



Connecticut interChange MMIS

Provider Manual

Chapter 7 - Home Health

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**Connecticut Department of Social Services (DSS)
55 Farmington Avenue
Hartford, CT 06105**

**Gainwell Technologies
10 Waterside Drive
Suite 105
Farmington, CT 06032**



CONNECTICUT MEDICAL ASSISTANCE PROGRAMS

Home Health Services Policy/Regulation

Chapter 7

Medical Services Policy

7.1

This section of the Provider Manual contains the Medical Services policy sections that pertain to home health providers.

Policy updates, additions, and revisions are approved in accordance with the Connecticut Uniform Administrative Procedure Act. Should this occur, providers are notified through the Provider Bulletin process and sent policy update pages to place in Chapter 7 of their manuals.

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Chapter 7

Medical Services Policy

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Requirements for Payment of Home Health Services.

Sec. 17b-262-1 Scope

Sections 17b-262-2 to 17b-262-9 inclusive set forth the requirements for payment of Home Health services provided to individuals who are determined eligible to receive services under Connecticut's Medical Assistance Program pursuant to Section 17b-262 of the Connecticut General Statutes.

Sec. 17b-262-2 Definitions

For the purpose of Sections 17b-262-1 through 17b-262-9 the following definitions apply:

- (1) "Commissioner" means the Commissioner of the department of social services, or his representative.
- (2) "Department" means the State of Connecticut department of social services, or its agent.
- (3) "Home" means the recipient's place of residence which includes a boarding home or Home for the Aged. Home does not include a hospital, Skilled Nursing Facility, Intermediate Care Facility, or Intermediate Care Facility for the Mentally Retarded.
- (4) "Home Health Care Agency" means the definition contained in subsection (d) of section 19a-490 of the Connecticut General Statutes (CGS).
- (5) "Home Health Provider" means any home health care agency licensed by the Department of Public Health and who also meets the requirements for participation in Medicare. Providers shall also meet all departmental enrollment requirements.
- (6) "Refusal to Serve" shall mean a refusal to accept a new client, a termination of service to an existing client, or an interruption of service to an existing client which lasts longer than 48 hours.
- (7) "Service Area" means those cities or towns designated by zip codes on forms provided by the department.
- (8) "Suspension of Service" shall mean an interruption of service to an existing client which lasts 48 hours or less.

Sec. 17b-262-3 Provider Participation

In order to receive payment from the department for home health services, all Home Health Care Agencies shall be licensed by the Department of Public Health and shall meet the requirements for participation in Medicare. [Home Health Care Agency Licensure Regulations: Public Health Code Sections 19-13-D66 to D79 Inclusive and Federal Regulation: Sections 42 (Code of Federal Regulations) 440.70 and 42 (Code of Federal Regulations) 441.15]. Providers shall also meet all departmental enrollment requirements.

Sec. 17b-262-4 Eligibility

Payment for home health services is available to all persons eligible for Medicaid subject to the conditions and limitations which apply to these services

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Sec. 17b-262-5 Policy

No home health care agency enrolled as a Medicaid provider shall select a service area, or refuse to serve any person, based on the geographical location of the service to be provided unless the home health care agency has a legitimate, non-discriminatory reason for its choice of service area or its refusal to serve. Referrals for service made to Medicaid enrolled home health care agencies shall not be refused if the patient's home is located within the home health care agency's designated service area. Any and all home health care agency refusals to serve shall be documented and based upon objective, legitimate, non-discriminatory reason(s). Upon receipt of a complaint of discriminatory action by a home health care agency, the home health care agency's proof of legitimate non-discriminatory purpose shall be evaluated to determine that it is not pre-textual.

Sec. 17b-262-6 Designation of Service Area

- (a) All home health care agencies shall designate their service area by identifying the zip codes of the areas which they serve on a form to be provided by the department. All changes in that service area shall be reported to the department on an annual basis. The designated service area shall not be smaller than that reported to the Department of Public Health. If an agency serves any zip code within a town or municipality, the agency shall serve all zip codes within such town.
- (b) The department shall timely evaluate all such designations, and changes in designations, to determine that the service area has not been chosen in a pattern which suggests an intent to avoid, or has the effect of avoiding, areas with a high concentration of minority residents, based on census data and other objective information. If the department determines that the choice of service area is designed to or has the effect of avoiding areas with a high concentration of minority residents, the agency shall be notified in writing of such determination and shall be required, within ten days, to provide written justification of its choice of service area based upon legitimate non-discriminatory reasons in accordance with subsection 17b-262-8, Legitimate Non-Discriminatory Reason.

