**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Centers for Medicare & Medicaid Services**


**MLN Matters® Number: MM9736** **Related Change Request (CR) #: CR 9736**

**Related CR Release Date: November 10, 2016** **Effective Date: January 1, 2017**

**Related CR Transmittal #: R3655CP** **Implementation Date: January 3, 2017**

# Implementation of Policy Changes for the CY 2017 Home Health Prospective

This article was revised on November 16, 2017, to add a reference to MLN Matters® Article SE17027 which is informational only and is intended to provide helpful information to providers of Negative Pressure Wound Therapy (NPWT) devices. All other information is unchanged

## Provider Types Affected

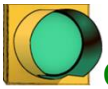
This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to MACs formerly known as FIs and Carriers, Regional Home Health Intermediaries (RHHIs) and A/B Medicare Administrative Contractors (A/B MACs)) for services to Medicare beneficiaries.

## Provider Action Needed

**STOP – Impact to You**

This article is based on Change Request (CR) 9736 which informs Medicare contractors about the implementation of a separate payment for home health agencies (HHAs) for disposable Negative Pressure Wound Therapy (NPWT) devices when furnished to a patient who receives home health services for which payment is made under the Medicare home health benefit. In addition, CR9736 will do the following:

- Implement changes to the methodology used to calculate outlier payments to HHAs and
- Create new G codes associated with registered nurse (RN) and licensed practical nurse (LPN) visits in the home health setting.



**GO – What You Need to Do**

Make sure that your billing staffs are aware of these changes. See the Background and Additional Information Sections of this article for further details regarding these changes.

## Background

### Provision of NPWT Using a Disposable Device

The Consolidated Appropriations Act of 2016 (Pub. L 114-113) requires a separate payment to be made to Home Health Agencies (HHAs) for disposable NPWT devices when furnished, on or after January 1, 2017, to an individual who receives home health services for which payment is made under the Medicare home health benefit.

## Key points in CR9736

### Change in the Methodology Used to Calculate Outlier Payments

Currently, the Centers for Medicare and Medicaid Services (CMS) calculates the estimated cost for an episode using the number of visits by discipline and multiplying them by the national per-visit rates finalized in our rules. The Report to Congress on home health access to care and payment for vulnerable patient populations (required per Section 3131(d) of the Affordable Care Act), indicated that HHAs can make a profit on outlier episodes by providing shorter visits than what is assumed in the national per-visit rates. Therefore, the current methodology for calculating the cost of an episode of care potentially overestimates the costs associated with an episode where shorter visits are provided than is assumed in the national per-visit rates. In addition, the study findings noted that certain types of patients may be associated with lower margins, such as those who require parenteral nutrition or require substantial assistance with bathing. These types of patients, on average, typically require longer visits and are thus more costly to treat.

Analysis of calendar year 2015 data indicates that there is significant variation in the visit length by discipline for outlier episodes. Those agencies with 5 percent or more of their total payments as outlier payments are providing shorter but more frequent skilled nursing visits than agencies with less than 5 percent of their total payments as outlier payments.

### Creation of New G Codes for RN and LPN In Home Health Episodes

Effective for January 1, 2016, CMS divided the G0154 code into two different codes (codes G0299 and G0300) that differentiate RN from LPN and may be used in both HH and hospice settings. This change was made in order to furnish a hospice add-on payment that is only payable for RN visits (not LPN visits) through the Service Intensity Add-on Payment.

As of CY 2015, CMS now annually recalibrates the HH case-mix weights. The weights are determined by calculating the cost for each episode of care, grouping the episodes by similar levels of resource use, and comparing the group's average resource use to overall mean. The cost of an episode of care is calculated using the BLS average hourly wage rate for the discipline that performed the visit multiplied by the minutes per visit reported on the HH

claim. Currently, CMS has separate G-codes for therapist versus therapist assistant visits so they are able to use the appropriate BLS average hourly wage rate depending on whether the visit was performed by a therapist or an assistant. However, for skilled nursing services, because G0163 and G0164 are for an RN or LPN, CMS has to assume a certain percentage are performed by a RN versus an LPN.

Since CMS has begun differentiating direct skilled nursing using the two new G-codes (codes G0299 and G0300), CMS believes it is appropriate to differentiate G0163 and G0164 as well so that there is no longer a need to use an assumption in calculating the cost per episode when those two services are performed, allowing for increased payment precision.

**Provision of NPWT Using a Disposable Device**

As described in the Consolidated Appropriations Act of 2016 (Pub. L 114-113), the separate payment amount for an applicable disposable device will be set equal to the amount of the payment that would otherwise be made under the Medicare Hospital Outpatient Prospective Payment System (OPPS) using the Level I Healthcare Common Procedure Coding System (HCPCS) code, otherwise referred to as Current Procedural Terminology (CPT-4) codes.

