# New Codes for Therapist Assistants Providing Maintenance Programs in the Home Health Setting

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Related Change Request (CR) Number: 11721
Related CR Release Date: May 1, 2020
Effective Date: January 1, 2020
Related CR Transmittal Number: R10086CP
Implementation Date: October 5, 2020

## PROVIDER TYPE AFFECTED

This MLN Matters® Article is intended for Home Health Agencies (HHAs) submitting claims to Medicare Administrative Contractors (MACs), including Home Heath & Hospice MACs, for therapy services to Medicare beneficiaries.

## PROVIDER ACTION NEEDED

CR 11721 informs you of the changes to Home Health (HH) billing and processing instructions, including new G-codes that describe therapy assistant services. It also makes a correction to the processing of HH claims that receive episode sequence edits. Make sure that your billing staffs are aware of these changes.

## BACKGROUND

Prior to January 1, 2020, the regulations at 42 CFR 409.44(c)(2)(iii)(C) stated that where the clinical condition of the patient is such that the complexity of the therapy services required to maintain function involves the use of complex and sophisticated therapy procedures to be delivered by the therapist himself/herself (and not an assistant) or the clinical condition of the patient is such that the complexity of the therapy services required to maintain function must be delivered by the therapist himself/herself (and not an assistant) in order to ensure the patient's safety and to provide an effective maintenance program, then those reasonable and necessary services shall be covered.

In the CY 2020 Home Health Prospective Payment System (HH PPS) Rule, the Centers for Medicare & Medicaid Services (CMS) stated that it would be appropriate to allow therapist assistants to perform maintenance therapy services under a maintenance program established by a qualified therapist under the HH benefit, if acting within the therapy scope of practice defined by their state licensure laws. The qualified therapist would still be responsible for the:

- Initial assessment
- Plan of care

- Maintenance program development and modifications
- Reassessment every 30 days
- Supervising the services provided by the therapist assistant.

This would allow HHAs more latitude in resource use. Furthermore, allowing assistants to perform maintenance therapy would be consistent with other post-acute care settings, including Skilled Nursing Facilities (SNFs). The requirements below revise Original Medicare systems to allow new codes that describe these services.

As finalized in the CY 2020 HH PPS final rule, CMS modified the regulations at 409.44(c)(2)(iii)(C) to allow therapist assistants (rather than only therapists) to perform maintenance therapy under the Medicare HH benefit. For analysis purposes, in order to track how much maintenance therapy is being furnished by therapist assistants in response to this regulatory change, effective January 1, 2020, CMS established a G-code for the maintenance services furnished by a physical therapist assistant and a G-code for the maintenance services furnished by an occupational therapist assistant.

The payment per visit will remain the same regardless of whether a therapist assistant is furnishing maintenance or other therapy services.

The two new G-codes are:

- G2168: Services performed by a physical therapist assistant in the home health setting in the delivery of a safe and effective physical therapy maintenance program, each 15 minutes
    - Short Descriptor: Svs by pt in home health
- G2169: Services performed by an occupational therapist assistant in the home health setting in the delivery of a safe and effective occupational therapy maintenance program, each 15 minutes
    - Short Descriptor: Svs by ot in home health

Medicare systems will accept these claims when submitted after the implementation date of CR 11721 for dates of service on or after January 1, 2020. HHAs should:

- Report G2168 with revenue code 042x on HH claims (Type of Bill (TOB) 032x other than 0322)
- Report G2169 with revenue code 043x on HH claims TOB 032x other than 0322

CR 11721 also makes various clarifying changes to the Medicare Claims Processing Manual, Chapter 10, in order to better reflect the policies of the Patient-Driven Groupings Model. The revised Chapter 10 is a part of CR11721.



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## ADDITIONAL INFORMATION

The official instruction, CR11721, issued to your MAC regarding this change is available at https://www.cms.gov/files/document/r10086CP.pdf.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

## DOCUMENT HISTORY

| Date of Change | Description |
|---|---|
| May 1, 2020 | Initial article released. |

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