BOSTON MEDICAL CENTER HEALTHNet PLAN
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WELL SENSE HEALTH PLAN
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Reimbursement Policy

Personal Care Management Services

Policy Number: 2149
Version Number: 6
Version Effective Date: 05/01/2022

Product Applicability ☐ **All Plan+ Products**

Well Sense Health Plan
☐ NH Medicaid
☐ NH Medicare Advantage

Boston Medical Center HealthNet Plan
☐ MassHealth MCO
☐ MassHealth ACO
☐ Qualified Health Plans/ConnectorCare/Employer Choice Direct
☒ Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan reimburses covered services based on the provider's contractual rates with the Plan and the terms of reimbursement identified within this policy.

Prior-Authorization

Please refer to the Plan's Prior Authorization Requirements Matrix at www.the Plan.org.

Definitions

Personal Care Management (PCM) Services - services provided by a personal care management agency that are designed to support a member participating in the Personal Care Attendant (PCA) Program.

+ *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.

Functional Skills Training — instruction provided by a PCM agency, including in-person comprehensive functional skills training, in-person issue-focused functional skills training, and telephonic functional skills training, to assist members who have obtained prior authorization for PCA services and their surrogates and administrative proxies, if necessary, in developing the skills and resources to maximize the member's management of the PCA program, including, but not limited to, personal health care, PCA services, activities of daily living, and activities related to the fiscal intermediary.

Provider Reimbursement

The Plan reimburses for PCM services when provided by an agency that is certified by the state and contracted with the Plan to provide these services.

Intake and Orientation Services

The PCM agency is responsible for providing intake and orientation services to a member prior to receiving services. The intake and orientation services include, but are not limited to the following:

- Determination of eligibility for PCA services
- Instruction and orientation in the rules, policies, and procedures of the PCA Program
- Instruction in the member's rights and responsibilities when using PCA services
- Instruction in the role of the personal care agency and the fiscal intermediary, including the use of activity forms
- Instruction in the skills and tasks necessary to manage PCA services

Payment for intake and orientation services is a per-member, per-month rate and is limited to a maximum of three consecutive months.

If the Plan authorizes an approval for PCA services during this 90-day period, billing at this rate ends, and billing for Functional Skills Training begins.

Evaluations and Reevaluations

The agency will perform an initial evaluation to determine the scope and type of personal care services to be provided to a member. Reevaluations must be conducted annually or more frequently when a significant change in the member's physical condition or living situation has occurred.

Rates for payment for evaluations and reevaluations are inclusive of, but not limited to, conducting the assessment and evaluations, obtaining necessary medical documentation, contacting the physician, nurse practitioner, or physician's assistant and responding to the Plan's inquiries or deferrals.

Functional Skills Training

Personal care management agencies must provide members and their surrogates and administrative proxies as applicable, with the functional skills training needed to successfully manage the PCA program and maximize the member's ability to self-direct care. Functional skills training should be

provided on at least a quarterly basis. Functional skills training include, but are not limited to, the following:

- PCA Training
- PCA Management
- Personal Health Care Maintenance
- Emergency Management
- Skills Training Related to the Fiscal Intermediary

Applicable Coding and Billing Guidelines

Applicable coding is listed below, subject to codes being active on the date of service. Because the American Medical Association (AMA), Centers for Medicare & Medicaid Services (CMS), and the U.S. Department of Health and Human Services may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes may not be all inclusive. These codes are not intended to be used for coverage determinations.

Personal Care Management Reimbursable Services		
CPT/ HCPCS	**Description**	**Comments**
99456	Work related or medical disability examination by other than the treating physician that includes: completion of a medical history commensurate with the patient's condition; performance of an examination commensurate with the patient's condition; formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; development of future medical treatment plan; and completion of necessary documentation/certificates and report.(initial evaluation of a member to determine the need and extent of the need for personal care services)	Per Evaluation
99456 TS	Work related or medical disability examination by other than the treating physician that includes: completion of a medical history commensurate with the patient's condition; performance of an examination commensurate with the patient's condition; formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; development of future medical treatment plan; and completion of necessary documentation/certificates and report.	Per Re-evaluation

Personal Care Management Reimbursable Services		
CPT/ HCPCS	**Description**	**Comments**
T1023	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter (per session charge for intake and orientation services provided to a member who does not yet have a PA for PCA services)	Maximum of 3 Sessions
T2022	Case management (Current PA for PCA services required for each member) (per member per month charge for functional skills training)	Per Member Per Month Use this code to bill administrative (per member per month. Bill code on the first of month. During a transfer both Personal Care Management Agencies may both bill for the month the transfer took place (one month limit).

