NWMOMENTUM
HEALTH PARTNERS

POST-DISCHARGE HOME VISIT

BENEFIT ENHANCEMENT FOR NEXT GENERATION ACCOUNTABLE CARE ORGANIZATION (ACO) PROVIDER

Medicare beneficiaries aligned with the Next Generation Accountable Care Organization (NGACO) are eligible to receive the post-discharge home visit waiver.

The post-discharge waiver removes the requirement for provider direct supervision to bill for services and allows providers to contract licensed clinicians for these visits. As a provider, you have the flexibility in billing for evaluation and management for nine in-home visits at the patient's home.

WHY ARE POST-DISCHARGE HOME VISITS IMPORTANT?

- ✓ Reduces the risk of avoidable emergency room utilization.
- ✓ Address barriers to transportation and mobility.
- ✓ Provides medication, education, and management services to promote adherence.
- ✓ Provides additional services to evaluate risks in home environments and the ability to identify needed resources for improved safety.

WHAT ARE THE BENEFICIARY ELIGIBILITY REQUIRE-

- ✓ Must be aligned with the Next Generation ACO.
- ✓ Has been discharged from an inpatient qualifying stay within past 30-days.
- ✓ Do not qualify for home health services.
- ✓ Can accept services in home / place of residence after discharge from an impatient facility.

DOES THIS AFFECT BILLING?

No. Providers can bill for both transitional care management services and post-discharge home visits as they apply to the billing requirements under each type of service. As a provider of the NGACO patient, you are able to bill Medicare for your oversight of home visits to high-risk patients who do not qualify for home health services.

FOR MORE INFORMATION

319 SEVENTH AVE SE, STE 201, OLYMPIA WA 98501
360.943.4337 opt 6 | M-F 8am - 5pm PST
www.nwmomentumhealthaco.com

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NW Momentum Health Partners and its network of healthcare providers are voluntarily participating in the Next Generation ACO Model in an effort to improve health outcomes and lower expenditures. Please contact the Centers for Medicare and Medicaid (CMS) at CMS.gov or Medicare at 1.800.663.4227 for additional information.

BILLING CODES POST-DISCHARGE NEW PATIENT HOME VISITS

HCPCS	Descriptor
G2001	Post-discharge home visit new patient 20 minutes.
G2002	Post-discharge home visit new patient 30 minutes
G2003	Post-discharge home visit new patient 45 minutes.
G2004	Post-discharge home visit new patient 60 minutes
G2005	Post-discharge home visit new patient 75 minutes

BILLING CODES POST-DISCHARGE ESTABLISHED PATIENT HOME VISITS

HCPCS	Descriptor
G2006	Post-discharge home visit existing patient 20 minutes.
G2007	Post-discharge home visit existing patient 30 minutes
G2008	Post-discharge home visit existing patient 45 minutes
G2009	Post-discharge home visit existing patient 60 minutes
G2013	Post-discharge home visit existing patient 75 minutes

BILLING CODES CARE PLAN OVERSIGHT

HCPCS	Descriptor
G2014	Post-discharge home visit care plan oversight 30 minutes
G2015	Post-discharge home visit existing patient 60 minutes

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