

Next Generation ACO Model Post-Discharge Home Visit Waiver: Frequently Asked Questions (FAQ)

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Currently, in traditional fee-for-service (FFS) Medicare, beneficiaries can receive the post-discharge home visit service when they return home after discharge from an inpatient facility (this service is not a home health service for the home bound). This service is an evaluation and management (E/M) service physicians can provide to their patients and bill Medicare for today.

Q1: What is a post-discharge home visit waiver?

A: The Next Generation ACO Model post-discharge home visit allows for flexibility in billing for evaluation and management home visits provided to beneficiaries in the period following discharge from an inpatient facility by eliminating the direct supervision requirement for billing “incident to” services. The waiver allows for a physician to contract with licensed clinicians (i.e., auxiliary personnel) to provide a home visit to a patient at the patient’s home under the general supervision of a Next Generation Participant or Preferred Provider following discharge from an inpatient facility. This waiver provides flexibility during the critical time when a Medicare beneficiary is discharged from an inpatient facility.

Q2: How does the Centers for Medicare & Medicaid Services (CMS) define “general supervision”?

A: 42 CFR § 410.32(b)(3) - “*General supervision* means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. Under general supervision, the training of the non-physician personnel who actually perform the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician.”

Q3: Who is eligible to use the waiver?

A: The waiver is available to approved Next Generation Participants and Preferred Providers for ACO-aligned beneficiaries to use if:

- the beneficiary does not qualify for Medicare coverage of home health services;
- the services are furnished in the beneficiary's home after the beneficiary has been discharged from an inpatient facility; and
- the services are furnished not more than nine times within 90 days following discharge from an inpatient facility (for example, hospital, Critical Access Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility).

Q4: How does CMS define Licensed Clinical Staff?

A: Licensed Clinical Staff means auxiliary personnel, as defined in 42 C.F.R. § 410.26(a)(1), licensed or otherwise appropriately certified under applicable state law to perform the services ordered by the supervising physician or other practitioner.

Q5: Who is certified or qualified as a clinician under *general supervision* for the post-discharge home visit waiver?

A: An ACO should consult with their legal advisors on how their state defines “clinician” and to ensure services are furnished in accordance with all other Medicare coverage and payment criteria.

Q5: What qualifies as an inpatient facility for the post-discharge home visit waiver?

- A:**
- a. Acute care hospital
 - b. Emergency department
 - c. Observation
 - d. Critical access hospital (CAH)
 - e. Skilled nursing facility (SNF)
 - f. Inpatient rehabilitation facility (IRF)
 - g. Inpatient psychiatric facility
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Q6: How do you bill for this service?

A: The physician billing for the service must be a Next Generation Participant or Preferred Provider with the post-discharge home visit benefit enhancement indicator. The following Current Procedural Terminology (CPT)¹ codes may be used by the Next Generation Participant or Preferred Provider to bill for these services:

Service	CPT Code	Description of E/M service
Evaluation & Management Services – Domiciliary, Rest Home, or Custodial Care Services	99324-99328	New Patient: Brief/Limited/Moderate/ Comprehensive/Extensive
	99334-99337	Established Patient: Brief/Limited/Moderate/ Comprehensive/Extensive
Evaluation & Management Services – Domiciliary, Rest	99339	Brief

¹ CPT (Current Procedural Terminology) Copyright Notice

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Service	CPT Code	Description of E/M service
Home, or Home Care Plan Oversight Services	99340	Comprehensive
Evaluation & Management Services – Home Services	99341- 99345	New Patient: Brief/Limited/Moderate/ Comprehensive/Extensive
	99347- 99350	Established Patient: Brief/Limited/Moderate/ Comprehensive/Extensive

Q7: Does billing post-discharge home visit service (which is an E/M service) change the ability to bill Transitional Care Management (TCM) services?

A: No. While Medicare will only pay one physician or qualified practitioner for TCM services per beneficiary per 30 day period following a discharge, other practitioners may continue to report other reasonable and necessary services, including other E/M services, to beneficiaries during those 30 days. In other words, a physician can bill for both TCM and a post-discharge home visit services.

Q8: How many post-discharge home visit services is a beneficiary eligible to receive after being discharged from the hospital?

A: A beneficiary is eligible to receive up to nine post-discharge home visits within 90 days following discharge. The nine services cannot be accumulated across multiple discharges; if the beneficiary is readmitted within 90 days of the initial discharge, the beneficiary may receive only the nine visits in connection with the most recent discharge.

Q9: What services can be provided at a post-discharge home visit?

A: Post-discharge home visits are evaluation and management (E/M) services, billed using CPT codes that are defined in the above table. It is beyond the scope of the Next Generation ACO Model Team to define what services are and are not considered E/M. The Model Team encourages ACOs and their providers to use existing CMS resources to identify what are appropriate E/M services.

- [CMS Medicare Claims Processing Manual, Chapter 12](#)
- [Medicare Learning Network, Evaluation and Management Services](#)