DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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The Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents – Payment Reform

Provider Types Affected

This article is intended for nursing facilities and practitioners participating in this initiative. Those are selected nursing facilities and practitioners in Alabama, Colorado, Indiana, Missouri, Nevada, New York, and Pennsylvania. The article is informational for other nursing facilities and practitioners.

Background

"The Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents – Payment Reform" tests a new payment model for nursing facilities and practitioners to incent early identification of changes in condition, treatment of specific conditions in a nursing facility without a hospital transfer, and improved care planning.

The objectives of this model are to reduce avoidable hospital transfers, improve health outcomes, and to reduce combined Medicare-Medicaid costs for long-stay nursing facility residents enrolled in Medicare and Medicaid. The model includes the introduction of six new Medicare Part B payment codes billable by nursing facilities for treatment of specific conditions and two new Medicare Part B payment codes billable by practitioners for onsite treatment and for care coordination.

The eligible beneficiaries for this initiative are long-stay nursing facility residents who have resided in the facility for 101 cumulative days or more, who are enrolled in Medicare (Parts

A and B Fee-for-Service), reside in a Medicare or Medicaid certified bed, and who have not opted out of participating in the initiative.

Note: Participation in this Initiative is limited to selected nursing facility and practitioners in Alabama, Colorado, Indiana, Missouri, Nevada, New York, and Pennsylvania. *At this time, all participating nursing facilities have been chosen and screened for their eligibility to participate. The Centers for Medicare & Medicaid Services (CMS) and its partners are* ***not*** *recruiting new facilities at this time.*

What You Need to Know

The payment model has three components:

- Nursing facility payments for the treatment of qualifying conditions (for beneficiaries not on a Medicare Part A skilled nursing facility stay)
- Practitioner payment for the treatment of conditions onsite at the nursing facility
- Practitioner payment for care coordination and caregiver engagement

Nursing Facility Payments for Treatment of Qualifying Conditions (Onsite Acute Care)

The following six new HCPCS codes can only be billed by participating nursing facilities when qualifying criteria has been met. Nursing facilities participating in this initiative should have received specific qualifying clinical criteria information from their Enhanced Care and Coordination Provider (ECCP). Please reach out to your ECCP if you do not have this information. The six codes are:

- **G9679:** Pneumonia - This code is for onsite acute care treatment of a nursing facility resident with pneumonia.
- **G9680:** Congestive Heart Failure (CHF) - This code is for onsite acute care treatment of a nursing facility resident with CHF.
- **G9681:** Chronic Obstructive Pulmonary Disease (COPD)/Asthma - This code is for onsite acute care treatment of a resident with COPD or asthma.
- **G9682:** Skin infection - This code is for the onsite acute care treatment of a nursing facility resident with a skin infection.
- **G9683:** Fluid or Electrolyte Disorder or Dehydration - This code is for the onsite acute care treatment of a nursing facility resident with fluid or electrolyte disorder or dehydration.
- **G9684:** Urinary Tract Infection (UTI) - This code is for the onsite acute care treatment of a nursing facility resident with a UTI.

Each of the six codes follows standard Medicare Part B billing requirements and should be billed on a 22x or a 23x type of bill. Nursing facilities, at a minimum, need to follow the billing rules from the National Uniform Billing Committee (NUBC). They maintain the allowable revenue codes for certain facilities. Within the rules set out by the NUBC, CMS did not limit which revenue codes could be used with the new codes and advises nursing facilities to select the revenue code most appropriate for their situation. More information on

SNF Part B billing (including those revenue codes that cannot be billed on a 22x) is available at **https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c07.pdf**.

Participating nursing facilities will be paid a per diem rate of **$218** for HCPCS codes G9679 through G9684. As a reminder, Medicare payments to providers for individual services under Medicare Parts A and B have been under sequestration for services beginning April 2013. This means that final payment to providers will be two percent less than the calculated payment amount.

Payment for these codes is limited to nursing facilities participating in the initiative. Beneficiary co-insurance and deductible will be waived for these codes. None of these codes may be billed more than once a day for a single beneficiary and only one of these codes may be billed in a day for a single beneficiary.

Practitioner Payment for the Treatment of Acute Changes in Condition Onsite at the Nursing Facility

New practitioner code G9685 (Practitioner Payment for the Treatment of Conditions Onsite at Nursing Facility) is billable for the initial visit for the evaluation and management of a beneficiary's acute change in condition in a nursing facility. Payment for this code is limited to practitioners participating in the initiative when billing for services rendered at a participating nursing facility. This code may only be billed once per day per beneficiary. Beneficiary co-insurance and deductible will be waived for these codes. Practitioners are permitted to bill for these services while a beneficiary is receiving Medicare Part A skilled nursing facility benefits. The payment rate for HCPCS code G9685 is aligned with CPT code 99223 (Initial Hospital Care), to help equalize the practitioner payment across sites.

Key Components Required

Key components required to bill code G9685 are:

- A comprehensive review of the beneficiary's history
- A comprehensive examination
- Medical decision making of moderate to high complexity, and
- Counseling and/or coordinating care with nursing facility staff and other providers or suppliers consistent with the nature of the problem(s) and the beneficiary's and family's needs.

Practitioners should reach out to their ECCP for questions and education on how and when to bill this code.

Practitioner Payment for Care Coordination and Caregiver Engagement

New practitioner code G9686 (Care Coordination and Caregiver Engagement Conference) is for the onsite nursing facility conference that is separate and distinct from an Evaluation and Management visit, including qualified practitioner and at least one member of the nursing facility interdisciplinary care team and resident or their designated caregiver. Payment for this code is limited to practitioners participating in the initiative when billing for services

rendered at a participating nursing facility. Beneficiary co-insurance and deductible will be waived for this code. The payment rate for HCPCS code G9686 is aligned with CPT code 99214 (Office or other outpatient visit for established patient).

The code may only be billed **once** per year for a single beneficiary in the absence of a significant change in condition. The code can be billed with the –KX modifier within 14 days of a significant change in condition that increases the likelihood of a hospital admission. The change in condition must be documented in the beneficiary's medical chart and include an MDS assessment.

Key Components Required

In order to qualify for payment for code G9686, the practitioner must conduct the discussion:

- With the beneficiary and/or individual(s) authorized to make health care decisions for the beneficiary (as appropriate)
- In a conference for a minimum of 25 minutes
- Without performing a clinical examination of the beneficiary during the discussion (this should be conducted as needed through regular operations and this session is focused on a care planning discussion), and
- With at least one member of the nursing facility interdisciplinary team.

The practitioner must also document the conversation in the beneficiary's medical chart. The change in condition must be documented in the beneficiary's chart and include a Minimum Data Set (MDS) assessment.

Additional Information

Nursing facilities and practitioners should reach out to their ECCP for questions and education on this initiative.