Sec. 17b-262-7 Refusal to Serve

- (a) All home health care agencies shall record each and every written or oral refusal to serve and suspension of service, including but not limited to discharges, including the date, the name and address of the patient or the reason why the name and address is unavailable, the reason for the refusal to serve, and identifying the support for this reason.
- (b) If the stated reason for the refusal to serve is that there is an immediate danger to the health and safety of the home health care agency's personnel, the home health care agency shall, within 48 hours of the refusal to serve or discharge:
 - (1) Complete a form to be provided by the department detailing the timely, objective and substantial evidence on which the refusal to serve is based, the reasonable efforts taken to protect the home health care agency personnel, the geographic area covered by the refusal to serve, and the actual or expected duration of the refusal to serve;
 - (2) If the name and address of the client are known, send the client written notice of the refusal to serve in a form prescribed by the department, which notice shall include the reason for the refusal to serve, the timely, objective and substantial evidence on which the refusal to serve is based, the length of time during which service shall be refused, the right of the client to file a complaint with the department; and informing the client of his or her right to seek legal advice if he or she feels his or her rights have been violated; and

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- (3) Send the department a copy of the form with a copy of the notice to the client attached. If the department determines that the agency has failed to comply with these requirements, the home health care agency shall be notified in writing of such determination, and shall be required, within ten days of receipt of the notice, to submit, in writing, justification for its failure to comply based on legitimate non-discriminatory reasons in accordance with section 17b-262-8.
- (c) The department shall review and monitor all forms prepared by home health care agencies pursuant to subsection (b) of section 17b-262-7, Refusal to Serve, to determine that the refusal to serve does not evidence a pattern which suggests an intent to avoid, or have the effect of avoiding, areas with a high concentration of minority residents, based on census data and other objective information. If the department determines that such a pattern exists, the home health care agency shall be notified of such determination, and shall be required, within ten days, to submit, in writing, justification for his refusals to serve based on legitimate non-discriminatory reasons in accordance with section 17b-262-8.
- (d) The department shall conduct random inspections to ensure compliance with record-keeping requirements.
- (e) The department shall respond to all complaints of refusal to serve by conducting a full investigation into the circumstances of the particular case, including but not limited to inspection of the home health care agency's records regarding refusals to serve.
- (f) The department shall, in its discretion, conduct investigations into any refusals to serve or discharges which it determines warrant investigation, even in the absence of a specific complaint.
- (g) If the department determines that a home health care agency has refused to serve a person located within its designated service areas, the agency shall be notified in writing of such determination and shall be required, within ten days, to submit, in writing, justification for its refusal to serve based upon legitimate non-discriminatory reasons in accordance with section 17b-262-8.
- (h) All suspensions of service shall be justified by timely, objective and substantial evidence, and oral or written notice of the suspension shall be given to the client.

Sec. 17b-262-8 Legitimate Non-Discriminatory Reason:

- (a) In any case in which a home health care agency is required to provide written justification based upon legitimate non-discriminatory reasons in accordance with this section, the home health care agency shall be afforded an opportunity to demonstrate, and shall have the burden of demonstrating, that it had a legitimate, non-discriminatory reason for its actions, including but not limited to:
 - (1) The patient's non-compliance with the plan of care;
 - (2) Lack of staff qualified for the client's particular medical needs; and
 - (3) Immediate danger to the health or safety of home health care agency personnel.
- (b) Immediate danger to the health or safety of home health care agency personnel shall not constitute a legitimate, non-discriminatory reason unless:

