Medicare Learning Network
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CMS
Information for Medicare Fee-For-Service Health Care Professionals

News Flash – The Centers for Medicare & Medicaid Services (CMS) has launched the 2011 Medicare Contractor Provider Satisfaction Survey (MCPSS) and is waiting to hear from you. This survey offers Medicare Fee-For-Service (FFS) providers and suppliers an opportunity to provide feedback on interactions with their Medicare contractors. The survey will be sent to a random sample of approximately 30,000 Medicare FFS providers and suppliers. Those who are selected to participate will be notified starting in January. If selected to participate, please complete this important survey. To learn more about the MCPSS, please visit http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCPSS/index.html on the CMS website.

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New Home Health Claims Reporting Requirements for G Codes Related to Therapy and Skilled Nursing Services

Note: This article was updated on December 11, 2012, to reflect current Web addresses. Previously, it was revised on February 9, 2011, to reflect a revised CR 7182 that was issued on February 8, 2011. The CR release date, transmittal number, and the Web address for accessing the CR were revised in this article. All other information remains the same.

Provider Types Affected

This article is for Home Health Agencies (HHAs) who bill Medicare Regional Home Health Intermediaries (RHHI) or Medicare Administrative Contractors (A/B MAC) for the provision of therapy and skilled nursing services to Medicare beneficiaries.

What You Need to Know

CR 7182, from which this article is taken, announces the requirement (effective January 1, 2011) to report additional, and more specific, data about therapy and nursing visits on your home health (HH) claims. The January 1, 2011, effective date means that these new and revised G-codes should be used for home health episodes beginning on or after January 1, 2011.

This requirement includes:

- The revision of the current descriptions for the G-codes for physical therapists (G0151), occupational therapists (G0152), and speech-language pathologists (G0153), to include that they are to be used to report services that are provided by a qualified physical or occupational therapist, or speech language pathologist;
- The addition of two new G-codes (G0157 and G0158) to report restorative physical therapy and occupational therapy provided by qualified therapy assistants;
- The addition of three new G-codes (G0159, G0160, and G0161, physical therapist, occupational therapist, and speech-language pathologist, respectively) to report the establishment, or delivery, of therapy maintenance programs by qualified therapists;
- The revision of the current G-code definition for skilled nursing services (G0154), and the requirement that HHAs use this code only for the reporting of direct skilled nursing care to the patient by a licensed nurse (LPN or RN); and
- The addition of three new G-codes (G0162, G0163, and G0164) that are required to report: 1) the skilled services of a licensed nurse (RN only) in the management and evaluation of the care plan;; 2) the observation and assessment of a patient's conditions when only the specialized skills of a licensed nurse (LPN or RN) can determine the patient's status until the treatment regimen is essentially stabilized; and 3) the skilled services of a licensed nurse (LPN or RN) in the training or education of a patient, a patient's family member, or caregiver.

You should ensure that your billing staff are aware of these new coding requirements on HHA therapy claims. It is important to note that only one G-code should be used per visit.

Background

Medicare makes payment under the Home Health Prospective Payment System (HH PPS) generally on the basis of a national standardized 60-day episode payment rate that includes the six home health disciplines (skilled nursing, home health aide, physical therapy, speech-language pathology, occupational therapy, and medical social services); and adjusts payment for the applicable case-mix and wage index.

The Centers for Medicare & Medicaid Services (CMS) currently uses the following G-codes to define therapy and skilled nursing services in the home health setting:

- G0151 – Services of physical therapist in home health setting, each 15 minutes;

- G0152 – Services of an occupational therapist in home health setting, each 15 minutes;
- G0153 – Services of a speech language pathologist in home health setting, each 15 minutes; and
- G0154 – Skilled services of a nurse in the home health setting, each 15 minutes to report the provision of skilled nursing services in the home.

In its March 2009 report, the Medicare Advisory Payment Commission (MedPAC) recommended that CMS improve the HH Prospective Payment System (PPS) to mitigate vulnerabilities. In the March 2010 report, it suggested that the HH PPS case-mix weights needed adjustment.

In order to respond to these recommendations, CMS needs more specific data on HH claims, and CR 7182 announces these new data requirements on types of bill (TOB) 32x and 33x, effective for episodes beginning on or after January 1, 2011.

Therapy Services

To ensure that the therapy case-mix weights are updated accurately, CMS needs to collect additional data on the HH claim to differentiate between the therapy visits provided by therapy assistants and those provided by qualified therapists. (A qualified therapist is one who meets the personnel requirements in the Conditions of Participation (CoPs), at 42 CFR 484.4.)

CMS is meeting this data collection need by: 1) Revising, and requiring, the current descriptions for existing G-codes for physical therapists, occupational therapists, and speech-language pathologists, to include in the descriptions that they are intended to report services provided by a qualified physical or occupational therapist or speech language pathologist; and 2) Adding two new G-codes to report restorative physical therapy and occupational therapy by qualified therapy assistants.

