The OPTIMISTIC Phase 2 Implementation Guide is designed to assist participating OPTIMISTIC nursing home leadership in successfully implementing the payment model. When turnover occurs, this is a great guide to orient new nursing home leadership to this project. Included are tools specifically developed to assist you in meeting CMS requirements. Our website, www.optimistic-care.org, has all of these tools plus additional resources.

Additionally, the Centers for Medicare & Medicaid Services has released guidance related to the initiative. We highly encourage you to review their guidance & FAQs which we have on our website here: http://www.optimistic-care.org/about/facility-provider-resources/general-project/

Do not hesitate to reach out with questions! We appreciate your partnership in revolutionizing nursing home care!

Best Wishes,

The OPTIMISTIC Implementation Team

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revans10@iuhealth.org
317- 880-6590

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317-274-9100
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Payment Model Implementation Overview

EDUCATE

New ED, DON, &/or OPTIMISTIC Champion
○ Contact Liza Cohen, 317-274-9100, lgcohen@regenstrief.org to schedule an orientation session with an Implementation Liaison

New providers (MD, NP, or PA) to OPTIMISTIC & to ensure they are aware of the requirements for certification and proper documentation
○ Contact Liza Cohen, 317-274-9100, lgcohen@regenstrief.org, to schedule an orientation session.
□ Assist the provider in completion of the OPTIMISTIC letter of intent (LOI).
□ Return the LOI to OPTIMISTIC by the 10th of the month.
  ➤ Please refer to page 5 for more details

All clinical & direct care staff in the building on the payment model
○ Introduce the project in new employee orientation.
  ➤ This guide is a good start to help familiarize team members with OPTIMISTIC.

IDENTIFY

A delegate who is responsible for periodic data submissions
□ Submit data through REDCap by the deadline (we will provide you a schedule reminder).

PARTICIPATE

In OPTIMISTIC quarterly visits or monthly engagement activities
□ Group A: Complete monthly engagement form and monthly call
  ➤ Monthly engagement forms due by the first Monday of the month
IMPLEMENT

A daily communication plan for identifying newly eligible participants

- Identify a team member who is responsible for sharing this information with the entire management team during morning meetings.

The participant opt-out process

- Provide each eligible resident with a copy of the opt-out letter.
- Opt-Outs need to be reported within 2 business days of being signed by a resident or their representative and submitted through the RedCap database.
  - Please refer to pages 10-12 for more details

A process for required documentation of the change in condition

- Document the use of a SBAR or other change in condition tool.
  - Please refer to pages 13-14 for more details

A process for your clinical staff to communicate to a provider when eligible residents have a change in condition which may be due to one of the six billable conditions

- Document a provider certification within two days.

A process for the delivery of enhanced care & monitoring while billing

- Document enhanced care and monitoring at least daily during period that patient is eligible.
  - Please refer to pages 15-16 for more details
The OPTIMISTIC Program of Indiana University (along with partners from University of Indianapolis, Regenstrief Institute, and Purdue University) is 1 of 6 sites in the country contracting with CMS to test a new payment model in nursing facilities. There are two groups of facilities: “Clinical + Payment” (19 facilities) & “Payment Only” (25 facilities). Clinical + Payment facilities have OPTIMISTIC clinical staff and are eligible to receive payments, while Payment Only facilities are only eligible to receive payments. All enrolled facilities and their providers complete a review process by CMS in order to participate in the project.

The goal is to reduce avoidable hospital transfers of long-stay residents (in the facility >100 days) who are not insured by Medicare managed care. The payment demonstration consists of 2 Medicare Part B billing codes – 1 for facilities and 1 for providers (MDs, NPs, and PAs). The intent is to provide resources to the facility and providers to deliver high level care in the facility.

**Facility Payments:** Facilities will receive an additional $218 per day, up to 7 days (or up to 5 days for Dehydration), for long stay residents with 1 of the 6 qualifying conditions. In order for the facility to bill, a provider has to certify that the resident has one of the conditions within 48 hours of the change in status.