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- (1) There is timely, substantial and objective evidence demonstrating that the provider has a well-founded belief that there is an immediate danger to the health or safety of home health care agency personnel in providing services at the particular time and location at which the home health care services were requested, or in accessing such location, which prevents the agency from delivering services;
 - (2) All reasonable efforts to protect the home health care agency personnel have been made prior to refusing service, including but not limited to the use of escorts, coordination with community patrols, and coordination with public and housing authority law enforcement;
 - (3) The refusal to serve covers an area no larger than necessary to avoid the immediate danger to the health and safety of the home health care agency personnel; and
 - (4) The refusal to serve is limited in duration so as to be no longer than necessary to avoid the immediate danger to the health or safety of the home health care agency personnel.
- (c) Proof of a legitimate non-discriminatory reason, including immediate danger to the health and safety of home health care agency personnel, shall be documented in writing and be based on timely, objective and substantial evidence. Such proof may include, but not be limited to, records maintained pursuant to Department of Public Health's regulations. Proof of immediate danger to the health and safety of home health care agency personnel, such as documented observation of significant drug dealing, criminal gang activity or threatening use of weapons or police department reports of ongoing criminal activity, shall relate to the particular location in question, or the means of access to that location.
- (d) All proof of legitimate non-discriminatory purpose submitted pursuant to subsection (c) of section 17b-262-8, Legitimate Non-Discriminatory Reason, shall be investigated and evaluated by the department to ensure that they are not pre-textual. For purposes of this section, an allegedly legitimate non-discriminatory purpose is pre-textual when:
- (1) The home health care agency is unable to offer timely, substantial and objective proof of its alleged legitimate non-discriminatory purpose; or
 - (2) Timely, substantial and objective evidence exists which demonstrates that there were alternative, neutral means of accomplishing the alleged purpose and that the home health care agency knew or should have known of the existence of such alternative, neutral means. The department shall issue its findings and recommendations in writing at the conclusion of its investigation.
- (e) If the home health care agency is unable to demonstrate a legitimate non-discriminatory purpose, or if the department finds an alleged legitimate non-discriminatory purpose to be pre-textual, the department shall issue a notice of violation and refer the case to the U.S. Department of Health and Human Services Office of Civil Rights.

Sec. 17b-262-9 Sanctions

If the department determines, in accordance with sections 17b-262-1 through 17b-262-9, that these regulations have been violated, the department shall provide the home health care agency a written notice of violation stating the basis of the department's determination and the sanctions to be imposed. Such sanctions may include any of the following, alone or in combination:

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- (a) Termination of provider agreement;
- (b) Monitoring and/or reporting requirements;
- (c) Public Notice; and
- (d) Such other and further sanctions as the department deems appropriate.

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**Requirements for Payment of Home Health Services of the
Regulations of Connecticut State Agencies**

(NEW) Section 17b-262-724. Scope

Sections 17b-262-724 to 17b-262-735, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for the payment of home health care services on behalf of clients who are determined eligible to receive services under the Connecticut Medicaid program pursuant to section 17b-262 of the Connecticut General Statutes.

(NEW) Sec. 17b-262-725. Definitions

As used in section 17b-262-724 to section 17b-262-735, inclusive, of the Regulations of Connecticut State Agencies:

- (1) "Activity of daily living" or "ADL" means any activity necessary for self care including bathing, dressing, toileting, transferring and feeding;
- (2) "Acute" means symptoms that are severe and have a rapid onset and a short course;
- (3) "Care plan" means the patient care plan as set forth in section 19-13-D73 of the Regulations of Connecticut State Agencies;
- (4) "Chronic disease hospital" means "chronic disease hospital" as defined in section 19-13-D1 (b) (2) of the Regulations of Connecticut State Agencies;
- (5) "Client" means a person eligible for goods or services under Medicaid;
- (6) "Commissioner" means the Commissioner of Social Services or his or her designee;
- (7) "Concurrent" means in the same time period covered by the care plan;
- (8) "Department" means the Department of Social Services or its agent;
- (9) "Early and Periodic Screening, Diagnostic, and Treatment Services" or "EPSDT" means the services provided in accordance with section 1905(r) of the Social Security Act, as amended from time to time;
- (10) "Emergency" means a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part;

