CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 859	**Date: February 8, 2011**
	Change Request 7182

Note to Contractors: Transmittal 824, dated December 17, 2010, is being rescinded and replaced with Transmittal 859, dated: February 8, 2011, in order to correct business requirement 7182.1. Placeholder values for the new G-codes are replaced with the actual HCPCS code values. Also, this transmittal provides clarification regarding the effective date of the change and the reporting of 15-minute increments for each visit. All other information remains the same.

SUBJECT: Additions To and Revisions of Existing G-Codes for the Reporting of Skilled Nursing Services and Skilled Therapy Services in the Home Health or Hospice Setting

I. SUMMARY OF CHANGES: This CR requires the reporting of new additional data on HH claims to further clarify the provider of therapy services by distinguishing between a qualified physical therapist and a qualified physical therapy assistant. This CR also requires the reporting of direct skilled nursing care provided to the patient by a licensed nurse, including 2 new related G codes.

EFFECTIVE DATE: January 1, 2011
IMPLEMENTATION DATE: January 3, 2011

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question

and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
One-Time Notification
**Unless otherwise specified, the effective date is the date of service.*

Attachment – One Time Notification

Pub. 100-20	Transmittal: 859	Date: February 8, 2011	Change Request: 7182

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SUBJECT: Additions To and Revisions of Existing G-Codes for the Reporting of Skilled Nursing Services and Skilled Therapy Services in the Home Health or Hospice Setting

Effective Date: January 1, 2011

Implementation Date: January 3, 2011

I. GENERAL INFORMATION

A. Background:

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

Claims must report all home health services provided to the beneficiary within the episode. Each service must be reported in line item detail.

Currently, we use the following G-codes to define therapy services in the home health setting:

- *G0151* Services of physical therapist in home health or hospice setting, each 15 minutes.
- *G0152* Services of an occupational therapist in home health or hospice setting, each 15 minutes.
- *G0153* Services of a speech language pathologist in home health or hospice setting, each 15 minutes.

Currently, we use the following G-code for the reporting of skilled nursing services in the home health setting:

- *G0154* Services of skilled nurse in the home health or hospice settings, each 15 minutes.

The March 2009 Medicare Advisory Payment Commission (MedPAC) report recommended that CMS improve the HH PPS to mitigate vulnerabilities such as payment incentives to provide unnecessary services. We believe that we need more specific resource use data to fully address these vulnerabilities.

In their March 2010 report, MedPAC recommended that CMS improve the HH PPS, and expressed concern with the significant variation in the services provided to beneficiaries. MedPAC also suggested that CMS adjust the HH PPS case-mix weights to more accurately reflect services required. In order to address MedPAC's

concerns and to more fully understand the services which are being provided, we believe there is a need to collect additional data on the HH claim regarding the specific sorts of therapy and nursing services being provided. Specifically, a number of the new and revised codes described below will differentiate between therapy services provided by a qualified therapist versus a therapy assistant. A qualified therapist is one who meets the personnel requirements in the Conditions of Participation (CoPs) at 42 CFR 484.4. Additionally, other new and revised codes below will provide for the reporting of training and/or education of the patient or family member and the skilled nursing services of a licensed nurse for the management and evaluation of the care plan and the observation and assessment of the patient's condition, when normal "direct" skilled nursing services of a licensed nurse are not provided.

Therefore, we are requiring Home Health Agencies (HHAs) to report additional and more specific data for therapy and nursing visits on *HH claims for episodes beginning on or after January 1, 2011*. While many of the new codes (described below) include the hospice setting in their description, we are not requiring hospices to use the new G-codes described below at this time. Medicare systems limitations prevent the use of the new codes on hospice claims at this time. A future instruction will expand the optional use of these codes to hospice claims. Revised, existing codes that include the hospice setting in their description will continue to be required of hospices reporting those services.

B. Policy:

In order for CMS to collect more specific information regarding the sort of services provided to home health patients, we are revising the current descriptions for existing G-codes for physical therapists (G0151), occupational therapists (G0152), and speech-language pathologists (G0153), to include in the descriptions that they are intended for the reporting of services provided by a qualified physical or occupational therapist or speech language pathologist.

In addition, we are adding two new G-codes (G0157 and G0158) for the reporting of physical therapy and occupational therapy services provided by qualified therapy assistants.

- *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.
- *G0158* Services performed by a qualified occupational therapist assistant in the home health or hospice setting, each 15 minutes.

We are also adding and requiring three new G-codes for the reporting of the establishment or delivery of therapy maintenance programs by qualified therapists. The following are descriptions for those new G-codes, for the reporting of the establishment or delivery of therapy maintenance programs by 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.

• *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.

Lastly, we are revising the current definition for the existing G-code for skilled nursing services (G0154), and requiring home health agencies (HHAs) to use G0154 only for the reporting of direct skilled nursing care to the patient by a licensed nurse (licensed practical nurse or registered nurse). Additionally, we are adding and requiring three new G-codes: One for the reporting of the skilled services of a licensed nurse in the management and evaluation of the care plan; another 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 another for the reporting of the training or education of a patient, a patient's family, or caregiver:

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

• *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.

We recognize 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. 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 service for 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 service for which most of the time was spent during that visit. 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 service for which most of the time was spent during that visit. *In all cases, however, the number of 15-minute increments reported for the visit should reflect the total time of the visit.*

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)

		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7182.1	Medicare contractors shall allow HCPCS G0157- G0164 on institutional claims with types of bill 32x and 33x effective for episodes beginning on or after January 1, 2011.	X				X					J14

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7182.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X		X					J14

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Kim Y. Evans (policy issues), kim.evans@cms.hhs.gov, 410-786-0009, and Wil Gehne (claims processing), wilfried.gehne@cms.hhs.gov, 410-786-6148

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):*
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Section B: *For Medicare Administrative Contractors (MACs)*:

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