**Provider Payments:** Providers will receive a $205 payment for an initial visit to treat an acute change in condition in the facility (NP/PA bills 85% of rate)

<table>
<thead>
<tr>
<th>Six Qualifying Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia</td>
</tr>
<tr>
<td>Urinary Tract Infection (UTI)</td>
</tr>
<tr>
<td>Congestive Heart Failure (CHF)</td>
</tr>
<tr>
<td>Fluid/Electrolyte Disorder</td>
</tr>
<tr>
<td>Skin ulcers, cellulitis</td>
</tr>
<tr>
<td>COPD, asthma</td>
</tr>
</tbody>
</table>

**Items to Note:**
- If the provider examines the patient and determines there is a different diagnosis, the provider still bills.
- Facilities cannot bill if resident is currently on a Medicare Part A post-acute care stay.

**Timeline**

Facilities and providers began billing the 3 new codes on October 1st, 2016. Facilities must renew their commitment to the project each year, until the project’s end in October 2020. **Additional information is available on the OPTIMISTIC website:** [www.optimistic-care.org](http://www.optimistic-care.org). If you have any questions, please contact: info@optimistic-care.org or 317-274-9114.
This Letter of Intent (LOI) states my agreement to participate with the Indiana University OPTIMISTIC project in response to the CMS Innovations Center and CMS Medicare-Medicaid Coordination Office funding opportunity: The Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents - Payment Reform (CMS-1E1-16-001).

As an eligible provider in a nursing facility participating in this initiative, if approved by CMS, I understand I will be able to utilize new billing codes when caring for eligible long stay (greater than 100 days in the facility) residents in the facility when assessing an acute change in condition suspected to be one of the six target conditions of the initiative. These codes may be billed during the project period – October 1st 2016-October 1st 2020 with agreements renewed annually.

I agree to:
- Make the best available decisions for care for patients at all times regardless of payments received through the initiative;
- Participate in trainings related to this initiative, via the OPTIMISTIC Learning Community;
- Adhere to CMS requirements and qualifying criteria related to the billing codes, including use exclusively for the target population;
- Respond to requests from CMS or its contractors for the purposes of oversight, monitoring or evaluation, e.g. participation in conference calls, data sharing, or chart reviews; and to
- Communicate promptly any changes to my information to OPTIMISTIC, e.g.- change of practice ownership, change in NPI number.

Please check the box below if applicable:

☐ I use an ONC-certified HER

☐ I use an electronic system for care planning or the creation and exchange of transition of care documents.

I attest that I have had an average panel of at least 7 long stay Medicare beneficiaries in the participating facility over the past 6 months. I am in good standing and have received no sanctions related to fraudulent billing in the past 3 years. I am committed to maintaining the above criteria throughout the initiative.

Signature of practitioner

Date

Facility name

Practitioner Legal name

Practitioner National Provider Identification (NPI) number

Practitioner Tax Identification Number (TIN)

Practitioner Email

Practitioner Phone

Practitioner- # OPTIMISTIC eligible residents (min. 7 residents)

*Name of Practice Group Administrator

*Practice Group Administrator Email

*Practice Group Administrator Phone

BOLD Denotes required fields

*If no practice group administrator, please include name of billing contact information
All recommended tools found at: https://www.optimistic-care.org/tools/change-in-condition-and-certification/

Payment Model Process & Available Tools

- Change in Condition
- Provider Certification Visit within 2 days
  - Recommended Tools:
    - OPTIMISTIC SBAR
    - Pocket Card
- Does not meet Diagnostic Criteria
  - Meets Diagnostic Criteria (facility bills project code beginning on CIC Date)
  - Treatment & monitoring plan implemented (with daily documentation)
  - Include certification in weekly data submission
  - Enrolled Provider bills project code for visit *STOP*

Documentation required in resident’s medical record
OPTIMISTIC Phase 2 Resident Eligibility Overview

Who is eligible to start OPTIMISTIC Phase 2?
- Residents who have been in your facility for 101 cumulative days, starting from their primary date of admission to your facility are eligible to start OPTIMISTIC Phase 2, and to receive services covered by the new CMS codes.

AND
- Are enrolled in Medicare (Part A and Part B FFS)
- Are NOT enrolled in a Medicare managed care plan (e.g., Medicare Advantage).
- Reside in a Medicare or Medicaid certified LTC facility bed.
- Have not elected to opt-out of OPTIMISTIC Phase 2.

Who is ineligible to start OPTIMISTIC Phase 2?
- Residents who have been in the facility for less than 101 cumulative days.
- Residents who are enrolled in a Medicare managed care plan (e.g., Medicare Advantage), who receive Medicare through the Railroad Retirement Board.
- Residents who are currently on the hospice benefit, even if they are receiving the benefit in the facility.