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- (11) "Extended nursing services" means nursing care services that are required for more than two continuous, consecutive hours on any given day;
- (12) "Hands on care" means the assistance with activities of daily living provided most often, but not exclusively, by home health aides. The assistance includes the prompting and cueing necessary for a client to perform an activity of daily living;
- (13) "Home" means the client's place of residence, including, but not limited to, a boarding home, residential care home or community living arrangement. "Home" does not include facilities such as hospitals, nursing facilities, chronic disease hospitals, intermediate care facilities for the mentally retarded (ICFs/MR) or other facilities that are paid an all-inclusive rate directly by Medicaid for the care of the client;
- (14) "Home health aide" means "homemaker-home health aide" as defined in section 19-13-D66 of the Regulations of Connecticut State Agencies;
- (15) "Home health care agency" means "home health care agency" as defined in section 19a-490 of the Connecticut General Statutes and which
 - A) is licensed by the Department of Public Health pursuant to sections 19-13-D66 to 19-13-D79, inclusive, of the Regulations of Connecticut State Agencies;
 - B) meets the requirements of 42 CFR Parts 440, 441 and 484, as amended from time to time; and
 - C) is enrolled in Medicaid;
- (16) "Home health care services" means the services provided by a licensed home health care agency on a part-time or intermittent basis in the client's home;
- (17) "Hospice" means "hospice" as defined in section 19-13-D1(b)(1)(C) of the Regulations of Connecticut State Agencies;
- (18) "Hospital" means "short-term hospital" as defined in section 19-13-D1(b)(1) of the Regulations of Connecticut State Agencies;
- (19) "Household" means a situation where two or more people are living: (A) in a group home, a residential care home or other group living situation; (B) at the same street address if it is a single family house that is not divided into apartments or units; or (C) at the same apartment number or unit number if clients live in a building that is divided into apartments or units;
- (20) "Instrumental activity of daily living" or "IADL" means any activity related to a person's ability to function in the home, including, but not limited to, meal preparation, housework, laundry and use of the telephone;
- (21) "Intermediate care facility for the mentally retarded" or "ICF/MR" means a residential facility for persons with mental retardation licensed pursuant to section 17a-227 of the Connecticut General Statutes, if applicable, and certified to participate in Medicaid as an intermediate care facility for the mentally retarded pursuant to 42 CFR 442.101, as amended from time to time;
- (22) "Intermittent" means less than twenty-four hour care within a twenty-four hour period;

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- (23) "Licensed practical nurse" or "LPN" means "licensed practical nurse" as defined in chapter 378 of the Connecticut General Statutes;
- (24) "Licensed practitioner" means a physician who orders home health care services in accordance with sections 19-13-D66 to 19-13-D79, inclusive, of the Regulations of Connecticut State Agencies;
- (25) "Licensed practitioner order" means an order that directs the home health care agency to provide services according to the licensed practitioner's care plan;
- (26) "Medicaid" means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act, as amended from time to time;
- (27) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate setting; and is the least costly of multiple, equally-effective alternative treatments or diagnostic modalities;
- (28) "Medical necessity" or "medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring;
- (29) "Medical record" means "medical record" as defined in section 19a-14-40 of the Regulations of Connecticut State Agencies;
- (30) "Medication administration" means the administration of oral, intramuscular or subcutaneous medication and also those procedures used to assess the client's medical or behavioral health status as ordered by the prescribing practitioner. Such procedures include, but are not limited to, glucometer readings, pulse rate checks, blood pressure checks or brief mental health assessments;
- (31) "Normal life activities" means any activity that the client attends or in which he participates in the community including, but not limited to, school, work and day care.
- (32) "Nursing care services" means the services provided by a registered nurse or a licensed practical nurse;
- (33) "Nursing facility" means "nursing facility" as defined in 42 USC 1396r(a), as amended from time to time;
- (34) "Occupational therapy" means the services provided by an occupational therapist or an occupational therapy assistant as set forth in section 20-74a of the Connecticut General Statutes;
- (35) "Physical therapy" means the services provided by a physical therapist or a physical therapy assistant as set forth in section 20-66 of the Connecticut General Statutes;
- (36) "Physician" means a physician or surgeon licensed pursuant to sections 20-8 to 20-14k, inclusive, of the Connecticut General Statutes;
- (37) "Postpartum" means the sixty-day time period immediately following childbirth;

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- (38) "Prenatal" means the time period between the beginning of a pregnancy and the end of a pregnancy;
- (39) "Prior authorization" or "PA" means the approval for the provision of a service or delivery of goods from the department before the provider actually provides the service or delivers the goods;
- (40) "Provider" means a home health care agency;
- (41) "Registered nurse" means "registered nurse" as defined in chapter 378 of the Connecticut General Statutes;
- (42) "Speech therapy" or "speech pathology" means the services provided by a speech pathologist as set forth in section 20-408 of the Connecticut General Statutes;
- (43) "Usual and customary charge" means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, "usual and customary" shall be defined as the median charge. Token charges for charity patients and other exceptional charges are to be excluded; and
- (44) "Week" means a calendar week beginning on Sunday and ending on Saturday.

(NEW) Sec. 17b-262-726. Provider Participation

To enroll in Medicaid and receive payment from the department, providers shall comply with sections 17b-262-522 to 17b-262-533, inclusive, and sections 17b-262-1 to 17b-262-9, inclusive, of the Regulations of Connecticut State Agencies.

