interChange Provider Important Message

Additional Guidance on the Use of the Home Health SOC/ROC and Recertification Service Codes for CHC, ABI, PCA and Autism Waiver Clients

(Updated on 4/9/18) Please note: Revised data will appear in red.

The Department of Social Services (DSS) has become aware that home health agencies are seeking additional guidance related to when to use the Start of Care (SOC)/Resumption of Care (ROC) code T1001 and the 60-day recertification code G0162 when servicing their waiver clients. This Important Message is intended to provide additional guidance on when it is appropriate to use the SOC/ROC T1001 or 60-day recertification code G0162 and the prior authorization (PA) process. For additional information on the therapy evaluation codes, please refer to provider bulletin 17-59 "Clarifying Billing Instructions for Therapy Evaluations and Services Performed as Part of the Home Health Care Plans (Revised)".

The SOC/ROC code is:

- T1001 – Nursing assessment/evaluation

The 60-day recertification code is:

- G0162 – Skilled Services by a Registered Nurse (RN) for management and evaluation of the care plan

Prior Authorization Recommendations

The 60-day recertification codes are to be used to bill for the review of a client's care plan. The recertification of care plans for skilled nursing services must be completed within the 60-day window after the completion of the start of care (SOC)/resumption of care (ROC). Every recertification visit thereafter must be completed within the 60-day window after the completion of the previous recertification.

DSS recommends that access agencies create an *annual* PA for at least a minimum of twelve (12) units for the recertification visits, (two (2) units per each 60-day recertification visit representing six (6) 30 -minute evaluation visits per year), for clients with the CT Home Care (CHC), Acquired Brain Injury (ABI), Personal Care Assistance (PCA) and Autism waivers. This annual PA will ensure that a PA for the service being provided is present on the Web portal prior to a visit being

conducted and is available for scheduling in the Electronic Visit Verification (EVV) Santrax® system for CHC, ABI and PCA waiver clients.

Please remember: If the visit duration extends beyond the initial authorized units of two (2) units per visit, the provider must contact the access agency overseeing the client's care to request additional units. The provider can request up to an additional four (4) units, to reach the maximum of the six (6) units allowed per visit. Units requested in excess of the maximum of six (6) units allowed per visit will require further authorization from DSS.

How to Bill for Clients Returning to Services after a Hospitalization

Providers have communicated confusion in determining which code is appropriate for billing when a client returns to care after a hospitalization.

If a client is active on their appropriate waiver benefit plan, is hospitalized, and returns to the same home health agency for services under their waiver benefit, the initial visit after the hospitalization should be billed as a ROC using service code T1001. A 60-day recertification (procedure code G0162) should be performed within the 60-day window after the Resumption of Care (ROC) was completed.

If a client has Medicare coverage as the primary payer, is hospitalized, and returns to home health services under **Medicare** coverage, per Medicare guidelines, an oasis evaluation is required to return the client to Home Health services. Medicare would be billed for the initial oasis evaluation, ordered services, and further 60-day oasis evaluations. When the client no longer meets the Medicare level of care, and the home health agency performs a medically necessary evaluation in order to open the home health case under Medicaid coverage, such evaluation may be billed to Medicaid as a SOC using service code T1001. A 60-day re-certification billed using procedure code G0162, G0151, G0152, or G0153 should be performed within the 60-day window of the start of care and within the 60-day window thereafter.

As a reminder, the practice of discharging a client under Medicare and readmitting the client under Medicaid is *not* a DSS requirement or policy.

If a client no longer meets Medicare's level of care for home health benefits, is hospitalized, and returns to home health services under Medicaid coverage via their waiver benefit plan, a ROC, service code T1001, should be performed and billed to Medicaid. A recertification must be completed within the 60-day window from the date of completion of the previous recertification and billed under the 60-day recertification procedure code, G0162.

Skilled Services and Health Assessment Recommendations

Skilled services performed on the same day as a health assessment or 60-day recertification, applicable to the services being evaluated, should be billed for the skilled service(s) performed in addition to the health assessment or appropriate 60-day recertification.

If a health assessment is scheduled on the same date of service as a 60-day recertification, since the 60-day recertification includes the components of a health assessment, the applicable code for the 60-day recertification should be the only code billed for that date of service.

Providers who have additional questions regarding SOC/ROC or the 60-day recertification code should contact the Provider Assistance Center at 1-800-842-8440 for assistance.