COMMUNITY HEALTH WORKER SERVICES

ELIGIBLE PROVIDERS

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 tenens 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. A complete list of programs approved by the State can be found in the Approved CHW Curriculum section. 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. New employee orientation must include a training on local providers and health resources.

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

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:

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

Refer to the Recipient Eligibility manual for additional information regarding eligibility including information regarding limited coverage aid categories.

COVERED SERVICES AND LIMITS

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**

**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;
- 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 in a clinic or medical facility setting with the exceptions of attending a medical appointment with a recipient and group services provided in a meeting room of a clinic or medical facility;
- 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.

**APPROVED CURRICULUMS**

The staff training policy must identify a process to certify that the individual has completed an approved curriculum. In addition to the Indian Health Service Community Health Representative basic training
and CHW programs approved by the South Dakota Board of Technical Education or the South Dakota Board of Regents, South Dakota Medicaid has approved the following CHW curriculums:

- Better Choices Better Health
- National Diabetes Prevention Program (NDPP)
- Family Spirit
- Texas A&M CHW Program
- Minnesota Community Health Worker Alliance (Northwest Technical College, Minnesota West Community & Technical College, Normandale Community College, Rochester Community and Technical College, Saint Catherine University, St. Paul Campus)
- MHP Salud (CHW Foundations, CHW Level 1, and CHW Level 2 must all be completed)

**CHW AND HEALTH HOME COMPARISON**

<table>
<thead>
<tr>
<th>Health Home</th>
<th>CHW</th>
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<tbody>
<tr>
<td>Health Home is a person-centered care management model designed to address a recipient’s medical, behavioral health and social service needs by forming a team of health care professionals around the recipient. At the center of a Health Home is an individual who oversees and coordinates the services a recipient needs for optimal health status.</td>
<td>A community health worker (CHW) who is a trusted member or has an unusually close understanding of the community served, which enables the person to provide information about health issues that affect the community and link individuals with the health and social services they need to achieve wellness.</td>
</tr>
</tbody>
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**Eligibility**

<table>
<thead>
<tr>
<th>Health Home</th>
<th>CHW</th>
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<tbody>
<tr>
<td>Recipients with full Medicaid coverage who meet the following criteria:</td>
<td>Recipients with two or more chronic conditions or recipients with one chronic condition who are at risk for a second chronic condition.</td>
</tr>
<tr>
<td>• Recipients who have a Severe Mental Illness or Emotional Disturbance.</td>
<td>A community health worker (CHW) who is a trusted member or has an unusually close understanding of the community served, which enables the person to provide information about health issues that affect the community and link individuals with the health and social services they need to achieve wellness.</td>
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<tr>
<th>CHW</th>
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<tbody>
<tr>
<td>Services are available to recipients with full Medicaid coverage and Pregnancy related coverage.</td>
</tr>
<tr>
<td>Individuals with a chronic condition or at risk for a chronic condition who are unable to self-manage; or</td>
</tr>
<tr>
<td>Individuals with a documented barrier that is affecting the individual’s health such as geographic distance from health services, cultural/language communication barriers, etc.</td>
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<thead>
<tr>
<th>CHW</th>
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<tbody>
<tr>
<td>Services are billed per member per month for recipients who have received a core service during the quarter.</td>
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<tr>
<td>Services are considered core services if the meet the following criteria:</td>
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<tr>
<td>• Tie to a Care Plan;</td>
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<tr>
<td>• Engage the recipient;</td>
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<table>
<thead>
<tr>
<th>CHW</th>
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<tbody>
<tr>
<td>Services are tied to a care plan created by a physician, physician assistant, nurse practitioner;</td>
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<tr>
<td>Can be for a group or individual;</td>
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<tr>
<td>Services must be associated with a medical intervention and cannot be social services (case management, advocacy, enrolling in gov’t programs);</td>
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</tbody>
</table>
• Documented in the EHR; and
• Cannot have been previously billed to Medicaid.