Personal Care Management Services for Reporting Only		
HCPCS	**Description**	**Comments**
T2022 U1 *Reporting Only*	Case management (Current PA for PCA services required for each member.) Use to bill for required Quarterly Comprehensive (in person) Functional Skills Training (FST) visits during the first year of approved PCA services.	Per Session Bill on the date FST was delivered. Bill code once in each calendar year quarter only. Cannot be billed on the same date as T2022 U2, U3, U4, U5, or another unit of T2022 U1 is billed.
T2022 U2 *Reporting Only*	Case management (Current PA for PCA services required for each member.) Use to bill for required Annual Comprehensive (in person) Functional Skills Training (FST) (limit one per year).	Per Session Bill on date FST was delivered. Cannot be billed on the same date as T2022 U3, U4, U5, or another unit of T2022 U2 is billed.

Personal Care Management Services for Reporting Only		
HCPCS	**Description**	**Comments**
T2022 U3 *Reporting Only*	Case management (Current PA for PCA services required for each member.) Use to bill for Issue-Focused (in person) Functional Skills Training (FST).	Per Session Bill on date FST was delivered. Cannot be billed on same date as T2022 U1, U2, U5, or another unit of T2022 U3 is billed.
T2022 U4 *Reporting Only*	Case management (Current PA for PCA services required for each member.) Use to bill for Issue-Focused (telephone contact with FST delivery) Functional Skills Training (FST).	Per Session Bill on date FST was delivered. Cannot be billed on same date as T2022 U1, U2, or U5 is billed.
T2022 U5 *Reporting Only*	Case management (Current PA for PCA services required for each member.) Use to bill for Functional Skills Training (FST) (in person) within 10 days of identifying a new surrogate	Per Session Bill on date FST was delivered. Cannot be billed on same date as T2022 U1, U2, U3, U4, or another unit of T2022 U5, is billed. May bill only once during a calendar year, regardless of multiple surrogate changes. This code does not apply to Administrative Proxy changes.

Policy History

Original Approval Date	Original Effective Date	Policy Owner	Approved by
11/11/2015	01/01/2016	Payment Policy	Payment Policy

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
02/19/2019	Annual review	04/01/2019	Payment Policy Committee
12/09/2019	Added T2022 with modifiers U1-U5	01/01/2020	Payment Policy Committee
01/21/2020	Added language per MH regulation for administrative proxies and PA's.	01/01/2020	Payment Policy Committee
06/15/2021	Annual review, added definition of functional skill training	07/01/2021	Payment Policy Committee
04/19/2022	Annual review	05/01/2022	Payment Policy Committee

Other Applicable Policies

- General Billing and Coding Guidelines, 2136
- General Clinical Editing and Payment Accuracy Review Guidelines, 2137
- Personal Care Attendant, 2148
- Aging Services Access Points (ASAP), 2128

References

- 101 CMR 309.00: Rates for Certain Services for the Personal Care Attendant Program
- MassHealth 130 CMR 422.000: Personal Care Provider Attendant Services
- Personal Care Manual Subchapter 6

Disclaimer Information

This Policy provides information about the Plan's reimbursement/claims adjudication processing guidelines. The use of this Policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement. Member cost-sharing (deductibles, coinsurance and copayments) may apply – depending on the member's benefit plan. Unless otherwise specified in writing, reimbursement will be made at the lesser of billed charges or the contractual rate of payment. Plan policies may be amended from time to time, at Plan's discretion. Plan policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization guidelines (including NCQA). The Plan reserves the right to conduct Provider audits to ensure compliance with this Policy. If an audit determines that the Provider did not comply with this Policy, the Plan will expect the Provider to refund all payments related to non-compliance. For more information about the Plan's audit policies, refer to the Provider Manual.