Authorization Form](#) to **1-866-431-0804** (toll free), indicating:

1. The first date service will be reinstated
2. The total number of units requested

Change in Recipient ID/PMI Number

When a recipient's ID/PMI number changes, the provider must submit the completed [Home Care Fax Form](#) (DHS-4074) to **1-886-431-0804** (toll free), indicating all of the following:

1. Previous PMI number
2. Previous name
3. New PMI number
4. New name
5. Birth date
6. Date of change to the new PMI number

Temporary PMAP Disenrollment

When a recipient is disenrolled from PrimeWest Health, PCA providers must contact DHS directly within 30 calendar days to request authorization so that services for the recipient can continue, and fee-for-service payment is made to the PCA provider. Refer to [Provider Update HOM 04-01](#).

If providers do not contact DHS within 30 calendar days, DHS will adjust the start date of the new service agreement to the date the MA [Home Care Fax Form](#) was received DHS.

If the recipient is not re-enrolled in PrimeWest Health within 60 days of the disenrollment, immediately request a PCA assessment from the county PHN.

Technical Change/Correction

Technical changes/corrections include, but are not limited to, incorrect:

1. Provider name/ID #
2. Recipient name/date of birth
3. HCPCS code/units/rate
4. ICD-9 codes

Submit the correct information on the *Home Care Fax Form* and use the "Comments" section to explain why the correction is being requested.

SNV, HHA, Rehabilitation Therapy, and PDN

When a change or correction is need for SNV, HHA, rehabilitation therapy, and PDN services, the provider must submit the completed [Home Care Fax Form](#) (DHS-4074) or the [PrimeWest Health Authorization Form](#) to **1-866-431-0804** (toll free). The submitted form must do the following:

1. State the correct information
2. Contain documentation in the "Comments" section stating the reason the correction is being requested

Non-Waiver Home Care to Waiver Home Care

The county case manager must do the following:

1. Provide an Service Request Form to the provider

Recovery of Excessive Payments

PrimeWest Health will seek monetary recovery from home care providers who exceed coverage and payment limits. This does not apply to services provided to a recipient at the previously authorized level pending an Appeal.

Non-covered Home Care Services

1. PDN or PCA services provided to non-pregnant MinnesotaCare recipients
2. Services provided to a person who is not an eligible PrimeWest Health recipient
3. Services provided by a provider that is not enrolled or does not have a valid provider agreement with PrimeWest Health
4. Services that are not ordered by the recipient's physician
5. Services that are not specified in the recipient's service plan or care plan
6. Services provided without authorization from PrimeWest Health when required
7. Services that have already been paid by Medicare, health plans, health insurance policies, or any other liable third party at more than the PrimeWest Health allowable amount
8. Services to other members of the recipient's household
9. Home care services included in the daily rate of a community-based residential facility where the recipient is residing
10. Services that are the responsibility of the foster care provider under the terms of the foster care placement agreement and administrative rules
11. Services provided when the number of foster care residents is greater than four (unless the county responsible for the recipient's foster placement made, prior to April 1, 1992, requests that home care service be provided, and county or state case management is provided)

Billing PrimeWest Health – Order of Payers

PrimeWest Health pays for services after the recipient has used all other sources of payment. PrimeWest Health is the payer of last resort. The order of payers for a PrimeWest Health member is as follows:

1. Third party payers or primary payers to Medicare (e.g., large and small group health plans, private health plans, group health plans covering the beneficiary with End Stage Renal Disease for the first 18 months, Workers' Compensation law or plan, no-fault or liability insurance policy or plan)
2. Medicare
3. PrimeWest Health Medical Assistance or MinnesotaCare
4. PrimeWest Health services programs or Alternative Care (AC) program

Providers must bill all third party payers, including Medicare, and receive payment to the fullest extent possible before billing. PrimeWest Health becomes the payer only after all other pay options (other than an MA waiver program) have been exhausted. Services that could have been paid by Medicare, an HMO, or insurance plan, if applicable rules were followed, are not covered by PrimeWest Health.

Providers must be familiar with Medicare coverage for the home care recipient. This includes billing Medicare when Medicare is liable for the service or, if the provider is not Medicare certified, referring the recipient to a Medicare-certified provider of the recipient's choice, and notifying recipients when Medicare is no longer the liable payer for home care services.

DHS Internet Forms Available

1. [MA Health Status Assessment \(DHS-3244\)](#)
2. [Home Care Service Plan \(DHS-3244A\)](#)
3. [PCA Decision Tree \(DHS-4201\)](#)
4. [Private Duty Nursing Service Decision Tree \(DHS-4071C\)](#)
5. [MA Private Duty Nursing Assessment \(DHS-4071A\)](#)
6. [Home Care Fax Form](#)
7. [PDN Hardship Waiver Application](#)
8. [Home Care Shared Services Agreement \(PDN or PCA\)](#)

Definitions

Activities of Daily Living (ADLs): Eating, toileting, grooming, dressing, bathing, transferring, mobility, and positioning.