(NEW) Sec. 17b-262-727. Eligibility

Payment for home health care services provided to persons eligible for Medicaid shall be available subject to the conditions and limitations that apply to these services as identified in sections 17b-262-724 to 17b-262-735, inclusive, of the Regulations of Connecticut State Agencies.

(NEW) Sec. 17b-262-728. Services Covered and Limitations

- (a) Subject to the limitations and exclusions identified in sections 17b-262-724 to 17b-262-735, inclusive, of the Regulations of Connecticut State Agencies, the department shall pay for medically necessary and medically appropriate home health care services provided by home health care agencies that are directly related to the client's diagnosis, symptoms or medical history. These services include:
 - (1) nursing care services limited to the following:
 - (A) physical nursing care or the teaching of nursing care, including, but not limited to, direct services such as enemas, irrigations, dressing changes, treatments and administration and supervision of medication;
 - (B) admission of clients to agency services; development of the initial care plan; and subsequent reviews of the care plan, no more than one every 60 days;

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- (C) diabetic teaching for thirty consecutive days per diabetic client;
 - (D) pregnancy-related preventive prenatal and postpartum nursing care services to women at high risk of negative pregnancy outcome that are performed during the prenatal or postpartum period of pregnancy for the purpose of, but not limited to:
 - (i) evaluation of medical health status, obstetrical history, present and past pregnancy related problems and psychosocial factors such as emotional status, inadequate resources, supportive helping networks and parenting skills; and
 - (ii) the provision of general health education and counseling, referral, instruction, suggestions, support or observation to monitor for any untoward changes in the condition of a prenatal or postpartum woman at high risk so that other medical or social services, if necessary, can be instituted during the prenatal or postpartum stage of childbearing;
 - (2) hands on care provided by a home health aide;
 - (3) home health aide assistance with an IADL provided in conjunction with hands on care;
 - (4) physical therapy services;
 - (5) speech therapy or speech pathology services;
 - (6) occupational therapy services; and
 - (7) EPSDT
- b. Limitations on covered services shall be as follows:
- (1) The department shall pay for home health care services only when these services are provided in the client's home. However, the department shall pay for medically necessary and medically appropriate nursing care services for clients who leave their place of residence to engage in normal life activities. The total number of hours of nursing care services shall be limited to those hours to which the client would be entitled if services were provided exclusively at the client's place of residence. Such services shall not be provided in hospitals, nursing facilities, chronic disease hospitals, intermediate care facilities for the mentally retarded or other facilities that are paid an all-inclusive rate directly by Medicaid for the care of the client.
 - (2) The department shall pay for only those services that are listed in the department's fee schedule for home health care services.
 - (3) The department shall pay for pregnancy-related preventive postpartum nursing care services only for high risk women as described in section 17b-262-731 of the Regulations of Connecticut State Agencies. Such payment shall be limited to services provided during the sixty-day time period immediately following childbirth.
 - (4) Home health aide services in excess of fourteen hours per week must be cost effective, as described in section 17b-262-730 of the Regulations of Connecticut State Agencies, for Medicaid payment to be available.

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- (5) Extended nursing services shall be cost effective as described in section 17b-262-730 of the Regulations of Connecticut State Agencies.
- (6) The fee for medication administration shall include the administration of medication(s) while the nurse is present as well as the pre-pouring of additional doses, less than a one week supply, that the client will self administer at a later time and the teaching of self administration of the medication that has been pre-poured.
- (7) When the purpose of the visit is to pre-pour medication for a week or more, the skilled nursing visit codes for either a registered nurse or a licensed practical nurse shall be used. The skilled nursing visit is provided for a client who has a documented need for this service because of his or her inability to correctly count out or draw up the medication for self-administration. Documentation shall include a full assessment of the client's medical and behavioral status as well as notes addressing the client's understanding of the drug therapy and his or her continued ability to self-administer the medications.
- (8) If during the course of a scheduled medication administration visit, there is a change in the client's condition and the client's prescribing practitioner is notified, the medication administration visit may become a skilled nursing visit. This may occur even if a revision to the client's plan of care is not required. The client's medical record shall be fully updated to reflect the change in medical and behavioral health observed during the visit, the additional skilled services provided to the client and the revisions, if any, made to the plan of care. If this situation occurs and the services have been prior authorized, the provider shall contact the department to request modification of the prior authorization.

