Connecticut Medical Assistance Program
Policy Transmittal 2019-17

Provider Bulletin 2019-49
July 2019

Deidre S. Gifford, MD, MPH, Commissioner

Effective Date: August 1, 2019
Contact: Dana Robinson-Rush @ (860)424-5615

TO: Access Agencies and Home Health Agencies

RE: Correction to the Guidance for Billing Evaluation and Assessment Services for Home Health Care Services

Effective August 1, 2019, when billing for start of care evaluations/assessments (SOC), resumption of care evaluations (ROC) and 60-day recertification reviews, the following modifiers are **not** required:

- TT-Individualized services provided to more than one patient in the same setting;
- TG-Complex/high level of care.

This policy transmittal supersedes and replaces previously posted PB 17-30 "Important Changes to Evaluation and Assessment Services for Home Health Care Services-Addition of Review of Care Plan Code-G0162 (Revised)". However, the information provided in this policy transmittal supplements the guidance provided in PB 17-59 "Clarifying Billing Instructions for Therapy Evaluations and Services Performed as Part of the Home Health Care Plans (Revised)".

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 Healthcare Common Procedure Coding System (HCPCS) code T1001 (nursing assessment/evaluation). Prior authorization (PA) is required when the same home health agency bills more than one initial assessment (HCPCS code T1001) within a calendar year.

HCPCS code T1001 is on the electronic visit verification (EVV) mandated service list and must be on the waiver member's care plan for HUSKY Health members and Connecticut Home Care (CHC) state funded members served by the Autism, Personal Care Assistant (PCA), Acquired Brain Injury (ABI) and Connecticut Home Care Program for Elders (CHC) waiver programs. If the HCPCS code for the initial assessment is not listed on the waiver member's care plan, then the home health agency will be denied reimbursement.

Review of Care Plans for Re-certification:

HCPCS code G0162 – Registered Nurse Management and Evaluation of the plan of care, each 15 minutes is billed for the review of a HUSKY Health members' care plan. This review 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 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.

Home health agencies must bill HCPCS code G0162 when the sole purpose for the visit is to complete the required 60-day recertification review of the care plan. A maximum of six (6) units is 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.

HCPCS code G0162 is on the EVV mandated services list for HUSKY Health members and must be on the care plan for the HUSKY Health members served by the Autism, PCA, ABI and CHC waiver programs.

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 Connecticut Medical Assistance Program (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 documenting and billing the accurate time taken in providing each service, including start and end times for each service.

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