What counts towards the 101 days?
- If a resident is eligible, days spent physically in the facility. These days do not need to be consecutive, unless the resident has been out of the facility for 60 consecutive days or more.

If the resident has been out of the facility for 60 or more consecutive days:
- If the resident returns to the facility after 60 or more days, and are otherwise still eligible for OPTIMISTIC, the 101-day clock resets. Their date of return would count as Day 1. The resident will not be eligible until an additional 101 days of residence.
What does not count towards the 101 days?

- Days on Hospice: If a resident in your facility elects the hospice benefit, their days on this benefit do not count towards the 101 days. If the resident later elects to stop this benefit, you may resume counting towards the 101-day requirement, but the days spent on hospice cannot be applied towards this total.

- Days out of the Facility:
  - Days in the hospital
  - Therapeutic Leave
  - Days in another facility
  - Days in Hospice outside of the facility

What special circumstances might affect eligibility?

- If an eligible resident elects the Medicare hospice benefit, but later discontinues that benefit, that individual’s eligibility would be restored after they disenroll as long as other criteria remain applicable. Days in hospice do not count toward the 101 day minimum.

- A resident who enrolls in Medicare Advantage and later disenrolls becomes eligible for OPTIMISTIC Phase 2 if they meet the other criteria. If they disenroll, the days of residence while on Medicare Advantage enrollment would then count toward the 101 day minimum.

How to use the OPTIMISTIC Phase 2 Scenarios: Counting the 101 Days in Facility

The attached graphic presents five hypothetical examples of determining whether a resident has reached the 101-day requirement. The color of the boxes indicates whether the days count towards this criteria, as follows:

- These days DO count towards the 101-day total
- These days DO NOT count towards the 101-day total; Not eligible to start
- This resident has 101 days or more and IS eligible to start

Who to Contact with Questions

Erln O’Kelly Phillips, CCRP | OPTIMISTIC Research Manager
Email: ekokelly@iu.edu     Tel: 317-274-9420
### OPTIMISTIC Resident Eligibility Scenarios

<table>
<thead>
<tr>
<th>Scenario</th>
<th>In Facility</th>
<th>Hospital Transfer &amp; Admission</th>
<th>Readmit to Facility on SNF Benefit (Medicare A)</th>
<th>Off of Skilled Benefit Private Pay or Medicaid</th>
<th>Total Days</th>
<th>Eligible for OPTIMISTIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident A Hospitalization</td>
<td>75 days as of 10/1/2016</td>
<td>4 days</td>
<td>16 days</td>
<td>26 days</td>
<td>117</td>
<td>Eligible for OPTIMISTIC</td>
</tr>
<tr>
<td>Resident B Hospice</td>
<td>86 days as of 10/1/2016</td>
<td>4 days</td>
<td>30 days</td>
<td>15 days</td>
<td>101</td>
<td>Eligible for OPTIMISTIC</td>
</tr>
<tr>
<td>Resident C SNF Benefit</td>
<td>Enters Facility on SNF Benefit (Medicare A) 41 days as of 10/1/2016</td>
<td>Off of Skilled Benefit 35 days</td>
<td>14 days</td>
<td>36 days</td>
<td>112</td>
<td>Eligible for OPTIMISTIC</td>
</tr>
<tr>
<td>Resident D Medicare Advantage</td>
<td>Nursing Facility Stay 60 days</td>
<td>Enrolls in Medicare Advantage (OPTUM, IUH, etc.) 120 days</td>
<td>6 days</td>
<td>15 days</td>
<td>60</td>
<td>Not Eligible for OPTIMISTIC</td>
</tr>
<tr>
<td>Resident E Disenrolls from Advantage</td>
<td>Nursing Facility Stay In Facility 30 days as of 10/1/2016</td>
<td>Enrolls in Medicare Advantage 120 days</td>
<td>Disenrolls in Medicare Advantage</td>
<td>Nursing Facility Stay Private Pay or Medicaid 12 days</td>
<td>162</td>
<td>Eligible for OPTIMISTIC</td>
</tr>
</tbody>
</table>
OPTIMISTIC Resident Eligibility Flow Chart

Is the resident enrolled in one of the following:
- A Medicare Advantage Plan,
- Medicare through Railroad Retirement,
- The Medicare Hospice Benefit, OR
- VA only?

