Connecticut Medical Assistance Program Provider Bulletin 2017-59
Policy Transmittal 2017-21

Roderick L. Bremby, Commissioner

Effective Date: September 13, 2017
Contact: Dana Robinson-Rush @ 860-424-5615

TO: Home Health Agencies

RE: Clarifying Billing Instructions for Therapy Evaluations and Services Performed as Part of the Home Health Care Plans (Revised)

Effective September 13, 2017 and forward, billing codes have been added for therapy services; physical therapy (PT), occupational therapy (OT) and speech and language pathology (SLP), performed as part of a home health plan of care. This policy transmittal supplements the guidance provided in PB 17-30 - *Important Changes to Evaluation and Assessment Services for Home Health Care Services-Addition of Review of Care Plan Code-G0162 (Revised).* This policy transmittal supersedes and replaces PB 04-11 – "*Claim Submission Review".*

Billing PT/OT/SLP Evaluations:

Home health agencies are required to use Revenue Center Code (RCC) 424 - Physical Therapy Evaluation, RCC 434 - Occupational Therapy Evaluation or RCC 444 – Speech Pathology Evaluation when billing for evaluations, including start of care (SOC) evaluations or resumption of care (ROC) evaluations for PT/OT/SLP services.

Billing PT/OT/SLP Services:

When billing for PT/OT/SLP visits performed as part the member's care plan, the home health agency must bill RCC 421 – Physical Therapy, RCC 431 – Occupational Therapy or RCC 441 – Speech Pathology, respectively.

Review of Care Plans for PT/OT/ SLP Recertification:

Effective for dates of service, September 13, 2017 and forward, the following Healthcare Common Procedure Coding System (HCPCS) codes have been added to the home health fee schedule to be used when a review of a care plan for PT, OT or SLP recertification is required.

HCPCS Code	Description	Rate
G0151	Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes	$23.80
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes	$23.80
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes	$23.80

Home health agencies must use RCC 580 when billing with one of the HCPCS codes listed above. Additionally, the HCPCS codes listed above can be billed with the same select modifiers identified in PB 17-30.

A maximum of six (6) units will be allowed for HCPCS codes G0151, G0152 and G0153, once every 60 days per member. These HCPCS codes have been added to each of the home health providers' fee schedules, and the rate for these HCPCS codes are based on the calculation of the rate for HCPCS code T1001 divided by four (4).

For dates of service April 1, 2017 to September 12, 2017, home health agencies are instructed to use HCPCS code G0162 to bill the care plan reviews, even when performed by a licensed therapist. Home health agencies should refer to PB 17-30 - Important Changes to Evaluation and Assessment Services for Home Health Care Services-Addition of Review of Care Plan Code-G0162 (Revised) for additional information about HCPCS G0162.

Recertifications of care plans for therapy services must be completed by the 60th day after the completion of a SOC/ROC evaluation. Care plans for all therapy services performed in a home health care setting must be reviewed and re-certified by a licensed PT/OT/SLP therapist. Further, every recertification thereafter must be completed by the 60th day after the completion of the previous recertification.

If the care plan review is not performed by the 60th day, the home health agency must 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.

If a therapy service is required during the same visit as the 60-day recertification review, then the home health agency must bill the appropriate HCPCS code (G0151, G0152 G0153, or G0162 and RCC 580) indicating the recertification review and the appropriate RCC (i.e. 421, 431 or 441) for the therapy service performed. HCPCS codes G0151, G0152 and G0153 are billable codes for the Personal Care Assistant (PCA), Acquired Brain Injury (ABI) and Connecticut Home Care Program (CHC) for Elders waiver programs; however, at this time these codes are not electronic visit verification (EVV) mandated services and are not required to be on the care plan. Providers will be notified when these codes become mandated for EVV.

These billing instructions for use of HCPCS codes and RCCs mentioned in this policy transmittal 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).

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

For dually-eligible patients covered by both Medicare and HUSKY Health, benefits for home health services covered under the Medicare plan must be exhausted before the home health agency is permitted to bill HUSKY Health. 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.

Prior Authorization:

For therapy services, prior authorization guidance for these services, as per Section 17b-262-732, currently still stands.

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 medical record and home health agencies must make this information available to the Department upon request. 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. Final adjustments will be made based upon post-claim audit if there is billing of HCPCS codes that does not comply with the instructions cited in this policy transmittal and PB 17-30.

Previously submitted claims that do not adhere to the guidance outlined in this revised policy transmittal must 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.

Responsible Unit: DSS, Division of Health Services, Medical Policy Section; Dana Robinson-Rush, Health Program Assistant, (860) 424-5615 or email Dana Robinson- Rush@ct.gov.

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