Assessment: A review and evaluation of a recipient's need for home care services.

Care Plan – PDN: A written description of professional nursing services needed by the recipient as assessed to maintain and/or restore optimal health.

Fiscal Agent Option: See PCA Choice Option.

Flexible Service Use Option: When prior authorized, PCA units may be used in varying amounts over the duration of the Service Agreement. The use of service units may differ from day to day or week to week, but must only be used for covered care needs

Health-related Functions: Functions that can be delegated or assigned by a licensed health care professional under state law to be performed by a PCA.

Home Care Agency (or Class A Agency): An agency holding a Class "A" license from MDH, authorized to provide PDN only. To enroll as a home health agency, the provider must be a Medicare certified home health agency.

Home Care Rating: Cost limits that establish a rating system based on the common assessed needs of individuals.

Home Care Services: Home health agency, PDN, and personal care services delivered to a recipient whose illness, injury, or physical or mental condition creates a medical need for the service.

Home Health Agency: A public or private agency or organization, or part of an agency or organization, that is Medicare-certified and holds a Class A home care license from MDH.

Home Health Aide (HHA): An employee of a home health agency who is certified and is supervised by a nurse.

Home Health Aide Services: Medically oriented tasks required to maintain the recipient's health or to facilitate treatment of an illness or injury. Services must be ordered by a physician and have professional supervision provided by a Medicare-certified agency.

Home Health Agency Services: Services provided by a Medicare-certified agency including SNVs, HHA, and physical, occupational, speech, and respiratory therapy.

Instrumental Activities of Daily Living (IADLs): Meal planning and preparation, managing finances, shopping for food, communication by telephone and other media, getting around and participating in the community.

Licensed Practical Nurse (LPN): Must hold current licensure from the MN State Board of Nursing; Class A Licensure from MDH; and be enrolled with DHS as an independent nurse.

Medically Necessary or Medical Necessity: A health service that is consistent with the recipient's diagnosis or condition, is recognized as the prevailing standard or current practice by the provider's peer group, and is rendered for one of the following reasons:

1. In response to a life-threatening condition or pain
2. To treat an injury, illness, or infection
3. To treat a condition that could result in physical or mental disability
4. To care for the mother and child through the maternity period
5. To achieve a level of physical or mental function consistent with prevailing community standards for the diagnosis or condition.

Private Duty Nursing (PDN) Agency: An agency holding a Class A Home Care license and is enrolled with DHS to provide PDN services

Private Duty Nursing (PDN) Services: Nursing services ordered by a physician for a recipient whose illness, injury, or physical or mental condition requires more individual and continuous care by an RN or LPN than can be provided in a single or twice daily SNV and requires greater skill than a HHA or PCA can provide.

Qualified Professional (QP): An RN or mental health professional responsible for supervision of PCA services. The mental health professional must meet credentials of a licensed psychologist, licensed psychological practitioner, licensed independent clinical social worker, psychiatrist, clinical nurse specialist (mental health), or marriage and family therapist.

Registered Nurse (RN): Must hold current licensure from the Minnesota State Board of Nursing and be enrolled with DHS as an independent nurse.

Residence: The place a recipient lives. A residence does not include a hospital, nursing facility, or intermediate care facility.

Shared Care Option – PDN: An option for two recipients to share the same nurse in the same setting at the same time.

Skilled Nurse Visits (SNVs): Intermittent nursing services ordered by a physician for a recipient whose illness, injury, or physical or mental condition creates a need for the service. Services under the direction of an RN are provided in the recipient's residence by an RN or LPN and provided under a plan of care or service plan that specifies a level of care which the nurse is qualified to provide.

Tele-Home-Care: The use of telecommunications technology by a home health care professional to deliver home health care services within the professional's scope of practice to a recipient located at a site other than the site where the practitioner is located. Currently approved for SNVs only.

Ventilator-dependent Recipients: A ventilator-dependent recipient means a recipient who receives mechanical ventilation for life support at least six hours per day and is expected to be or has been dependent for at least 30 consecutive days.

Legal References

[MN Stat. secs. 256B.0625 and 256B.06257](#)

[MN Rules parts 9505.0290 – 9505.0295](#)

[MN Rules part 9505.0335](#)

[Title 42 Code of Federal Regulations \(CFR\) Part 441.15](#)

[42 CFR 440.70](#)

[42 CFR 440.80](#)

[42 CFR 440.167](#)

[42 CFR 441.302](#)

[Public Law 97 – 35: OBRA 1981](#)

[Title XIX, section 1915 of the Social Security Act](#)