Home Health Care Services Payment Policy

Applies to the following CarePartners of Connecticut products:

☒ CareAdvantage Preferred

☒ CarePartners Access

The following payment policy applies to providers who render home health care services to members of the CarePartners of Connecticut plans selected above.

Note: Audit and disclaimer information is located at the end of this document.

Policy

CarePartners of Connecticut covers medically necessary skilled home health care services for homebound members services, in accordance with the member's benefits.

General Benefit Information

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider portal or by contacting CarePartners of Connecticut Provider Services at 888-341-1508.

CarePartners of Connecticut requires medication reconciliation documentation for all members.

Referral/Prior Authorization/Notification Requirements

Certain procedures, items and/or services may require referral and/or prior authorization. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that prior authorization has been obtained. For more information, refer to the Referral, Prior Authorization and Notification Policy.

No referrals are required for in-network services. Referrals are required for out-of-network services rendered for HMO members.

Initial Evaluation

A provider order is required for the initial home health care assessment/evaluation visit.

Post-Evaluation Visits

Prior notification is required for all home health care services beyond the initial assessment/evaluation visit. Notifications must be submitted after the initial evaluation and assessment, but before continued services are rendered. To submit prior notification, the home health care provider must fax a copy of the Home Health or Part B Services Notification Form and their plan of care to the appropriate care manager (CM) identified in the Care Management List within two business days of the evaluation visit.

Subsequent/Ongoing Visits

For ongoing requests beyond the initial coverage period, providers should fax a copy of their plan of care to the appropriate care manager (CM) identified in the Care Management List at least **two business days** prior to the coverage period end date (or before the last visit, whichever is sooner) to prevent a gap in coverage.

Discharge Summary

When members are being discharged from service, submit a discharge summary **within two business days** following the discharge from home health care services, including the number of visits provided, date of last visit and patient disposition for each discipline. Include the date that the Notice of Medicare Noncoverage (NOMNC) was delivered to the member. CarePartners of Connecticut reserves the right to deny payment of services if the provider fails to submit the discharge summary and required clinical information.

Note: In rare circumstances, providers may be asked to provide the information in a shorter timeframe. CarePartners of Connecticut reserves the right to deny coverage of services when the provider fails to submit the required information.

Billing Instructions

Unless otherwise stated, CarePartners of Connecticut follows industry-standard coding guidelines. Refer to current industry-standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules.

Use of noncontracting labs may have the unintended consequence of subjecting the member to unnecessary services not ordered by the treating provider or other unreasonable financial exposure. In such circumstances, CarePartners of Connecticut may hold the ordering provider accountable for any inappropriate behavior on the part of the nonparticipating lab that has been selected.

- Submit a Health Insurance Prospective Payment System (HIPPS) and treatment authorization code from the Outcome and Assessment Information Set OASIS assessment on all home health care claims. The line item date of service of the line reporting the HIPPS code must match the earliest dated home health visit line. All service units on the HIPPS code lines must be greater than zero.

Effective for dates of service on or after July 1, 2023, the following codes will be required. These codes are considered informational:

- G0320: Home health services furnished using synchronous telemedicine rendered via a real-time two-way audio and video telecommunications system
- G0321: Home health services furnished using synchronous telemedicine rendered via telephone or other real-time interactive audio-only telecommunications system
- G0322: The collection of physiologic data digitally stored and/or transmitted by the patient to the home health agency (for example, remote patient monitoring)

Note: All home health care services include certain commonly used incidental supplies that are not compensated separately, such as routine dressings, sterile Q-tips, and nonsterile gloves. All other medical supplies, such as for complex wound care or DME, must be obtained from a CarePartners of Connecticut participating DME provider and may require prior authorization by CarePartners of Connecticut. Refer to the Durable Medical Equipment and Medical Supplies Payment Policy for additional information.

Compensation/Reimbursement Information

Providers are compensated according to the applicable contracted rates and applicable fee schedules.

CarePartners of Connecticut Reimburses

- Intermittent skilled nursing visits furnished by RN or LPN
- Medical social services
- Physical, speech and occupational therapies, including services provided by physical therapy assistants and occupational therapy assistants
- Services of a home health aide when considered a medically necessary part of skilled home care services
- Nutritional counseling, only when considered a medically necessary part of skilled home care services

CarePartners of Connecticut reimburses the following services in the home setting when billed by the appropriate provider (See “Additional Resources” section below”

CarePartners of Connecticut Does *Not* Reimburse

- Incidental supplies, such as routine dressings, sterile Q-tips, and nonsterile gloves
- Custodial care in the absence of qualified skilled services
- Domestic housekeeping services
- Meal services
- Private duty nursing
- Respite care for family/caretakers
- Telehealth services
- Venipuncture as the sole purpose of the home care visit
- Vaccines that are available from the state

Additional Resources

- Durable Medical Equipment and Medical Supplies Payment Policy
- Home Infusion Payment Policy
- Hospice Services Payment Policy

- Physical, Occupational, and Speech Therapy Professional Payment Policy

Document History

- October 2024: Annual policy review; added billing instructions for G0320, G0321 and G0322; removed edit language for home infusion, nursing care services and physician recertification; updated additional resources
- September 2023: Annual policy review; administrative updates
- September 2022: Annual policy review; administrative updates
- March 2021: Reviewed by committee; removed codes and referred to provider agreements; added previously communicated claim edits
- December 2020: Added applicable CarePartners Access PPO content, effective for dates of service on or after January 1, 2021
- February 2019: Updated care management contact information
- January 2019: Policy created

Audit and Disclaimer Information

CarePartners of Connecticut reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, CarePartners of Connecticut will expect the provider/facility to refund all payments related to noncompliance. For more information about CarePartners of Connecticut's audit policies, refer to the CarePartners of Connecticut public Provider website.

This policy provides information on CarePartners of Connecticut claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the CarePartners of Connecticut products identified by the checkboxes on page one. CarePartners of Connecticut reserves the right to amend a payment policy at its discretion.