DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Medicare-Medicaid Coordination Office

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

Facility Billing

Last updated June 12, 2019

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 along as the condition has not yet been resolved.

2. 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.

3. 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.

4. 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.

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: 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.

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. 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.

17. 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.

18. 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.

19. 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.

20. 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.

21. 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.

22. 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.

23. 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.

24. 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.

25. 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.

26. 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.

27. 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 (Palmetto GBA): 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