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

CMS Guidance on Nursing Facility Billing under the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents

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CMS is seeking to clarify confusion among nursing facilities on when they should begin billing for an acute episode of care under the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents. This document is not a change of any CMS policy, but rather provides further clarification and examples for nursing facilities on proper episode billing (i.e., billing codes G9679, G9680, G9681, G9682, G9683, and G9684).

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1. General Guidelines

For the purposes of billing an episode of care, under this the Initiative CMS defines Day One as the day when facility staff first identified an acute change in condition in a resident whose symptoms, pending practitioner confirmation, appear to meet the criteria for a qualifying diagnosis.

In most cases, this would be based on specific symptoms documented in the resident's medical record (please see NFI Clinical Criteria for more information on specific symptoms). Sections 4 and 5 below discuss additional detail relating to skin infection and urinary tract infection.

In order to qualify for payment, a practitioner *assessment* and *confirmation* of the suspected diagnosis is **required.** To begin billing on the day the initial acute change in condition is identified (Day One of the episode), the practitioner confirmation **must** occur no later than the end of the second day *after* that day (Day Three).

The billing episode typically lasts for seven days (Day One to Day Seven) or when the resident has recovered, whichever comes first. For fluid/electrolyte disorders, the billing episode typically lasts for five days (Day One to Day Five) or when the resident has recovered, whichever comes first. If a resident remains acutely ill at the end of the typical billing episode, see Section 3 for details on re-confirmation of a qualifying diagnosis.

For example, if a resident presents with symptoms that would meet a qualifying diagnosis of pneumonia (e.g. fever, high respiratory rate, etc.) on Monday (Day One), the practitioner **must** complete their confirmation visit no later than 11:59 pm on Wednesday (Day Three) to confirm a diagnosis of pneumonia for the facility to begin billing on Monday (Day One). With this practitioner confirmation in place, the facility may bill Medicare for services through Sunday (Day Seven).

Scenario 1: Primary confirmation window

Day One	Day Two	Day Three	Day Four	Day Five	Day Six	Day Seven
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Practitioner confirmation visit occurs in this window; confirmation occurs no later than Day Three						
Eligible resident presents with pneumonia symptoms that meet clinical criteria Enhanced treatment begins	Enhanced treatment continues	Enhanced treatment continues	Enhanced treatment continues	Enhanced treatment continues	Enhanced treatment continues	Last billable day for episode†
Facility eligible to bill for G9679	Facility eligible to bill for G9679	Facility eligible to bill for G9679	Facility eligible to bill for G9679	Facility eligible to bill for G9679	Facility eligible to bill for G9679	Last day facility is eligible to bill G9679
† Unless a successful re-confirmation occurs. Please see Section 3 Re-confirmation of a Qualifying Diagnosis						

For billing purposes, practitioner confirmations can only occur with an in-person visit or a qualifying telemedicine visit as described in the Funding Opportunity Announcement.

2. Timing of Practitioner Confirmation Visit

In general, the practitioner confirmation should occur as soon as possible after the acute change in condition is identified. Under the Initiative CMS expects that facilities would begin to provide enhanced treatment or other care in advance of the practitioner confirmation, whenever appropriate, based on the resident's needs. Regardless, enhanced services can only be paid under the Initiative if the practitioner confirms a qualifying diagnosis.

CMS understands that in rare situations, more time may be needed. If the practitioner confirmation occurs three or four days after an eligible resident presents with symptoms that meet the clinical criteria (i.e., on Day Four or Day Five of the episode), the facility may still be eligible to receive payment for part of the episode (see Scenario 2, Secondary Confirmation Window, below). In these cases, the facility **is not** permitted to begin back billing to the start of the episode. The facility must begin billing on the day of the practitioner confirmation and **only** for the remaining days of the episode. The facility is not granted a new seven-day billing window and is only permitted to bill for the **remainder** of the episode. For example, if a practitioner cannot confirm a pneumonia diagnosis until Day Four, the facility may only bill for Days Four through Seven, and cannot bill for Days One to Three. Re-confirmation rules beyond Day Seven (see Section 3 below) remain in effect.

For best patient care, these situations should only occur in unusual circumstances, for example when events were out of the control of the practitioner or facility, such as severe weather issues or other natural disasters. CMS reserves the right to investigate facilities that submit frequent claims under these circumstances to ensure that residents are receiving appropriate care.

If the practitioner confirmation visit occurs any time after the Secondary Confirmation Window, the facility is **not** eligible for payment for that episode.

Scenario 2: Secondary confirmation window

Day One	Day Two	Day Three	Day Four	Day Five	Day Six	Day Seven
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Primary practitioner confirmation visit window			Secondary window for practitioner confirmation*; confirmation occurs no later than Day Five			
Eligible resident presents with pneumonia symptoms that meet clinical criteria Enhanced treatment begins	Enhanced treatment continues	Enhanced treatment continues	Practitioner confirmation visit occurs Enhanced treatment continues	Enhanced treatment continues	Enhanced treatment continues	Last billable day for episode†
Not eligible for billing	Not eligible for billing	Not eligible for billing	Facility eligible to bill for G9679	Facility eligible to bill for G9679	Facility eligible to bill for G9679	Last day facility is eligible to bill G9679*
* The facility **is not** granted a new seven-day billing window if the practitioner confirmation visit occurs during the secondary window. Facilities are only permitted to bill for the *remainder of the episode*. † Unless a successful re-confirmation occurs. Please see Section 3. Re-confirmation of a Qualifying Diagnosis						

