Next Generation ACO Home Visit Waivers: Frequently Asked Questions (FAQs)

Updated January 2019

This document highlights frequently asked questions related to the Next Generation ACO (NGACO) Model home visit waivers and includes the following:

- Section I addresses policy and requirements of the post-discharge home visit waiver, as well as data submission expectations
- Section II considers policy and requirements of the care management home visit waiver
- Section III includes general home visit waiver questions that pertain to both benefit enhancements.

Section I. Post-Discharge Home Visit Waiver

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.

Post-Discharge Home Visit Waiver Policy and Requirements

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

A: The NGACO Model post-discharge home visit provides flexibility in billing for E/M 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 (that is, 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: **Who is eligible to use the waiver?**

A: The waiver is available to approved Next Generation participants and preferred providers for accountable care organization (ACO)-aligned beneficiaries to use under the following circumstances:

- 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.
- The services are furnished not more than nine times within 90 days following discharge from an inpatient facility (for example, a hospital, critical access hospital, skilled nursing facility, 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 using the post-discharge home visits waiver?**

A: The post-discharge home visit waiver can be used in this scenario if the beneficiary is not eligible for home health services and the physical or occupational therapist (or any provider) is billing the E/M codes required to use the post-discharge home visit waiver.

Q4: **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. Through March 31 2019, the Next Generation Participant or Preferred Provider can use the following Current Procedural Terminology (CPT)[1] codes 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 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

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[1] CPT (Current Procedural Terminology) Copyright Notice. Throughout this FAQ, we use CPT codes and descriptions to refer to a variety of services. We note that CPT codes and descriptions are copyright 2016 American Medical Association. All Rights Reserved. CPT is a registered trademark of the American Medical Association (AMA). Applicable Federal Acquisition Regulations (FAR) and Defense Federal Acquisition Regulations (DFAR) apply.

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

A: For the post-discharge home visit waiver, discharges may be from the following inpatient facilities:

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

Q6: **Does billing after the discharge home visit service (which is an E/M service) change the ability to bill Transitional Care Management (TCM) services?**

A: No. Although Medicare will pay only 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 post-discharge home visit services.

Q7: **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.

Q8: **I learned on a recent webinar that ACOs will submit claims for the post-discharge home visit waiver using HCPCS codes in 2019. When will the shift from CPT codes to HCPCS codes occur and what are those HCPCS codes?**

A: The shift from aforementioned CPT codes to the Healthcare Common Procedure Coding System (HCPCS) codes below will take effect as of April 1, 2019. The Next Generation Participant or Preferred Provider can use the following HCPCS codes to bill for these services:

G2001	Post D/C Home Vst new pt 20 m
G2002	Post-D/C Home Vst new pt 30 m
G2003	Post-D/C Home Vst new pt 45 m
G2004	Post-D/C Home Vst new pt 60 m
G2005	Post-D/C Home Vst new pt 75 m
G2006	Post-D/C Home Vst ext pt 20 mins
G2007	Post-D/C Home Vst ext pt 30 m
G2008	Post-D/C Home Vst ext pt 45 m
G2009	Post-D/C Home Vst ext pt 60 m
G2013	Post-D/C Home Vst ext pt 75 m
G2014	Post-D/C Hom Vst care plan overs30 m
G2015	Post-D/C Home Vst care plan overs 60 m

Data Submission for the Post-Discharge Home Visit Waiver

Q9: **Which home visits should be included in the Microsoft Excel-based data submission tool?**

A: Data should be submitted for all home visits that meet the following criteria:

- Home visit occurred within 90 days of discharge from the most recent inpatient facility stay
- Home visit is related to an inpatient facility discharge that occurred on or after January 1, 2018
- Beneficiary is aligned with a Next Generation ACO at the time of the home visit
- Home visit took place during the reference period noted in the data submission tool

Q10: **I noticed the data submission tool contains multiple worksheets. Am I required to complete all the worksheets, including entering beneficiary-level data into the data entry worksheet?**

A: No, only the summary report worksheet, which contains aggregated data, is required for submission. Completing the beneficiary-level data entry worksheet is optional. If your ACO has not already calculated aggregated data, the beneficiary-level data entry worksheets might help with data collection efforts.

There are two options to submit data:

1. Enter aggregate data directly into the summary report worksheet. (To overwrite the formulas that link the data entry worksheet to the summary report worksheet, go to the review tab in the ribbon at the top of your screen and click on the button labeled unprotect sheet.)

   OR

2. Enter beneficiary-level data into the worksheet labeled data entry – beneficiary level. These beneficiary-level data will automatically populate the summary report worksheet with predefined, locked formulas.

Q11: **I entered data into the data submission tool and noticed that some cells have turned either red or orange. What does this mean?**

A: The worksheet will automatically turn a cell red to flag a potential inaccuracy when the data entered are inconsistent. For example, on the data entry tab, cells in row 106 will turn red if you select "Yes" for measure 8.i (Is this patient expected to receive another waiver-related home visit after this visit?) and then select one of the reasons in measure 8.ii. Similarly, the worksheet will turn a cell orange to flag that more than one provider was selected as present during the home visit in measure 4; this should be verified and corrected if only a single provider was present during the visit.

Q12: **How do I enter data in the data submission tool for waiver-eligible patients that were offered but did not receive a single home visit?**

A: To capture data for waiver-eligible patients that were offered but did not receive a single home visit following discharge from the most recent inpatient facility stay, select "No Visit" from the dropdown for home visit number. The worksheet will automatically populate "NA" for all measures except measure 9. Select one of the reasons in measure 9 to indicate why the patient did not receive a home visit.

