Connecticut Department of Social Services
Medical Assistance Program
www.ctdssmap.com

Provider Bulletin 2014-19
March 2014

TO: Access Agencies and Home Health Agencies

RE: Home Health Agency Care Plan and Claim Submission Changes Under the Connecticut Home Care Program for Elders

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This bulletin serves to notify Home Health Agencies servicing Connecticut Home Care Program for Elders (CHCPE) clients of changes the Department of Social Services (DSS) will be making to the CHCPE. These changes impact how medical services are authorized and will appear on the client's care plan. **These changes will be made in a staggered approach that will occur throughout April 2014.** As a result, these changes may not be immediately apparent to providers, if applicable, to any or all of their client's care plans beginning April 1, 2014.

The following changes are being made to provide more flexibility in the authorization and reimbursement of services which occur outside of the original plan of care. Providers should carefully review the following information to ensure appropriate claim submission.

- Implementation of a **new modifier, U2 One Time Only**. This modifier will uniquely identify a care plan service that overlaps with another service order for the same time period. Use of this modifier is retroactive for dates of service **July 1, 2013** and forward for one-time only services that must be added to the client's plan of care. Use of the U2 modifier will allow the Access Agency to:

  - Add a one - time only service July 1, 2013 and forward that increases the units or frequency of an existing care plan service without end dating and restarting the care plan. As a result, providers will no longer need to recoup their claims in order to have a one - time only service added to the care plan.

  - Add an overlapping service order of the same or different frequency for the same service currently on the care plan. As a result, a client may have overlapping span dates of service or both a weekly and a monthly frequency of the same service on the care plan, depending on the service billed. Care plans will no longer be over or under stated, leading to over service or claim denials depending on when the service is provided.

  Please Note:

  Use of the U2 modifier **<u>will not apply</u>** to physical therapy, occupational therapy, or speech therapy services and will not appear on the care plan when a Revenue Center Code (RCC) is authorized.

  Explanation of Benefits Code (EOB) 749 "Modifier U2 not allowed" will post if the U2 modifier is submitted on a claim for a client who does not have a CHC benefit plan or if the claim denies for some other reason against the CHC benefit plan of a client who has multiple benefit plans on their eligibility file.

The following codes will continue to be authorized by procedure code and if

applicable, the U2 modifier will be authorized and associated to the procedure code on the care plan:

- T1002
- T1003
- T1004

When a one - time only service is authorized for one of the above procedure codes, the U2 modifier will appear in the Prior Authorization (PA) search results under the "Modifier" heading next to the "Procedure Code". The U2 modifier will also appear in the "Modifier" field, directly under the "Procedure Code" field, when the PA line detail is opened.

When a one - time only service is authorized, providers must submit both the procedure code and the U2 modifier on the claim.

- **Unique Procedure Code with Modifier Lists for one time only services** are being added and when authorized will appear on the care plan for the following services:
  - Skilled Nursing – One Time Only
  - Medication Administration – One Time Only

The following lists will allow for greater billing flexibility when the services provided must be modified due to changes in the client's circumstances, resulting in a change or frequency of service. The following lists are retroactive for dates of service **July 1, 2013** and forward.

Skilled Nursing One Time Only Service

Service Description	Procedure/Modifier List Code = **SS**
Nurse Visit RN – one - time only	S9123 U2
Nurse Visit RN - one time only Subsequent Client	S9123 U2 TT
Nurse Visit LPN – one time only	S9124 U2
Nurse Visit LPN - one time only Subsequent Client	S9124 U2 TT

Medication Administration One Time Only Service

Service Description	Procedure/Modifier List Code = **MM**
Medication Administration oral/injectable – one time only	T1502 U2
Medication Administration, oral/injectable - one time only Subsequent Client	T1502 U2 TT
Medication Administration, other – one time only	T1503 U2
Medication Administration, other – one time only Subsequent Client	T1503 U2 TT

Please Note: The above lists are subject to the same limitations as the SN and MA Procedure Code Modifier lists and will require DSS approval if the care plan exceeds two visits per week.

As a reminder, when an SS or MM code list is authorized, any service associated to the list may be provided and billed with the applicable procedure code and modifier combination as long as the list code is on the care plan.

New Service

DSS recently added a new service, Med Tech, effective January 1, 2014 to the Home Health Fee Schedule, which may be provided to a client with a HUSKY and or CHC benefit plan. As a result, two new Procedure Code Modifier Lists have been added and will appear on the care plan, if applicable.

Medication Administration by a Certified Home Health Aide

Service Description	Procedure/Modifier List Code = **MT**
Medication Administration, Certified Home Health Aide	T1021
Medication Administration, Certified Home Health Aide – Subsequent Client	T1021 TT

Medication Administration by a Certified Home Health Aide One Time Only

Service Description	Procedure/Modifier List Code = **MU**
Medication Administration, Certified Home Health Aide one time only	T1021 U2
Medication Administration, Certified Home Health Aide one time only Subsequent Client	T1021 U2 TT

The above services **currently require DSS approval from the first visit** and are authorized by the MT and MU list codes based on 1 unit per visit. As previously indicated, any service associated to the list may be provided and billed with the applicable procedure code and modifier combination as long as the list code and units of service are on the care plan.

Future Changes

Additional changes are being developed to allow the Access Agency to make retroactive changes to the care plan without requesting that the provider recoup their claims (for example, when a client is hospitalized and the care plan needs to be terminated and then resumed upon the clients' return home). These changes will be made later on this year in conjunction with a PA mass adjustment process that will systematically adjust claims when a PA has been updated. As a result, claims paid to a provider when the client was hospitalized or out of the community will be systematically recouped.

Until this mass adjustment process is implemented, providers will continue to be required to recoup claims inappropriately paid due to periods of non-service. Inappropriately paid claims or details on a paid claim can easily be recouped or adjusted via the provider's secure Web account. Providers should select claims, claim inquiry and enter the 13 digit ICN of the paid claim. If the entire claim must be recouped, providers should scroll to the bottom of the claim and select the blue button for the option to void the claim. If the claim is to be adjusted, providers should delete the service line details on the claim corresponding to the periods of non-service, scroll to the bottom of the claim and select the blue button for the option to adjust the claim. In cases where the dates of service on the care plan exceed the period of non-service, the Access Agency should add an external note to the care plan. The external note should clearly indicate the periods of non-service to eliminate further claims being inappropriately submitted by the provider.

Please Note: For additional information on performing Web claim transactions, providers should refer to the "Instructions for Submitting Professional Claims" document. This document can be found on the provider's secure Web account by clicking on Claims > Professional > and selecting the "Instructions for Submitting Professional Claims" link under "Quick Links."

Ongoing Communications

From the www.ctdssmap.com Web site Home Page, under Important Messages, providers should click on the "Welcome to the CT Home Care Program Implementation" link. This link will be updated with the latest changes and communications regarding the CT Home Care Program as they become available to provide a one stop resource for CT Home Care Program Information. Providers should make a point of checking this message for future changes.