Connecticut Medical Assistance Program
Policy Transmittal 2017-14

Provider Bulletin 2017-30
August 2017

Roderick L. Bremby, Commissioner

Effective Date: April 1, 2017
Contact: Dana Robinson-Rush @ 860-424-5615

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 (Revised)

The Department of Social Services (DSS) is issuing this revised policy transmittal to provide further guidance on correct billing for start of care evaluations/assessments, resumption of care evaluations and 60-day recertification reviews.

This policy transmittal supersedes and replaces all previously posted documents, including PB 05-19 – "*Clarification of Payment for Review of Care Plans*", PB 17-03- "*Important Changes to Evaluation and Assessment Services for Home Health Care Services-Addition of Review of Care Plan Code-G0162*" and Important Message- "*Update to the Billing Requirements for Evaluations and Recertifications Performed by Home Health Agencies and Access Agenci*es".

Please note that billing instructions for the recertification reviews of care plans for physical therapy, speech and language pathology and occupational therapy services will be addressed in a separate policy transmittal.

Start of Care and Resumption of Care Evaluations:

Start of care (SOC) and resumption of care (ROC) services, when performed by a registered nurse, are billed under HCPCS code T1001 (nursing assessment/evaluation). Prior authorization (PA) is required when the same home health agency bills HCPCS code T1001 more than once within a calendar year.

HCPCS code T1001 must be on the waiver member's care plan and on the electronic visit verification (EVV) mandated service list for HUSKY Health members and CHC state funded clients served by Personal Care Assistant (PCA), Acquired Brain Injury (ABI) and Connecticut Home Care Program (CHC) for Elders waiver programs.

Review of Care Plans for Re-certification:

Effective April 1, 2017 and forward, DSS added HCPCS G0162 for the review of members' care plans. This is required by Section 19-13-D73 of the Connecticut Public Health Code for Home Health Care Agencies (Department of Public Health regulations).

This code supports the development and management of the HUSKY Health member's care plan for home health services, as required for both medical and behavioral health conditions. This continuous review of the care plan will (1) ensure that the member is receiving the appropriate level of care; and (2) provide an opportunity to adjust the care plan in a clinically appropriate fashion.

Recertifications of care plans must be completed within the 60-day window after the completion of a SOC/ROC evaluation. All care plans for all medical and/or behavioral health services must be reviewed and re-certified by a registered nurse. Further, every recertification thereafter should be completed within the 60-day window after the completion of the previous recertification.

If the care plan review is not performed within the 60-day window, the home health agency should arrange for the review to be completed as quickly, as possible. An explanation of the delay must be written in the member's health record for auditing purposes.

Home health agencies must bill HCPCS G0162 when the sole purpose for the visit is to complete the required 60-day recertification review of the care plan. HCPCS code G0162 has been added to each of the home health providers' fee schedules, and is based on the calculation of an agency's current rate for HCPCS code T1001 divided by four (4). A maximum of six (6) units will be allowed for HCPCS code G0162, once every 60 days per member.

If a skilled nursing service or medication administration is required during the same visit as the 60-day recertification review, then the home health agency must bill HCPCS code G0162 for the recertification review and the appropriate HCPCS code (i.e. S9123/T1502/T1503) for the medically necessary services that are rendered during the same visit.

These billing instructions for use of HCPCS code G0162 apply only to services reimbursed under the Medicaid State Plan (HUSKY A, C and D) and the Children's Health Insurance Plan (CHIP) (HUSKY B members). HCPCS code G0162 is a billable code for the PCA, ABI and CHC waiver programs; however, this code is not an EVV mandated service and is not required to be on the care plan.

Usage of Select Modifiers with HCPCS codes T1001 and G0162

Both the evaluation code, (T1001) and review of plan code, (G0162) can be billed with the following modifiers as appropriate:

- TT-Individualized services provided to more than one patient in the same setting;
- TG-Complex/high level of care; or
- TH-Obstetrical treatment/services, prenatal or postpartum.

Effective for dates of service April 1, 2017 and forward, DSS is no longer requiring home health agencies to bill modifier TD with HCPCS code T1001 for a SOC or a ROC evaluation.

Care Plans Approved Prior to April 1, 2017:

All previously approved prior authorizations (PAs) for ROC evaluations and 60th day recertification reviews that expired after April 1st will be honored. However, beginning April 1st, PAs will not be renewed if HCPCS codes S9123 or S9124 are submitted instead of the correct HCPCS codes for ROC evaluations (T1001) or 60th day recertifications (G0162). PA is not required for HCPCS G0162.

Home Health Care Services for Medicare and Medicaid Dually Eligible Patients:

Dually-eligible members covered by Medicare and HUSKY Health must exhaust home health benefits covered under Medicare prior to billing for services under HUSKY Health. For more information about billing for services provided to dually-eligible members, please refer to Chapter 8 of the Home Health Provider Manual on the CMAP Web site at www.ctdssmap.com.

Documentation:

In addition to the documentation regulations outlined by Section 17b-262-735, all services performed during home health care visits must be documented in the HUSKY Health member's file and home health agencies must make this information available to the Department for auditing purposes. Home health agencies are responsible for billing the

accurate time taken in providing each service, including start and end times for each service.

In addition, home health agencies must maintain the supporting documentation in the HUSKY Health member's file. Previously submitted claims that do not adhere to the guidance outlined in this revised policy transmittal should be recouped and resubmitted by the home health agencies accordingly.

Posting Instructions: Policy transmittals can be downloaded from the Web site at www.ctdssmap.com.

Distribution: This policy transmittal is being distributed to providers of the Connecticut Medical Assistance Program by DXC Technology.

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Date Issued: August 2017