NO

Starting from the resident’s date of admission to your LTC facility, has he/she been in your facility for AT LEAST 101 CUMULATIVE days?
- If resident was enrolled in a Medicare Advantage Plan, then opted out and has Medicare A/B, days he/she was previously enrolled in the plan in your facility DO count toward the 101 cumulative days
- If resident was enrolled in Medicare Hospice, those days DO NOT count toward 101 cumulative days
- If resident is out of the facility for more than 60 days, total cumulative days begin at readmission

YES

NO

Is the resident enrolled in:
- Medicare (Part A and Part B FFS)

YES

NO

Is the resident in a Medicare- or Medicaid- certified bed?

YES

NO

Eligible for Phase 2 Payment and Group B Clinical Intervention

Not Eligible

Not Eligible

Not Eligible
**OPTIMISTIC Opt-Out Protocol for Facilities**  
**Version 2018.03.08**

**Background**  
Each eligible resident in a participating facility must receive an opportunity to opt-out of participating in the initiative. It is the facility’s responsibility to comply with this requirement as stated in the Memorandum of Agreement to participation.

Each eligible resident will receive a copy of the opt-out letter, and OPTIMISTIC Family Fact Sheet at the time the resident becomes eligible* for participation in OPTIMISTIC. OPTIMISTIC Opt-out and OPTIMISTIC Family Fact Sheet are available on the Optimistic-care.org under the Demonstration Project tab.

- Opting out indicates that the resident (or their representative) does not wish to participate in the OPTIMISTIC project, or share their billing or clinical service data with Centers for Medicare and Medicaid services (CMS).
- Residents who have opted out may opt back in at any time by submitting a signed letter of request to participate.

* See the OPTIMISTIC Eligibility Overview & Scenarios for more information on determining eligibility.

**Facility Opt-Out Reporting Responsibilities**

1. Opt-Outs need to be reported to the OPTIMISTIC Data Team within 2 business days of being signed by a resident or their representative.

2. Opt-Out letters should be scanned and attached to the REDCap Phase II Facility Opt-Out/In form using the “Upload document” link in the resident’s record. You will also need to enter the date the resident or their legal representative signed the letter using this REDcap form. For more information, please see the Phase II REDCap User Guide.
   a. If scanning is not an option, opt-outs may be transmitted by fax to 317-274-9307. The cover sheet should address the fax to Erin Phillips, OPTIMISTIC. You will still need to use the resident’s opt-out form in REDCap to record the date of the opt-out.

3. If a resident elects to opt back in to the project after opting out, this should also be reported using the resident’s Opt Out/In form. If a resident elects to opt back in to OPTIMISTIC after previously signing an Opt-Out letter, you will need to submit a short statement indicating this decision. This statement should be signed by the resident or the resident’s legal representative, and include the resident’s printed name and the date.
   a. Enter the date the letter was signed into the Opt-Out/In form, and attached a copy of the signed letter to the form using the “Upload document” link provided.

Each quarter, the Data Team will compare the letters received by the team to the opt-outs reported in the resident roster. The Data Team will report to the facilities:

- If there are no discrepancies
- Any residents who appear to have opted out on the resident roster, but do not have a signed letter on file.
- Any residents who have a signed letter on file, but are not properly recorded as opted out in the facility’s resident roster.
- Any residents who have opted back in according to a letter, but are not marked accordingly in the resident roster.
- Any residents who are reporting as opting back in the resident roster, but who do not have a signed letter on file.

If the Data Team notices any discrepancies, we will contact you so that we can work together to identify the correct information for your facility.
This form will guide communication with the on-call provider.

Resident Name __________________________ Age ________ Nurse __________________
Date ____________ Symptom/Condition Change: ______________________________________

Background Be sure to have the chart ready

Associated medical conditions include (check all that apply):
- CHF
- chronic pressure ulcer
- diabetes
- HTN
- CAD or hx of MI
- COPD/asthma
- Dementia
- Hospitalized within past 30 days
- Surgery within past 30 days
- Other _________________

□ Full Code □ DNR □ Do not hospitalize POST: Y/N: __________________

POST Section B:
- Comfort Measures
- Limited Intervention
- Full Intervention

POST Section C:
- Use antibiotics only if comfort cannot be achieved fully through other means
- Use antibiotics consistent with treatment goals

