



Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents – Payment Reform: Frequently Asked Questions

Facility Billing

Last updated November 8, 2017

Examples below assume a seven-day maximum benefit period for enhanced facility care. For fluid/electrolyte disorder or dehydration, which only triggers a maximum benefit period of five days, please adjust accordingly.

1. If a resident, who has been assessed with one of the six conditions, is transferred to the hospital for 2 or 3 days for an unrelated condition during the benefit period, do they have to be reassessed upon return in order for the facility to continue billing for the eligible condition? Also, does the benefit period start over or would it continue from the original assessment?

A: A re-evaluation is not needed if the resident is still within original seven-day period. As an example, consider a resident treated by a facility for Days 1-3, then transferred to the hospital for two days (Days 4-5), returning on Day 6. The facility may bill for Day 6 and Day 7 without a re-evaluation as long as the condition has not yet been resolved.

2. Is the day of the practitioner assessment Day 1 of the period for the facility payments?

A: **[Updated]** Generally, Day 1 would be the day that the change in condition is identified, provided that the practitioner evaluation and confirming diagnosis occurs by the end of the second day following this change (Day 3). This allows the facility to begin treatment as soon as the change in condition is identified, as appropriate, even if the practitioner cannot conduct an in-person evaluation immediately.

If the evaluation occurs after the second day following the acute change in condition, then the day of evaluation must be treated as Day 1.

3. We were hoping to get clarity on the timing of the certification of a condition by the practitioner. Sometimes it says that the practitioner needs to see the resident within 48 hours and sometimes it says by the end of the second day after the acute change of



condition. These can differ based on the situation. Can you please confirm if it is 48 hours or end of second day?

A: **[Updated]** The resident must be evaluated by the end of the second day following the change in condition. For example, if a resident experienced an acute change in condition on June 1, the evaluation must occur no later than 11:59 pm on June 3 to satisfy Initiative requirements. In that case, facilities may bill the new codes for June 1-3 as appropriate. For this example, if the evaluation does not occur until June 4, then the facility would only be eligible for payments beginning on that day. However, the 4th day is the last day a facility is allowed to have a practitioner certify a resident for this specific acute change in condition. If a practitioner sees a resident on day 5 or beyond, the facility must document a new acute change in condition, including demonstrating the resident currently meets the clinical criteria. In all cases, the residents' medical records should document the treatment(s) provided on any day being billed, in the same manner as for other Medicare claims.

4. If the resident remains acutely ill and there needs to be a second assessment to re-trigger the building's ability to charge, does that need to happen on Day 7 of the first 7 days or does the second assessment happen on Day 8 (or Day 1) of the second 7 days? Or does it matter?

A: The evaluation must occur no later than Day 9, which is the second day after the initial seven-day period ends.

5. If the resident is transferred out, is there NO billing allowed by the building for that 24 hour period of time? Seems like it would make a difference if the transfer occurred at 1AM vs 11PM during that 24 hour period.

A: The facility may not bill a per diem on the calendar day during which a resident is discharged, regardless of the time of discharge.

6. Clarifying---after the initial qualifying condition visit, an MDS change in condition is completed only if it meets the standard MDS requirements.

A: Correct, there are no new MDS requirements for participating facilities.



7. If the beneficiary continues to meet the qualifying criteria at the end of the first 5 or 7 days, does the provider re-confirmation of the diagnosis need to be face to face assessment of the beneficiary or a qualifying telemedicine assessment? Or can it be by phone....

A: The same rules as for the original qualifying visit would apply.

8. If there is more than one qualifying diagnosis and one has resolved but the other one hasn't or if there is a new qualifying diagnosis, can the benefit be retriggered following a practitioner assessment?

A: Yes.

9. After the care coordination code is billed by the practitioner, is a new MDS assessment required? Or is it just needed per standard MDS requirements?

A: A new MDS assessment is required only if it has been less than a year since the last time the practitioner billed for a care conference with this resident.

10. After the qualifying visit, the building can begin to bill the code for the eligible number of days. What data transfer is required and how is the data transferred (via the ECCP or directly to CMS)?

A: **[Updated]** The facility would submit a claim to Medicare just like any other Medicare Part B claim. Separately, we will be collecting data on each use of the new billing code as well as other information the CMS needs to monitor the Initiative. ECCPs are required to collect data from all participants and submit data to the CMS Operational Support Contractor on a quarterly basis.

11. Are there any additional data collection expectations for the practitioner when the payment code is triggered?

A: Practitioners are not responsible for collecting or submitting data relating to facility billing. We currently plan to collect data from practitioners only for the care conference visits.

