

Next Generation ACO Model

Post-discharge and Care Management Home Visit Waivers

May 2021

This document highlights frequently asked questions related to the Next Generation ACO (NGACO) Model Home Visits Benefit Enhancements and includes the following:

- Section I addresses [policy and requirements](#) of the Post-Discharge Home Visits Benefit Enhancement
- Section II considers [policy and requirements](#) of the Care Management Home Visits Benefit Enhancement
- Section III includes [general questions](#) that pertain to both benefit enhancements.

Frequently Asked Questions

Section I. Post-Discharge Home Visits Benefit Enhancement

Currently, in traditional fee-for-service (FFS) Medicare, beneficiaries can receive a post-discharge evaluation and management (E/M) visits when they return home after discharge from an inpatient facility. A physician or non-physician practitioner can furnish this E/M service in the beneficiary's home. (This service would **not** be a home health service for the home-bound.)

Q1: What is the Post-Discharge Home Visits Benefit Enhancement?

A: The NGACO Model Post-Discharge Home Visits Benefit Enhancement provides flexibility to furnish home visits to beneficiaries in the period following discharge from an inpatient facility by eliminating the requirement that, since these services are furnished as an incident to the professional services of a physician or other practitioner, they must be furnished under direct supervision. The waiver allows for a physician to contract, for example, with licensed clinicians (that is, auxiliary personnel) to provide a visit to an aligned beneficiary at the beneficiary's home under the *general supervision* of a Next Generation Participant or Preferred Provider following discharge from an inpatient facility. This benefit enhancement provides flexibility during the critical time when a Medicare beneficiary is discharged from an inpatient facility.

Q2: Who is eligible to furnish services under the benefit enhancement?

A: The benefit enhancement may be furnished by Next Generation Participants and Preferred providers to ACO-aligned beneficiaries to use under the following circumstances:

- The beneficiary does not qualify for Medicare coverage of home health services (or qualifies for Medicare coverage of home health services on the sole basis of living in a medically underserved area).
- The beneficiary is an aligned beneficiary at the time the services are furnished or within the grace period.
- The services are furnished by auxiliary personnel under the general supervision of a Next Generation Participant or Preferred Provider who is identified by the ACO as participating in the Post-Discharge Home Visits Benefit Enhancement and who is a physician or other practitioner capable of billing for these services.

- The services are furnished in the beneficiary's home after the beneficiary has been discharged from an inpatient facility.
- The services are furnished not more than nine times within 90 days following discharge from an inpatient facility (for example, an acute inpatient hospital, inpatient psychiatric facility, skilled nursing facility, long-term care hospital, or an inpatient rehabilitation facility).

Q3: If a beneficiary is not eligible for home health services, can he or she receive physical or occupational therapy from a home health provider under the Post-Discharge Home Visits Benefit Enhancement?

A: The Post-Discharge Home Visits Benefit Enhancement can be used in this scenario if the beneficiary is not eligible for home health services, the physician (or other health care provider) is billing for the services using the HCPCS codes required under the terms of the Post-Discharge Home Visits Benefit Enhancement, and all other requirements are met. Please remember that these are incident to services, billed with the physician's (or other practitioner's) NPI. As incident to services, they would be part of the physician's (or other practitioner's) personal professional services and part of the patient's normal course of treatment. More information on incident to services can be found in the [Medicare Benefit Policy Manual, Chapter 15, Section 60 \(https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf\)](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf)

Q4: How do you bill for this service?

A: The physician or other practitioner billing for the service must be a Next Generation Participant or Preferred Provider with the post-discharge home visits benefit enhancement indicator. The Next Generation Participant or Preferred Provider must use the following G-codes codes to bill for these services:

G-Code Number	Code Description	G-Code Number	Code Description
G2001	Post-Discharge Home Visit new patient 20 minutes	G2007	Post-Discharge Home Visit existing patient 30 minutes
G2002	Post-Discharge Home Visit new patient 30 minutes	G2008	Post-Discharge Home Visit existing patient 45 minutes
G2003	Post-Discharge Home Visit new patient 45 minutes	G2009	Post-Discharge Home Visit existing patient 60 minutes
G2004	Post-Discharge Home Visit new patient 60 minutes	G2013	Post-Discharge Home Visit existing patient 75 minutes
G2005	Post-Discharge Home Visit new patient 75 minutes	G2014	Post-Discharge care plan over 30 minutes
G2006	Post-Discharge Home Visit existing patient 20 minutes	G2015	Post-Discharge care plan over 60 minutes

Q5: I understand that this waiver allows for general (rather than direct) supervision while providing incident-to services for home visits, which were already billable under FFS Medicare. What were the Medicare FFS codes that were used prior to the implementation of the model-specific G-codes in April of 2019 (for historic context)?

A: Prior to 4/1/2019, the PDHV waiver applied to the following FFS Medicare home visit billing codes (these billing codes are not used for PDHV waiver services conducted on or after 4/1/19):

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 Home, or Home Care Plan Oversight Services	99339	Brief
	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

Q6: What qualifies as an inpatient facility for the Post-Discharge Home Visits Benefit Enhancement?