POST Section D:
- No artificial nutrition
- Defined trial of artificial nutrition
- Long term artificial nutrition

If no POST, describe the patient’s/ family’s preferences for treatment if known:
________________________________________________________________________________________

Assessment You do not have to complete every section

<table>
<thead>
<tr>
<th>Temp</th>
<th>Pulse</th>
<th>Resp. Rate</th>
<th>02 Sats</th>
<th>B/P</th>
<th>Blood Sugar</th>
<th>Weight/Change?</th>
<th>Most recent BM</th>
</tr>
</thead>
</table>

Faced physical assessment findings (refer to back for guidance on focused physical exam):

Mental Status/Mood/Behavior:
- not pertinent □ non responsive □ personality change □ hallucinations (worse or new)
- depressed □ withdrawn □ restless □ increased confusion
- agitated □ increased aggression (verbal or physical)

Neuro:
- not pertinent □ weaker on RUE/RLE/LUE/LLE (circle) □ leaning to right/left side
- speech irregularity □ facial asymmetry □ decreased sensation □ tingling
- abnormal gait □ dizzy □ numbness

Symptom-Based Exam Guide

If presenting this symptom: Do this assessment:
- Abdominal pain or Nausea/ Vomiting/ Diarrhea/ Constipation: Abdominal/Genital/Urinary
- Chest pain: Lungs/ Heart
- Cough or Shortness of breath: Lungs/ Heart
- Altered mental status: Full Exam
- Fever: Full Exam
- Rash/ Itching: Skin
- Facial droop/ arm or leg weakness, or headache/ blurry vision: Neurological
- Leg swelling: Lungs/ Heart/ Skin
- Hematuria or vaginal discharge: Genital/Urinary
- Fall: Neurological/ Skin
- Muscle or Joint Pain: Musculoskeletal
Head/Eyes/Ears/Mouth/Throat:
- not pertinent
- jaundiced eyes
- headache
- pupils unequal
- pupils non-reactive
- mouth lesion
- difficulty swallowing
- ringing in ears
- pupils non-reactive
- mouth lesion

Lungs:
- not pertinent
- abnormal lung sounds
- painful deep breaths
- orthopnea
- dyspnea on exertion
- cough (productive, non-productive)
- labored
- shallow
- short of breath

Heart/Pulses:
- not pertinent
- irregular pulse
- edema
- chest pain
- weak pulse
- abnormal heart sound

Abdominal:
- not pertinent
- tender
- distended
- hypoactive bowel sounds
- new incontinence
- change in stool color
- constipation
- hyperactive bowel sounds
- nausea
- vomiting
- bloody emesis
- absent bowel sounds
- bloody stool

Skin:
- not pertinent
- jaundice
- cyanotic
- bruising
- excoriation
- itch
- blister
- wound
- laceration
- skin tear
- pain
- rash
- localized warmth
- localized swelling
- drainage

Musculoskeletal:
- not pertinent
- falls
- joint pain
- joint swelling
- general weakness

Genital/urinary:
- not pertinent
- new incontinence
- new nocturia
- increased urinary frequency
- dysuria
- hematuria
- abnormal discharge
- lesion

Pain (elaborate on previously mentioned pain or discuss new symptom):
- not pertinent
- location
- pain scale (1-10)
- pain quality is sharp/dull/constant/intermittent/other
- pain is relieved by
- pain is made worse by
- any non-verbal signs of pain

Review and Notify Next steps below

Decision:
- Monitor the patient here
- OR
- Send the patient to the hospital (If going to hospital, STOP here)

Orders:

<table>
<thead>
<tr>
<th>Check if yes</th>
<th>Option</th>
<th>What are the orders?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Labs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Imaging</td>
<td></td>
</tr>
<tr>
<td></td>
<td>EKG</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vitals</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medication</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6 condition trigger</td>
<td></td>
</tr>
</tbody>
</table>

When will PCP be contacted again? ___________________________

Some content adapted from INTERACT® SBAR.
Recommended Monitoring During Benefit Period

For **ANY** patient receiving treatment for the **6 Conditions** under the OPTIMISTIC CMS Benefit:

- Vitals Every shift: temperature, blood pressure, heart rate, respiratory rate, O2 saturation
- Daily discussion of patient’s progress during nursing rounds
- Daily nursing assessment documented
- Pharmacy monitoring of any new medications ordered for significant interactions

