Connecticut Medical Assistance Program Provider Bulletin 2017-03
Policy Transmittal 2016-34 March 2017

Effective Date: April 1, 2017
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TO: Access Agencies and Home Health Agencies

RE: Important Changes to Evaluation and Assessment Services for Home Health Care Services-Addition of Review of Care Plan Code-G0162

Effective April 1, 2017 and forward, the Department is adding a new Healthcare Common Procedure Coding System (HCPCS) code (G0162) for the review of patients' care plans which must occur at least every sixty (60) days, as required by Section 19-13-D73 of the Connecticut Public Health Code for Home Health Care Agencies (Department of Public Health regulations). This new code should be used to support the development and management of the patient's plan of care for home health services, as required for both medical and behavioral health conditions.

Start of Care Assessment/Evaluation:
Providers are reminded that at the start of care (SOC) for medical or behavioral health home health services, home health care agencies **must bill HCPCS code T1001 with modifier TD** for the initial assessment/evaluation to create the plan of care, which must include all home health services.

When a resumption of care (ROC) occurs, a new assessment/evaluation must be created to supplement the current plan of care, and must be billed using HCPCS code T1001, with modifier TD.

Review of Plans of Care for re-certification:
The re-certification review of the plan of care **must** be billed using HCPCS procedure code G0162-Skilled services by a registered nurse for management and evaluation of the plan of care; each 15 minutes.

By the 60th day after the completion of the initial assessment/evaluation for a SOC, all plans of care for all medical and/or behavioral health home health services must be reviewed and re-certified by a registered nurse. Further, each recertification thereafter must be completed by the 60th day after the completion of the previous re-certification.

This continuous review of the plan of care will (1) ensure that the member is receiving the appropriate level of care; and (2) provide an opportunity to adjust the plan of care in a clinically timely fashion. As previously stated, an assessment/evaluation must be performed at the SOC or when there is a need for an ROC, and both must be billed accordingly.

HCPCS code G0162 will be added to each of the Home Health Agency (HHA) providers' fee schedules, and will be based on the calculation of an agency's current rate for HCPCS code T1001-TD divided by four (4). A maximum of six (6) units will be allowed for HCPCS code G0162, once every 60 days.

These required billing instructions for use of the G0162 code apply only to services reimbursed under the Medicaid State Plan (HUSKY A, C and D members) and the Children's Health Insurance Plan (CHIP) (HUSKY B members). Providers should be aware that other payers may use this code to reimburse for different or other services (e.g., Medicare uses G0162 for Management and Evaluation of the Plan of Care).

Home Health Care Services for Medicare and Medicaid Dually Eligible Patients:
For dually-eligible patients covered by the Medicare and HUSKY Health plans, benefits for home health services covered under the Medicare plan must be exhausted before the HUSKY Health plan can be billed by the home health agency. For more information about billing for services provided to dually-eligible HUSKY Health members, please refer to Chapter 8 of the Home Health Provider Manual on the Web site at www.ctdssmap.com.

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Date Issued: March 2017