A: For the Post-Discharge Home Visits Benefit Enhancement to apply, the beneficiary must have been discharged from one of the following types of inpatient facilities:

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| Acute care hospital | Skilled nursing facility (SNF) |
| Emergency department | Inpatient rehabilitation facility (IRF) |
| Observation | Inpatient psychiatric facility |
| Critical access hospital (CAH) | Long-term acute care hospital (LTACH) |

Q7: How many Post-Discharge Home Visits services is a beneficiary eligible to receive after being discharged from an inpatient facility?

A: Under the benefit enhancement, 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, following the subsequent discharge, the beneficiary may receive only the nine visits in connection with the most recent discharge.

Section II. Care Management Home Visits Benefit Enhancement

The Care Management Home Visits Benefit Enhancement equips NGACOs with a tool to provide home visits proactively and in advance of a potential hospitalization. Aligned beneficiaries, at risk of hospitalization, and for whom a Next Generation Participant or Preferred Provider has initiated a care treatment plan is eligible to receive up to two care management home visits within 90 days of seeing a Next Generation Participant or Preferred Provider who has initiated a care treatment plan for the beneficiary. Beneficiaries may become eligible to receive a third care management home visit within the 90-day period if the beneficiary first has an in-office visit with a Next Generation Participant or Preferred Provider in which an E/M service is provided. This is not part of the home health benefit, and beneficiaries eligible to receive home health services generally are not eligible for this benefit enhancement. The items and services provided as part of these care management home visits are intended to supplement, rather than substitute for, visits to a primary care provider or specialist in a traditional health care setting.

Q1: What is the Care Management Home Visits Benefit Enhancement?

A: The NGACO Model Care Management Home Visits Benefit Enhancement provides flexibility in billing for home visits, provided to beneficiaries to prevent possible hospitalization, by eliminating the requirement that these incident to services must be furnished under direct supervision. The benefit enhancement allows licensed clinicians (that is, auxiliary personnel) to provide a visit to a patient at the patient's home under the *general supervision* of a Next Generation Participant or Preferred Provider. These incident to services must be furnished within 90 days of the patient seeing a Next Generation Participant or Preferred Provider who has initiated a care treatment plan.

Q2: Who is eligible to furnish services under the Care Management Home Visits Benefit Enhancement?

A: The Care Management Home Visits Benefit Enhancement is available to ACO-aligned beneficiaries to use under the following circumstances:

- The beneficiary is determined to be at risk of hospitalization;
- The beneficiary does not qualify for Medicare coverage of home health services (unless the sole basis for qualification is living in a medically underserved area);
- The services are furnished in the beneficiary's home after a Next Generation Participant or Preferred Provider has initiated a care treatment plan;
- The beneficiary is not receiving services under the Post-Discharge Home Visits Benefit Enhancement.
- The services are furnished not more than two times within ninety (90) days of the beneficiary seeing a Next Generation Participant or Preferred Provider who has initiated a care treatment plan, except that a beneficiary may receive one additional care management home visit within this 90-day period if the beneficiary first has another in-office visit with a Next Generation Participant or Preferred Provider where a service identified by an E/M code is furnished.

For a complete list of criteria, please consult Appendix Q of the Participant Agreement.

Q3: How do you bill for this service?

A: The physician or other practitioner billing for the service must be a Next Generation Participant or Preferred Provider with the Care Management Home Visit Benefit Enhancement indicator. The Next Generation Participant or Preferred Provider must use the following HCPCS codes to bill for these services:

G-Code Number	Code Description	G-Code Number	Code Description
G0076	Care Management Home Visits new patient 20 minutes	G0082	Care Management Home Visits existing patient 30 minutes
G0077	Care Management Home Visits new patient 30 minutes	G0083	Care Management Home Visits existing patient 45 minutes
G0078	Care Management Home Visits new patient 45 minutes	G0084	Care Management Home Visits existing patient 60 minutes
G0079	Care Management Home Visits new patient 60 minutes	G0085	Care Management Home Visits existing patient 75 minutes
G0080	Care Management Home Visits new patient 75 minutes	G0086	Care Management Home Visits care plan overs 30 minutes
G0081	Care Management Home Visits existing patient 20 minutes	G0087	Care Management Home Visits care plan overs 60 minutes

Please remember that these are incident to services, billed with the physician's (or other practitioner's) NPI. As incident to services, they would be part of the physician's (or other practitioner's) personal professional services and part of the patient's normal course of treatment. More information on incident to services can be found in the [Medicare Benefit Policy Manual, Chapter 15, Section 60](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf) (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf)

Q4: For beneficiaries receiving care management home visit services, what information must be included in the care treatment plan?

A: There are no specific model requirements that define the care treatment plan. Care management home visits can be incorporated into a broader care treatment plan for the beneficiary, and need not be a standalone document.

Q5: Eligible beneficiaries may receive up to two care management home visits within 90 days of seeing the Next Generation Participant or Preferred Provider who initiated the beneficiary's care treatment plan. What qualifies as "seeing" a Next Generation Participant or Preferred Provider?