(NEW) Sec. 17b-262-729. Services not covered

The department shall not pay a home health care agency:

- (1) for services provided to a client who is receiving the same service concurrently from an individual therapist, clinic, hospital, practitioner, rehabilitation center or other health care provider;
- (2) for services provided by or through another agency or facility as part of its licensing requirements. For example, the department shall not pay for home health aide services if the client lives in a facility that provides home health aide services as part of its licensing requirements;
- (3) when the client is in a hospital, nursing facility, chronic disease hospital, ICF/MR or other facility that is paid an all-inclusive rate directly by Medicaid for the care of the client;
- (4) when the client is receiving the same home health care services concurrently from another home health care agency. This limitation does not preclude a home health care agency from contracting with another agency as described in section 19-13-D70 of the Regulations of Connecticut State Agencies;
- (5) for well child care or for prenatal or postpartum care that is not high risk;
- (6) for medical and surgical supplies or durable medical equipment used by the nurse, home health aide or therapist as part of the course of treatment for a client;

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- (7) for cancelled visits, appointments not kept or services not provided;
- (8) for information or services provided to a client over the telephone; or
- (9) for anything of an unproven, experimental or research nature or for services in excess of those deemed medically necessary and medically appropriate by the department to treat the client's condition or for services not directly related to the client's diagnosis, symptoms or medical history.

(NEW) Sec. 17b-262-730. Cost effectiveness test

- (a) The department shall apply a cost effectiveness test for all prior authorization requests for: (1) home health aide services in excess of fourteen hours per week; and (2) all extended nursing services. The purpose of said test is to ensure that the services requiring PA, when combined with other services provided and within the home health care agency's scope of practice, whether or not provided by the home health agency, are not more expensive than the cost of the care would be for the client if the client were to be placed in the appropriate institution.
- (b) In determining whether the home health care services are cost effective, the department shall compare the monthly cost of the home health care services with the monthly rate at the appropriate institution. The monthly cost of service in the appropriate institution means the average monthly Medicaid rate, calculated by the department, for a particular type of institution, for example, a nursing facility or ICF/MR. The monthly cost of home health care services is defined as the projected costs of providing these services for the client.
- (c) The department shall total the costs of the following services to determine the cost of the home health care services: nursing, home health aide, physical therapy, speech therapy and occupational therapy. All costs of providing these services shall be included whether provided by a single home health care agency or multiple Medicaid providers including any other entity that the department reimburses for these services.
- (d) The department shall determine whether a nursing facility, ICF/MR, chronic disease hospital or hospice is the appropriate institutional placement. Such determination shall depend on the criteria for admission to the institution and the client's care needs.
- (e) The department shall approve PA requests for home health aide services for more than fourteen hours per week or extended nursing services only if:
 - (1) the total monthly cost of the home health care services as described in subsection (c) of this section is less than the monthly cost of services provided at the appropriate institution as described in subsection (d) of this section; and
 - (2) all other requirements of sections 17b-262-724 to 17b-262-735, inclusive, of the Regulations of Connecticut State Agencies are met.
- (f) Notwithstanding subsections (a) and (e) of this section, the department shall not apply the cost-effectiveness test for a PA request for home health aide services or extended nursing services provided during the first week after a hospital discharge. However, said services shall require prior authorization.

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(NEW) Sec. 17b-262-731. Need for Service

- (a) The department shall pay for medically necessary and medically appropriate home health care services only under orders of a licensed practitioner as part of a care plan.
- (b) The department shall pay for pregnancy-related preventive prenatal or postpartum nursing care services only if the woman has one, or a combination of, high risk indicators including, but not limited to, the following, which, in the opinion of her licensed practitioner, places the woman at high risk for negative pregnancy outcomes:
 - (1) an age under 20;
 - (2) an age over 39;
 - (3) a late registration for prenatal care that starts after the sixteenth week of gestation;
 - (4) no prenatal care;
 - (5) a serious weight loss or inadequate weight gain of seven pounds or less;
 - (6) a prenatal weight of more than eighty percent above the standard for height and age;
 - (7) more than one abortion, or an abortion within three months before the current pregnancy;
 - (8) a previous neonatal or fetal death;
 - (9) a previous preterm birth;
 - (10) an infant with a significant congenital anomaly or central nervous system damage;
 - (11) violence or deprivation that was abusive or damaging to the woman or her children;
 - (12) active substance abuse or an addiction, or a history of substance abuse or addiction, such as alcohol, drugs or nicotine;
 - (13) an active sexually transmitted disease or a history of such a disease;
 - (14) diseases or conditions including, but not limited to:
 - (A) human immunodeficiency virus (HIV), including related conditions such as acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC);
 - (B) cancer;
 - (C) acute or chronic cardiac disease;
 - (D) chronic renal disease;
 - (E) a seizure disorder;