These new code descriptions follow:

- G0151 – Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes;
- G0152 – Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes;
- G0153 – Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes;
- G0157 – Services performed by a qualified physical therapist assistant in the home health or hospice setting, each 15 minutes; and
- G0158 – Services performed by a qualified occupational therapist assistant in the home health or hospice setting, each 15 minutes.

Readers should note that while many of the new codes include the hospice setting in their description, CMS is not requiring hospices to use the new G-codes described at this time.

In addition, CMS is adding, and requiring, the following three new G-codes for reporting the establishment or delivery of therapy maintenance programs by qualified therapists:

- G0159 – Services performed by a qualified physical therapist, in the home health setting, in the establishment or delivery of a safe and effective physical therapy maintenance program, each 15 minutes;
- G0160 – Services performed by a qualified occupational therapist, in the home health setting, in the establishment or delivery of a safe and effective occupational therapy maintenance program, each 15 minutes; and
- G0161 – Services performed by a qualified speech-language pathologist, in the home health setting, in the establishment or delivery of a safe and effective speech-language pathology maintenance program, each 15 minutes.

Skilled Nursing Services

The current definition for the existing G-code for skilled nursing services (G0154) is being revised, and CMS is requiring HHAs to use this code only for the reporting of direct skilled nursing care to the patient by a licensed nurse.

- G0154 – Direct skilled services of a licensed nurse (LPN or RN) in the home health or hospice setting, each 15 minutes.

Further, CMS is adding and requiring three new G-codes, one to be used to report the skilled services of a licensed nurse in the management and evaluation of the care plan, a second for the observation and assessment of a patient's conditions when only the specialized skills of a licensed nurse can determine the patient's status until the treatment regimen is essentially stabilized; and a third for the reporting of the training or education of a patient, a patient's family member, or caregiver:

- G0162 – Skilled services by a licensed nurse (RN only) for management and evaluation of the plan of care, each 15 minutes (the patient's underlying condition or complication requires an RN to ensure that essential non-skilled care achieves its purpose in the home health or hospice setting).
- G0163 – Skilled services of a licensed nurse (LPN or RN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting).

- G0164 – Skilled services of a licensed nurse (LPN or RN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes.

Note: Please refer to Section 40.1.2.2, Chapter 7, on the Medicare Benefit Policy Manual for more information regarding management and evaluation of a patient's care plan observation and Section 40.1.2.1, Chapter 7, for more information regarding observation and assessment of a patient's condition.

CMS recognizes that, in the course of a visit, a nurse or qualified therapist could likely provide more than one of the nursing or therapy services reflected in the new and revised codes above. However, as noted above, HHAs must not report more than one G-code for the nursing visit regardless of the variety of nursing services provided during the visit. Similarly, the HHA must not report more than one G-code for the therapy visit, regardless of the variety of therapy services provided during the visit. In cases where more than one nursing or therapy service is provided in a visit, the HHA must report the G-code which reflects the primary reason for the visit, which typically would be the service which the clinician spent most of his/her time. For instance, if direct skilled nursing services are provided, and the nurse also provides training/education of a patient or family member during that same visit, we would expect the HHA to report the G-code which reflects the primary reason for the visit. Most times, this service will also be the service for which the nurse spent the most time. Similarly, if a qualified therapist is performing a therapy service and also establishes a maintenance program during the same visit, the HHA should report the G-code which reflects the primary reason for the visit. Most times, this service will also be the service for which the therapist spent the most time.

It is important to note that when HHA personnel visit a patient to initially assess the patient's eligibility for Medicare's home health benefit, such a visit is not a billable service. (Please refer to Section 70.2, Chapter 7, of the Medicare Benefit Policy Manual.) However, once eligibility is established, if skilled services are provided during this initial visit, the HHA should report the G-code which corresponds to the skilled service provided.

Additional Information

You can find more information about new HH claims therapy and skilled nursing services G code reporting requirements by going to CR 7182, located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R859OTN.pdf on the CMS website.

If you have any questions, please contact your RHHI or A/B MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-

and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

A download of these G-codes is available on the 2011 HCPCS File Page, located at http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/TransactionCodeSetsStands/CodeSets.html on the CMS website.

News Flash - Get Your Flu Vaccine - Not the Flu. Don't forget to immunize yourself and your staff. Protect your patients. Protect your family. Protect yourself. While seasonal flu outbreaks can happen as early as October, flu activity usually peaks in January. This year's vaccine will protect against three different flu viruses, including the H1N1 virus that caused so much illness last flu season. The risks for complications, hospitalizations and deaths from the flu are higher among individuals aged 65 years and older. Medicare pays for the seasonal flu vaccine and its administration for seniors and others with Medicare with no co-pay or deductible. Health care workers, who may spread the flu to high risk patients, should get vaccinated too. Remember – Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is NOT a Part D covered drug. For information about Medicare's coverage of the influenza vaccine and its administration, as well as related educational resources for health care staff, please visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Flu_Products.pdf and http://www.cms.gov/Medicare/Prevention/Immunizations/index.html on the CMS website.