A: Beneficiaries must be present for an in-person office visit with a Next Generation Participant or Preferred Provider in which an E/M service is provided to qualify as seeing the Next Generation Participant or Preferred Provider.

Q6: If a beneficiary received two care management home visits within 45 days, when can they receive an additional series of care management home visits?

A: Care management home visits may be furnished not more than two times within ninety (90) days of the beneficiary seeing a Next Generation Participant or Preferred Provider who has initiated a care treatment plan. A beneficiary may receive one additional care management home visit within this 90-day period if the beneficiary first has an in-office visit with a Next Generation Participant or Preferred Provider where a service identified by an E/M code is furnished.

A beneficiary can receive an additional series of care management home visits only after the conclusion of this 90-day period. A beneficiary cannot receive two concurrent series of care management home visits during the same 90-day period, even if initiated by a different Next Generation Participant or Preferred Provider. Also, to receive each new series of care management home visits, all eligibility criteria must be met for the new series (e.g., the beneficiary must be seen by a Next Generation Participant or Preferred Provider who has initiated a care treatment plan, ineligible for the post-discharge home visit waiver or home health services, determined to be at risk of hospitalization, etc.).

Q7: A beneficiary is determined eligible to receive care management home visits during a visit with a Next Generation Participant or Preferred Provider. Within 90 days of that visit, the beneficiary is treated for an acute care need in the inpatient setting and discharged. Can the beneficiary receive the care management home visits, as planned?

A: No; to be eligible for care management home visits services, the beneficiary must not be eligible for post-discharge home visits services.

Q8: Would a telehealth visit meet the requirements that the beneficiary had seen a Next Generation Participant or Preferred provider within 90 days, and therefore would be eligible for a care management home visit if all other criteria were also met?

A: If the telehealth visit is video-based, the practitioner currently uses telehealth as a regular means of conducting beneficiary visits, and all other criteria for CMHVs are met, a telehealth visit could meet the prerequisite for the beneficiary having seen the Next Generation Participant or Preferred Provider who initiated the care management plan.

As a reminder, the 2 CMHVs must be within 90 days of the (telehealth) visit. An additional (third) care management home visit within the 90 day period would require an in-office visit with a Next Generation Participant or Preferred Provider where an E/M service is provided.

Section III. General Questions

Care Management Home Visits and Post-Discharge Home Visits Benefit Enhancements

Q1: How does CMS define general supervision?

A: In our regulation at 42 CFR §410.26(a)(3), general supervision means that the service is furnished under the physician's (or other practitioner's) overall direction and control, but the physician's (or other practitioner's) presence is not required during the performance of the service.

Q2: 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 as directed by, and under the general supervision of, the supervising physician or other practitioner.

Q3: Who is certified or qualified as a licensed clinician that can furnish services under general supervision for the home visits benefit enhancements?

A: An ACO should consult with its legal advisors on how the state defines licensed *clinician* and to ensure services are furnished in accordance with all applicable laws, including Medicare coverage and payment criteria.

Q4: What services can be provided at a home visit?

A: Care Management and Post-Discharge Benefit Enhancement home visits are billed using codes that are defined in the aforementioned tables in Section I. Q5 and Section II. Q3. The items and services provided as part of these home visits are those that would be covered under Medicare Part B as "incident to" the services of a physician or practitioner. It is beyond the scope of the NGACO Model Team to define what services are and are not appropriate to provide as incident to services, but services would be part of the physician's (or other practitioner's) personal professional services and part of the patient's normal course of treatment. The Model Team encourages ACOs and their providers to use existing CMS resources to identify what are appropriate services to provide while conducting PDHVs and CMHVs.

- [CMS Medicare Claims Processing Manual, Chapter 12 \(https://www.rcbilling.com/assets/docs/Medicare_Claims_Processing_Manual_Physicians_and_Non-Physician_Practitioners.pdf\)](https://www.rcbilling.com/assets/docs/Medicare_Claims_Processing_Manual_Physicians_and_Non-Physician_Practitioners.pdf)
 - [Medicare Learning Network, Evaluation and Management Services \(https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/\)](https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/)
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Q5: What qualifies as a "home" for providing home visits under the Post-Discharge Home Visits or Care Management Home Visits Benefit Enhancements?

A: Care management and post-discharge home visits can be conducted at a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.

Q6: Suppose a beneficiary is aligned to the ACO at the beginning of the performance year (PY), but later becomes excluded from ACO alignment. Is there a grace period by which CMS would pay for a post-discharge home visit or care management home visit under the waiver?

A: Yes, a 90-day grace period applies to the Post-Discharge and Care Management Home Visit Waivers for beneficiaries originally aligned to the ACO during the performance year and who subsequently become excluded during the same performance year. Beneficiaries may be excluded for a number of reasons including joining Medicare Advantage, losing Part A or Part B coverage, having Medicare as a secondary payer, or moving outside of the ACOs service area. The grace period is not intended to cross performance years. For example, if a beneficiary is aligned for PY2019, but not PY2020, the grace period would not apply if the home visit occurred in PY2020. More information is available in the appendices of the NGACO participation agreement.