Q13: **Does the data collection tool change between reference periods?**

A: We expect the vast majority of the data collection tool to remain constant over time, but the reference period is revised each quarter and some refinements to measures may occur based on ACOs' requests. Please look to the Connect site before a given reference period begins to download the data collection tool.

Q14: **Our ACO does not have the data to complete some of these measures but the providers conducting the home visit and the patients' primary care providers have this information. Can those providers complete these measures?**

A: Yes, other providers may enter beneficiary-level data directly into the data entry worksheet or provide you with the relevant data to complete the data submission tool. Please ensure that the other providers use secure file transfers if transmitting personally identifiable data (PII) and do not include PII when transmitting the completed tool to Mathematica.

Q15: **How should I submit the completed self-monitoring measure data to CMS?**

A: Next Generation ACOs should email the Excel-based tool as an attachment to NextGenerationACOModel@cms.hhs.gov (subject line "Benefit Enhancements"). Please do not include any PII (for example, names, Social Security numbers, health insurance claim numbers, or birth dates). Mathematica Policy Research will complete the analysis of all of Next Generation ACOs' quarterly data submissions.

Q16: **Where can I find materials related to the home visit waiver, such as chartbooks, webinar recordings, and data collection tools?**

A: Materials are available on the Next Generation ACO Connect site (https://app.innovation.cms.gov/NGACOConnect/CommunityLogin), within the library and noted on the home visit waiver group page. For Connect site support, please contact: CMMIForceSupport@cms.hhs.gov.

Q17: **Who should I contact with questions about the measures and data submission?**

A: Next Generation ACOs should email NextGenerationACOModel@cms.hhs.gov (subject line "Benefit Enhancements"). We look forward to assisting you with any questions, and we welcome suggestions for improving the tool for future rounds of data collection.

Q18: **If the waiver allows for nine visits within 90 days of inpatient discharge, why do I see learning system materials describing the two visits within 30 days of inpatient discharge?**

A: Beginning January 1, 2018, home visits may be furnished nine times within 90 days following discharge from an inpatient facility. Learning system waiver materials from 2016 and 2017 reflect the previous waiver policy of two visits within 30 days of an inpatient discharge.

Section II. Care Management Home Visits Waiver

The Care Management Home Visits Benefit Enhancement equips NGACOs with a new tool to provide home visits proactively and in advance of a potential hospitalization. Next Generation Participants and Preferred Providers who have initiated a care treatment plan for aligned beneficiaries will be eligible to receive up to two care management home visits within 90 days of seeing that Next Generation Participant or Preferred Provider. 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 a home health benefit and beneficiaries eligible to receive home health services will not be 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.

Care Management Home Visit Waiver Policy and Requirements

Q1: **What is a care management home visit waiver?**

A: The NGACO Model care management home visits provide flexibility in billing for evaluation and management (E/M) home visits provided to beneficiaries to prevent possible hospitalization by eliminating the direct supervision requirement for billing incident to services. The waiver allows for a physician to contract with licensed clinicians (that is, 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 who has initiated a care treatment plan.

Q2: **Who is eligible to use the waiver?**

A: The waiver is available to approved Next Generation Participants and Preferred Providers for accountable care organization (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 provider has initiated a care treatment plan to receive such services;
- The beneficiary is not eligible for the post-discharge home visit waiver

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 management 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 Participation Agreement.

Q3: **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 Care Management Home Visit Benefit Enhancement indicator. The Next Generation Participant or Preferred Provider can use the following HCPCS codes to bill for these services:

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

Q4: **For beneficiaries receiving CMHV services, what information must be included in the care treatment plan?**

A: The provision of care management home visits would be included in the beneficiary's care treatment plan. 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 that Next Generation Participant or Preferred Provider. What qualifies as "seeing" a Next Generation Participant or Preferred Provider?**

A: Beneficiaries must be present for an in-person office visit 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: A beneficiary can receive an additional series of care management home visits after the conclusion of the 90-day period for the previous series of care management home visits. A beneficiaries cannot receive two concurrent series of care management home visits during the same 90-day period, even if initiated by different Next Generation Participants or Preferred Providers.

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 visit services, the beneficiary must not be eligible for post-discharge home visit services.

Data Submission for the Care Management Home Visit Waiver

Q8: **Does my ACO need to provide quarterly data submissions on use of the care management home visit waiver?**

A: No, NGACOs are not required to provide data on use of the care management home visit waiver using an Excel file or in any other tool. CMS and the learning system contractor, Mathematica, will use claims data to complete analyses of NGACOs' use of this waiver.

Section III. General Home Visit Waiver Questions

(For both Care Management Home Visit and Post-Discharge Home Visit waivers)

Q1: **How does 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."

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 ordered by the supervising physician or other practitioner.

Q3: **Who is certified or qualified as a clinician under *general supervision* for the home visit waivers?**

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

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

A: Care management and post-discharge home visits are E/M services, billed using CPT codes that are defined in the aforementioned tables in Section I. Q5 and Section II. Q3. It is beyond the scope of the NGACO 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 (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/)

Q5: **What qualifies as a "home" for providing home visits under the PDHV or CMHV waivers?**

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 within 90 days following discharge from an inpatient facility.