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- (F) hypertension, either pre-existing or gestational;
 - (G) mental disorder without social or psychiatric supervision;
 - (H) mental retardation without supervision or support;
 - (I) endocrine or metabolic disorder;
 - (J) hepatitis;
 - (K) multiple sclerosis; or
 - (L) nutritional deficiency; and
- (15) an infant up to sixty days of age with one or a combination of diseases or conditions such as:
- (A) HIV, including related conditions such as AIDS or ARC;
 - (B) a birth before thirty-six weeks of gestation or a birth weight under two thousand five hundred grams;
 - (C) central nervous system damage;
 - (D) a failure to thrive or a significant infant feeding problem;
 - (E) an admission to a neonatal intensive care unit;
 - (F) a sibling who required treatment for recurring apnea or had sudden infant death syndrome;
 - (G) mental retardation;
 - (H) neonatal asphyxia;
 - (I) a seizure disorder;
 - (J) a significant congenital anomaly; or
 - (K) a supervising relative under sixteen years of age.

(NEW) Sec. 17b-262-732. Prior Authorization

- (a) To receive payment from the department the provider shall comply with the prior authorization requirements described in section 17b-262-528 of the Regulations of Connecticut State Agencies and this section. The department, in its sole discretion, shall determine what information is necessary to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.
- (b) Prior authorization, on forms and in a manner as specified by the department, shall be required for:
 - (1) nursing care services in excess of an initial evaluation and two visits per week;

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- (2) all extended nursing services;
 - (3) pregnancy-related preventive prenatal nursing care services in excess of two visits during the prenatal period;
 - (4) pregnancy-related preventive postpartum nursing care services in excess of two visits during the postpartum period;
 - (5) home health aide services in excess of fourteen hours per week;
 - (6) physical therapy services in excess of an initial evaluation and two visits per week;
 - (7) speech therapy services in excess of an initial evaluation and two visits per week;
 - (8) occupational therapy services in excess of an initial evaluation and one visit per week;
 - (9) physical therapy, occupational therapy or speech therapy services in excess of nine visits per therapy type per calendar year per provider per client, when the therapy is for the treatment of the following diagnoses:
 - (A) all mental disorders including diagnoses relating to mental retardation and specific delays in development covered by the International Classification of Diseases (ICD), as amended from time to time;
 - (B) cases involving musculoskeletal system disorders of the spine covered by the ICD, as amended from time to time; or
 - (C) cases involving symptoms related to nutrition, metabolism and development covered by the ICD, as amended from time to time; and
 - (10) Early and Periodic Screening, Diagnostic and Treatment services requested under section 1905(r) (5) of the Social Security Act, as amended from time to time.
- (c) The provider shall obtain, and the department may give, the initial prior authorization either verbally or by mail. The length of the initial authorization is at the department's discretion, but shall be for no longer than a three-month period. The provider shall submit subsequent prior authorization requests in writing by mail at least thirty days in advance of providing services or delivering goods beyond the period of initial approval. If there is a need to change the prior authorization request, the provider shall notify the department not more than two working days after the modification was made. Any authorization period for home health aide services shall be for at least one month.
- (d) If continued treatment is needed beyond an initial or subsequent authorization period, the department shall consider, and may approve, an additional prior authorization request that shall be for a period of up to twelve months. The provider shall submit subsequent prior authorization requests in writing by mail at least thirty days in advance.

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- (e) The provider shall present pertinent medical or social information adequate for evaluating the client's medical need for services when requesting prior authorization. The home health care agency shall maintain a valid practitioner's order on file. Except in emergency situations, the provider shall obtain approval from the department before services are rendered.
- (f) In an emergency situation that occurs after working hours or on a weekend or holiday, the provider shall secure verbal authorization on the next working day for the services provided. This applies only to those services that normally require prior authorization. If verbal authorization is obtained, the provider shall submit a written request not more than ten days after the date of service.