Currently CPT codes 97607 and 97608 (APC 5052), with status indicator "T" (Procedure or Service, Multiple Procedure Reduction Applies), include payment for both performing the service and the disposable NPWT device:

- HCPCS 97607 - Negative pressure wound therapy, (e.g., vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters.
- HCPCS 97608 - Negative pressure wound therapy, (e.g., vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters.

To avoid duplication of payment, for instances where the sole purpose for an HHA visit is to perform NPWT using a disposable device (integrated system of a vacuum pump, receptacle for collecting exudate, and dressings for the purposes of wound therapy), Medicare will not pay for a skilled nursing or therapy visit under the HH PPS. Rather, performing NPWT using a disposable device for a patient under a home health plan of care is being separately reimbursed the OPPS amount relating to payment for covered OPD services. In this situation, the HHA bills under type of bill 034x and reports the appropriate revenue code (0559, 042X, 043X), along with the appropriate HCPCS code (97607 or 97608).

**NOTE:** This visit is not reported on the HH PPS claim (type of bill 32x).

If NPWT using a disposable device is performed during the course of an otherwise covered home health visit (e.g., to perform a catheter change), the visit would be covered as normal but the HHA must not include the time spent performing NPWT in their visit charge or in the length of time reported for the visit. Performing NPWT using a disposable device for a

patient under a home health plan of care will be separately reimbursed the OPPS amount relating to payment for covered OPD services. In this situation, the HHA bills under type of bill 34X and reports revenue code (0559, 042X, 043X) along with the appropriate HCPCS code (97607 or 97608).

**NOTE:** This visit is also reported on the HH PPS claim (type of bill 32x).

**Denial Message**

When a claim with HCPCS 97607 and 97608 on TOB 034x is identified as not falling within a HH episode, your MAC will deny lines reporting revenue code 0559 (Skilled Nursing Care, Comprehensive Visit) using the following remittance advice codes:

- Group Code: CO
- CARC: 170 (Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.)
- RARC: N95 (Services subjected to Home Health Initiative medical review/cost report audit.)

**Change in the Methodology Used to Calculate Outlier Payments**

Given the analysis described above, as well as the findings from the 3131(d) study, CMS is concerned the current methodology for calculating outlier payments creates a financial disincentive for providers to treat medically complex beneficiaries that require longer visits. In addition, the current methodology does not accurately calculate the precise cost of an episode of care for instances where the length of the visit is greater than or less than the average length of a visit assumed in the national per visit rates. Therefore, CMS is changing the methodology used to calculate outlier payments to a cost per unit approach rather than a cost per visit approach.

HHAs currently report visit lengths in 15 minute increments (15 minutes = 1 unit). To implement this new methodology, the national per visit rates will be converted into per unit rates (as described in Attachment 1 in CR9367). The new per unit rates will then be used to calculate the estimated cost of an episode to determine whether the claim will receive an outlier payment and the amount of payment for an episode of care. This change in the methodology will be budget neutral as CMS would still target to pay up to, but no more than, 2.5 percent of total HH PPS payments as outlier payments.

In conjunction with the change to a cost-per unit approach to estimate episode costs and determine whether an outlier episode should receive outlier payments, CMS is implementing a cap on the amount of time per day that would be counted toward the estimation of an episode's costs for outlier calculation purposes, limiting the amount of time per day (summed across the six disciplines of care) at 8 hours or 32 units total.

For rare instances when more than one discipline of care is provided and there is more than 8 hours of care provided in one day, the episode cost associated with the care provided during that day will be calculated using a hierarchical method based on the cost per unit per discipline. The discipline of care with the lowest associated cost per unit will be discounted

in the calculation of episode cost in order to cap the estimation of an episode's cost at 8 hours of care per day.

**Creation of New G Codes for RN and LPN in Home Health Episodes**

Given the reporting needs articulated above, CMS is requesting that G0163 and G0164 be retired, effective January 1, 2017, and instead replaced with four new G-codes:

1. G0493 - Skilled services of a registered nurse (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).

2. G0494 - Skilled services of a licensed practical nurse (LPN) 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).

3. G0495 - Skilled services of a registered nurse (RN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes.

4. G0496 - Skilled services of a licensed practical nurse (LPN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes.

## Additional Information

The official instruction, CR 9736 issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3655CP.pdf** on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work.

## Document History

| Date of Change | Description |
|---|---|
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