12. What are the documentation requirements for the detection of acute change of condition? By what type of healthcare professional (e.g., LPN, RN, CNA)? Does the documentation



need to be noted in the medical record? If the documentation needs to be in the medical record, what formats are acceptable (e.g., STOP AND WATCH tool, SBAR, free text note, structured clinical documentation)?

A: Documentation must be noted in the medical record. Any of the above format would be acceptable as long as they are part of the medical records. We expect that the notation would be made by a physician or a nurse at the LPN level or higher.

13. If there is >1 qualifying diagnosis, should both be reported even if it doesn't make a difference re the payment to facility/provider?

A: Yes.

14. How is the end of an episode determined?

A: The episode should end when the resident improves enough that they no longer meet the treatment criteria. We expect that this will be generally be determined by the resident's practitioner. Otherwise, the billing period would continue to the maximum days (5 or 7 days) unless the resident is discharged. As with Part A billing, the facility should not bill the new codes on a day when the resident is discharged or when a practitioner determines that the resident no longer meets the relevant criteria.

If the person is still acutely ill at the end of the billing period, a practitioner may re-confirm the qualifying diagnosis for another billing cycle.

15. Suppose a long-stay enrolled patient breaks her hip, transitions back to the facility on a Medicare Part A skilled stay, 5 days later develops pneumonia. May the facility may bill during the skilled stay because the diagnosis is unrelated to the original hospitalization)?

A: No. A facility may never bill the new codes on the same day that the facility receives a Part A per diem payment. However, a practitioner may bill the new code for Acute Nursing Facility Care.

16. We understand that a change of condition requalification can occur at any time during the change of condition episode. So, if a resident is requalified with the qualifying condition, will an additional 5-7 eligible payment days will be applied from the date of requalification regardless of when the requalification occurred (i.e. Day 2 or Day 7).



A: **[Updated]** No, this is only the case when the diagnosis changes; for example, if the original diagnosis met the qualifying criteria for both COPD and Cellulitis, but the resident was later assessed and met the qualifying criteria for COPD-only, the facility would be eligible for seven days of payment beginning with the reassessment. In essence, the original (COPD + Cellulitis) billing period ends with the reassessment, and a new billing period begins.

Without a change in diagnosis, the reassessment must occur between Day 6 and Day 9 of the initial billing period in order to trigger an additional seven days.

17. Urine cultures typically take greater than 48 hours to obtain results, how do we confirm diagnosis within 48 hours?

A: **[Updated]** The qualifying criteria only state there must be 100,000 colonies of bacteria with no more than 2 species. This information is usually available within 24 hours of submitting a urinalysis with culture (not reflex) even if the final culture takes longer. As long as other qualifying criteria are met (fever OR WBC count OR other symptom), the facility may begin to bill and receive payment for enhanced treatment, based on this presumptive diagnosis, while waiting for final culture results. However, if these results indicate that the patient does not meet the qualifying criteria after all, the facility should discontinue billing immediately. A practitioner confirmation visit within two days is still required for the presumptive diagnosis.

This UTI presumptive diagnosis is an exception to the general rule for qualifying diagnoses, because of the time needed for a urine culture.

18. Does the primary diagnosis on the claim need to match the ICD10 code?

A: The claims should be submitted just like any other Part B claim. The Initiative has no additional requirements for ICD-10 codes.

19. Can the MD or NP confirm the diagnosis over the phone or does it have to be a face to face?

A: The confirmation must be done face to face or via qualified telemedicine. The confirmation cannot be done over phone. If you are unsure whether your telemedicine system meets Initiative qualifications, please contact your ECCP.



20. If a facility bills the new codes for a resident whose Part A benefit expired in the past 60 days, will that affect the resident's eligibility for Part A benefits in the future?

A: No.

21. **[New]** Can a qualifying diagnosis occur off-site?

A: While the intent of this Initiative is for the assessment to occur on-site, a qualifying diagnosis may be obtained off-site as long as the off-site visit was not a hospital transfer (inpatient, observation stay, or emergency department). One example, is if a resident receives care at a local clinic, a qualifying diagnosis from the clinic would allow the facility to bill the new codes. As always, the resident's medical record should document both the diagnosis and the treatment provided at the facility.

22. **[New]** For acute care skin infection, is there a minimum temperature required for documented fever?

A: We would expect the fever to exceed 100 ° F (oral). As noted in the Facility Guidance, though, fever is just one of many possible signs of infection that would trigger a qualifying diagnosis.

23. **[New]** For a resident with pneumonia, is a second chest x-ray required for recertification after the initial 7 day period?

A: No, as described in the criteria, the resident needs a chest x-ray confirmation of new pulmonary infiltrate OR two or more of additional criteria. So if several of the required criteria persist after the first seven days, then a new x-ray is not required.