• Billing is fee for service. It is limited to 2 units of service per day, 104 units per plan year; and
• Unit rate is based on if the service is provided to an individual or in a group setting.

<table>
<thead>
<tr>
<th>Health Home</th>
<th>CHW</th>
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</thead>
<tbody>
<tr>
<td><strong>Covered Services</strong></td>
<td><strong>Covered Services</strong></td>
</tr>
<tr>
<td>• Comprehensive care management;</td>
<td>• System Navigation and Resource Coordination;</td>
</tr>
<tr>
<td>• Care coordination;</td>
<td>o Example: Arranging transportation to a medical appointment.</td>
</tr>
<tr>
<td>• Health promotion;</td>
<td>• Health Promotion and Coaching; and</td>
</tr>
<tr>
<td>• Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;</td>
<td>o Example: Supporting self-management disease prevention education, leading self-management group services.</td>
</tr>
<tr>
<td>• Individual and family support, which includes authorized representatives; and</td>
<td>• Health Education.</td>
</tr>
<tr>
<td>• Referral to community and social support services if relevant.</td>
<td>o Example: Providing disease specific education to an individual or group.</td>
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<tr>
<th>Non-Covered Services</th>
<th>Non-Covered Services</th>
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<tr>
<td>Core services may not be claimed for a service which may be individually billed to South Dakota Medicaid on a fee for service, daily, or encounter rate.</td>
<td>CHW services must be provided in the community and are not payable when performed in the clinic or other health care setting.</td>
</tr>
<tr>
<td>• Groups may meet in a space provided by a clinic or health care setting and still be a billable CHW service.</td>
<td></td>
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</tbody>
</table>

If you are going to claim something as a Health Home core service, you cannot bill it as a CHW service. If you are going to bill as a CHW service, you cannot also claim it as a Health Home core service.

<table>
<thead>
<tr>
<th>Examples</th>
<th>Examples</th>
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<tbody>
<tr>
<td>Health Home Core Services</td>
<td>CHW Services</td>
</tr>
<tr>
<td>Instruction in a clinic setting regarding ways to improve diet/nutrition weight loss.</td>
<td>Meeting the recipient in their home to discuss ways to implement lifestyle changes.</td>
</tr>
</tbody>
</table>

**DOCUMENTATION REQUIREMENTS**

**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**

**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.

<table>
<thead>
<tr>
<th>Unit</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Unit</td>
<td>16-45 Minutes of Service</td>
</tr>
<tr>
<td>2 Units</td>
<td>46 or More Minutes of Service</td>
</tr>
</tbody>
</table>

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**

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**

- Administrative Rule of South Dakota (ARSD)
- South Dakota Medicaid State Plan
- Code of Federal Regulations

**QUICK ANSWERS**

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 Telemedicine Services 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.

7. **Where can CHW services be provided?**

   CHW services can be provided in a community setting or a recipient’s home. Services provided in a clinic or medical facility setting are not covered with the exceptions of attending a medical appointment with a recipient and group services that are provided in a meeting room of a clinic or medical facility.

8. **If CHW services are co-facilitated by two different CHWs can they both be reimbursed?**

   No, only one provider can submit for reimbursement for CHW services for one recipient. Reimbursement is the same regardless of the number of people facilitating the service.

9. **Can a nurse or other health professional provide CHW services?**

   Yes, a nurse or other health professional can be employed by a CHW provider and facilitate CHW services. The CHW service cannot be billed at the same time as any other professional service.
National Diabetes Prevention Program

1. Can a CHW certified in the National Diabetes Prevention program (NDPP) provide all CHW services?
   A CHW can only provide services that are within the scope of the certification they have obtained.

2. Can an NDPP that is working toward their full status enroll as a Medicaid CHW provider?
   Yes, NDPPs that have preliminary or full status can enroll as a Medicaid CHW provider.