**SPECIAL** considerations for any patient prescribed an **antibiotic**:

- Antibiotic stewardship is key: avoid excessive antibiotic use and limit dose, duration, and antibiotic choice to match condition and pathogen
- Set a stop date
- Facility nurse should inform primary provider when culture and sensitivity come back for consideration of antibiotic change
- Monitor INR closely if on warfarin
- Pharmacy to monitor dosing and medication blood levels when appropriate
Best Practices for each condition:

1. Pneumonia
   - Daily CBC with differential until the WBC trends down
   - O2 saturation (indicate whether room air or on oxygen)
   - See special considerations for any patient on an antibiotic

2. CHF
   - Daily weights → alert provider if weight increase ≥ 3 pounds in 1 day
   - Daily I/O monitoring → alert provider if intake or output decreased
   - If continent consider using “hat” or urinal to monitor output
   - Daily BMP for first 3 days of diuresis and then as clinically indicated
   - Consider BNP if patient not improving
   - O2 saturation (indicate whether room air or on oxygen)

3. Skin Infection
   - Assessment by wound care team
   - Minimum of daily dressing changes (or at frequency recommended by wound team)
   - If infected pressure ulcer, initiate facility’s frequent turning protocol
   - See special considerations for any patient on an antibiotic

4. Electrolyte disturbance/dehydration
   - Monitor BMP for first 3 days of treatment and then as clinically indicated
   - Evaluate medications for renal toxicity
     - Reduce dose or hold nephrotoxic medications when appropriate

5. COPD/Asthma
   - Prednisone can alter INR and cause GI bleeding so alert staff to monitor patients on warfarin and prednisone closely
   - O2 saturation (indicate whether room air or on oxygen)
   - If using antibiotic, see special considerations for any patient on an antibiotic

6. UTI
   - Order a urinalysis with culture if indicated (“reflex culture”)
   - See special considerations for any patient on an antibiotic
# Nursing Home Billing Guidance Worksheet

<table>
<thead>
<tr>
<th>Resident Name</th>
<th>Condition</th>
<th>Key Dates (put date in boxes below)</th>
<th>CIC note in chart?</th>
<th>Provider Cert in Chart?</th>
<th>Certifying Provider</th>
<th>REDCap data entered?</th>
<th>Daily documentation in Chart (put date in boxes below)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Example</strong></td>
<td>CHF</td>
<td>1.18.18 1.19.18 1.18.18 1.23.18</td>
<td>Yes</td>
<td>Yes</td>
<td>Dr. Sherry Roots</td>
<td>Yes</td>
<td>1.18.18 1.19.18 1.20.18 1.21.18 1.22.18 1.23.18 N/A</td>
</tr>
<tr>
<td>Ruby Mae Sloan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Maximum billing of 5 days; All other conditions allow billing up to 7 days.
Guide to completing the worksheet:

1. Ensure the resident being certified is ELIGIBLE for the program (please see Resident Eligibility Overview on www.optimistic-care.org)

2. Dates:
   a. CIC - record date of Change in Condition; ensure there evidence of the CIC in the medical record.
   b. Cert - Date provider saw the resident in person and certified for one of 6 conditions; ensure there is a provider note in the chart that indicates they saw the resident AND the clinical criteria to certify for one of the 6 conditions were met.
   c. Begin – Date the facility will begin the billing period
   d. End – Last day of billing period

3. CIC Note in the chart? – Answer yes if you have placed this in the resident’s chart.

4. Provider Certification Note in the chart? – Answer yes if you have placed this in the resident’s chart?

5. Provider Name who Certified? – Record the name of the practitioner that saw the resident in person and certified

6. REDCap data entered? – Have you entered this data into the REDCap database?

7. Documentation – Please ensure there are nursing notes EACH DAY during the certification period in the medical record. Check off by recording dates in the appropriate boxes

8. Recertification – If the resident qualifies for a recertification, this is a new billing episode and should be completed on a new row.

Provider Certification Window

**BEST PRACTICE:**

If provider certifies CIC within this window, the facility begins billing back to the date of the CIC (Day 1)

If provider certifies CIC within this window, the facility begins billing on the date of the provider visit (either Day 4 or Day 5)

Provider cannot certify CIC – new CIC must be documented and process starts over