24. **[New]** For a resident with congestive heart failure, is another chest x-ray required to recertify the condition after the initial 7 day period?

A: No, as described in the criteria, a chest x-ray confirmation of a new pulmonary congestion OR two of more of the other criteria is necessary to certify the condition. So if several of the required criteria persist after the first seven days, then a new x-ray is not required.



25. **[New]** For a resident with a urinary tract infection, is another urine culture required for recertification after the initial 7 day period?

A: In the unlikely case that a UTI has not resolved after seven days, then yes, a new urine culture would be required.

26. **[New]** For a resident with a skin infection, what is considered “new” redness? How would this condition be recertified after the initial 7 day period?

A: New redness means there would need to be evidence of an acute change in condition with evidence of a new infection. To be recertified, a new acute change in condition with evidence of a new infection that meets the criteria would be required, not just continuation of care for the previous infection.

27. **[New]** How does CMS’ UTI criteria under this program align with national standards?

A: To develop the UTI criteria, CMS used the McGeer criteria. Please refer to Finucane TE, J Amer Geriatrics Soc, 2017; 65:1650-55 for additional information.

28. **[New]** For a resident showing signs of COPD/Asthma, the criteria states a “known diagnosis of COPD/asthma”, what if this is the first time a practitioner is diagnosing a resident with COPD or asthma, would this count even though it’s not previously “known”?

A: As stated in the criteria, if a COPD/Asthma diagnosis is not already established, it would require a chest x-ray to do so. Once that was established as the diagnosis then the resident would need to meet the additional criteria required.

29. **[New]** The radiologist my facility works with is hesitant to diagnosis pneumonia or even report “new pulmonary congest or infiltrates” in their reports. How can I continue to diagnosis and treat residents with pneumonia under the program?

A: As the criteria states, a resident needs either a chest x-ray confirmation OR two of the other four criteria. If the chest x-ray does not provide adequate confirmation, a resident can qualify by



meeting two of the four other criteria.

30. **[New]** We have an Initiative-eligible resident who elected the Medicare hospice benefit, but then chose to discontinue hospice and return to our care. Does the resident automatically become Initiative-eligible again?

A: Not necessarily. If there is any period of 60 consecutive days when the individual was *not* receiving nursing facility care, the individual is no longer considered a long-stay resident. That 60-day gap includes days in hospice care as well as days receiving care elsewhere. In those cases, the resident would not become eligible again until another 100 days of residency have elapsed. Otherwise, as long as the gap period (including hospice care) is less than 60 days, then Initiative eligibility is restored.

31. I'm having trouble submitting a claim. What should I do?

A: Please contact your local Medicare Administrative Contractor (MAC) for assistance with claims submission. If your claim is being rejected and the MAC cannot give you an explanation, please contact your ECCP.

As a reminder, MACs are private health care insurers that have been awarded geographic jurisdiction to process claims for Medicare Fee-For-Service (FFS) beneficiaries. CMS relies on a network of MACs to serve as the primary operational contact between the Medicare FFS program and the health care providers enrolled in the program. MACs perform many activities including:

- Process Medicare FFS claims
- Make and account for Medicare FFS payments
- Enroll providers in the Medicare FFS program
- Handle provider reimbursement services and audit institutional provider cost reports
- Handle redetermination requests (1st stage appeals process)
- Respond to provider inquiries
- Educate providers about Medicare FFS billing requirements
- Establish local coverage determinations (LCD's)
- Review medical records for selected claims
- Coordinate with CMS and other FFS contractors

Please reach out to the MAC in your jurisdiction with any questions related to billing, billing statements, or other related questions.



Alabama

Jurisdiction J (Cahaba): <https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Who-are-the-MACs-A-B-MAC-Jurisdiction-J-JJ.html>

Colorado

Jurisdiction H (Novitas): <https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Who-are-the-MACs-A-B-MAC-Jurisdiction-H-JH.html>

Indiana

Jurisdiction 8 (WPS): <https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Who-are-the-MACs-A-B-MAC-Jurisdiction-8-J8.html>

Missouri

Jurisdiction 5 (WPS): <https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Who-are-the-MACs-A-B-MAC-Jurisdiction-5-J5.html>

Nevada

Jurisdiction E (Noridian): <https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Who-are-the-MACs-A-B-MAC-Jurisdiction-E-JE.html>

New York:

Jurisdiction K (NGS): <https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Who-are-the-MACs-A-B-MAC-Jurisdiction-K-JK.html>

Pennsylvania

Jurisdiction L (Novitas): <https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Who-are-the-MACs-A-B-MAC-Jurisdiction-L-JL.html>