(NEW) Sec.17b-262-733. Billing procedures

- (a) Claims from home health care agencies shall be submitted on the department's designated form or electronically transmitted to the department or its agent, in a form and manner as specified by the department, and shall include all information required by the department to process the claim for payment.
- (b) The provider shall bill the usual and customary charge and the department shall pay the lowest of:
 - (1) the provider's usual and customary charge;
 - (2) the lowest non-managed care Medicare rate;
 - (3) the amount in the applicable fee schedule as published by the department; or
 - (4) the amount billed by the provider to the department.

(NEW) Sec. 17b-262-734. Payment

- (a) Payment
 - (1) The commissioner shall establish the fees for home health care services in the department's fee schedule pursuant to section 17b-242 of the Connecticut General Statutes.
 - (2) The department shall pay for home health aide services based on each unit of service the aide spends providing the services as described in the fee schedule.
 - (3) The department shall pay therapists as described in the fee schedule.
 - (4) The department shall pay for nursing services based on each visit or unit of service the nurse spends providing the services as described in the fee schedule.
- (b) Payment Limitations
 - (1) The department shall reimburse a provider when all of the requirements of sections 17b-262-726 to 17b-262-735, inclusive, of the Regulations of Connecticut State Agencies have been met.

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- (2) When two or more clients in the same household are receiving nursing care services, except extended nursing services, the department shall pay the full unit fee for the primary client and a reduced fee for each subsequent client. The procedure code and modifier used for billing shall reflect the purpose of the visit for each subsequent client.
- (3) The following limitations shall apply when extended nursing services are required to care for multiple clients in the same household:
 - (A) If one nurse is required, the department shall pay the full unit fee for the primary client and a reduced unit fee for the unit of time during which the nurse is providing care to one subsequent client. No payment shall be made for additional subsequent clients. The billing instructions for home health agencies shall include a detailed description of the billing process. The care plans shall support the ability of one nurse to provide services safely to multiple clients.
 - (B) If more than one nurse is required, the department shall pay the fee as described in section 17b-262-734(b) (3) (A) of the Regulations of Connecticut State Agencies for each nurse. The care plans shall support the need for multiple nurses.
- (4) When home health aides are caring for multiple clients in the same household, the department shall pay each aide the full unit fee. The department shall pay for the home health aide to care for one client for any one 15-minute unit of time.
- (5) The fee for home health care services shall include transportation.
- (6) The fee for home health aide services shall include supervision of the home health aide by a registered nurse.
- (7) The department shall pay the same fee for out-of-state providers as for in-state providers.

(NEW) Sec. 17b-262-735. Documentation

- (a) All required documentation shall be maintained for at least five years, or longer by the provider in accordance with statute or regulation, subject to review by the department. Documentation as set forth in sections 19-13-D75 and 19-13-D77 of the Regulations of Connecticut State Agencies shall be maintained for seven years. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute, five years or the length of time required by statute or regulation, whichever is longest.
- (b) Failure to maintain and provide all required documentation to the department upon request shall result in the disallowance and recovery by the department of any future or past payments made to the provider for which the required documentation is not maintained and not provided to the department upon request.
- (c) The following information shall be documented in writing or electronically, consistent with the requirements described in the Provider Enrollment Agreement and maintained on file with the home health care agency for each Medicaid client:
 - (1) initial and subsequent care plans signed and dated by the licensed practitioner in accordance with section 19-13-D73 of the Regulations of Connecticut State Agencies;

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- (2) verbal and telephone orders signed and dated by a licensed practitioner in accordance with section 17b-242 of the Connecticut General Statutes;
 - (3) Medicaid identification number;
 - (4) pertinent diagnostic information;
 - (5) documentation of each service provided and its duration;
 - (6) dates of services provided;
 - (7) for pregnancy-related preventive prenatal or postpartum nursing care services, evidence that the client is high risk as described in section 17-262-731 of the Regulations of Connecticut State Agencies;
 - (8) time sheets documenting all home health aide hours worked and duties performed that are signed by the client or his or her representative. A client representative shall not be an employee of, or under contract to, the home health care agency. All signatures shall be accompanied by a printed name; and
 - (9) all information described in section 19-13-D75 (b) of the Regulations of Connecticut State Agencies.
- (d) Each home health care agency shall maintain fiscal and medical records that fully disclose services and goods rendered or delivered to Medicaid clients.
- (e) The licensed practitioner order shall include the projected number of hours needed for home health care services. The actual number of hours provided may be less than, or the same as, the projected number of hours, but the actual number of hours provided may not exceed the projected number of hours.
- (f) Providers shall maintain documentation supporting all prior authorization requests.