3. Re-confirmation of a Qualifying Diagnosis

If the resident remains acutely ill, an additional episode of care may be triggered as long as the resident meets the qualifying diagnosis criteria for a condition. There is no requirement for a gap between benefits if the qualifying criteria **persists after seven days.** In these instances, a second practitioner confirmation visit **is required** to permit the facility to bill. In these cases, the practitioner confirmation visit must occur no later than Day Ten, which is the end of the second day after the facility determined that the resident continues to meet the qualifying diagnosis criteria. **There is no secondary confirmation window for a re-confirmation.**

Scenario 3: Practitioner Re-Confirmation beyond initial period

Day Eight	Day Nine	Day Ten	Day Eleven	Day Twelve	Day Thirteen	Day Fourteen
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Practitioner re-confirmation visit occurs in this window, confirmation occurs no later than Day Ten						
Facility determines that the eligible resident continues to meet the clinical criteria for pneumonia Enhanced treatment continues	Enhanced treatment continues	Enhanced treatment continues	Enhanced treatment continues	Enhanced treatment continues	Enhanced treatment continues	Last billable day for episode†
Facility eligible to bill for G9679	Facility eligible to bill for G9679	Facility eligible to bill for G9679	Facility eligible to bill for G9679	Facility eligible to bill for G9679	Facility eligible to bill for G9679	Last day facility is eligible to bill G9679
† Episodes requiring additional re-confirmations should be extremely rare. Facilities are reminded to maintain appropriate documentation of any unusual circumstances.						

For fluid/electrolyte disorders, normally limited to five-day episodes, a practitioner re-confirmation would need to occur no later than Day Eight.

Scenario 4: Practitioner Re-Confirmation beyond initial period for fluid/electrolyte disorders

Day Six	Day Seven	Day Eight	Day Nine	Day Ten
Saturday	Sunday	Monday	Tuesday	Wednesday
Practitioner re-confirmation visit occurs in this window, confirmation occurs no later than Day Eight				
Facility determines that the eligible resident continues to meet the clinical criteria for fluid disorder Enhanced treatment continues	Enhanced treatment continues	Enhanced treatment continues	Enhanced treatment continues	Last billable day for episode†
Facility eligible to bill for G9683	Facility eligible to bill for G9683	Facility eligible to bill for G9683	Facility eligible to bill for G9683	Last day facility is eligible to bill G9683
† Episodes requiring additional re-confirmations should be extremely rare. Facilities are reminded to maintain appropriate documentation of any unusual circumstances.				

4. Special Billing Rules for Urinary Tract Infections

Urinary tract infections (UTIs) require as part of the qualifying diagnosis the presence of ≥100,000 colonies of bacteria growing in the urine with no more than 2 species of microorganisms. CMS understands that, in some instances, it may take more than 48 hours to obtain urine culture results, complicating the practitioner's ability to confirm that the UTI meets the clinical criteria.

If the results from the urine culture are not yet available at the time of the practitioner confirmation visit, then 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 starting on Day One, based on this *presumptive diagnosis* while waiting for final culture results. However, if the urine culture results indicate that the resident does not meet the qualifying criteria after all, the facility should discontinue billing that same day; no additional practitioner visit is necessary. Because of the time needed for a urine culture, CMS allows this UTI *presumptive diagnosis* as an exception to the general rule for requiring qualifying diagnoses to be confirmed at the time of practitioner visit.

Scenario 5: UTI Presumptive Diagnosis (Culture meets the clinical criteria for a UTI)

Day One	Day Two	Day Three	Day Four	Day Five	Day Six	Day Seven
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Practitioner confirmation visit occurs in this window, confirmation occurs no later than Day Three						
Eligible resident presents with UTI symptoms Urine sample collected and sent to laboratory Enhanced treatment begins	Enhanced treatment continues	Enhanced treatment continues	Urine culture confirms ≥100,000 colonies of bacteria Enhanced treatment continues	Enhanced treatment continues	Enhanced treatment continues	Last billable day for episode†
Facility eligible to bill for G9684	Facility eligible to bill for G9684	Facility eligible to bill for G9684	Facility eligible to bill for G9684	Facility eligible to bill for G9684	Facility eligible to bill for G9684	Last day facility is eligible to bill G9684
† Unless a successful re-confirmation occurs. Please see Section 3. Re-confirmation of a Qualifying Diagnosis						

Scenario 6: UTI Presumptive Diagnosis (**Does Not** meet the clinical criteria for a UTI)

Day One	Day Two	Day Three	Day Four	Day Five	Day Six	Day Seven
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Practitioner confirmation visit occurs in this window, confirmation occurs no later than Day Three						
Eligible resident presents with UTI symptoms Urine sample collected and sent to laboratory Enhanced treatment begins	Enhanced treatment continues	Enhanced treatment continues	Urine culture returned with ≤ 100,000 Colonies of Bacteria			
Facility eligible to bill for G9684	Facility eligible to bill for G9684	Last day facility is eligible to bill G9684	Not eligible for billing	Not eligible for billing	Not eligible for billing	Not eligible for billing

5. Regarding Skin Infections

Since the qualifying diagnosis criteria for a skin infection requires the use of oral or parenteral antibiotic (or antiviral) therapy, the first day of billing would begin only when a practitioner prescribes oral or parenteral antibiotic (or antiviral) therapy.

While a resident may present with other skin infection symptoms (such as a fever with indurated skin, etc.), the qualifying diagnosis is not complete without an order for the antibiotic. Typically, a practitioner would make this determination at the time of their in-person assessment. Therefore, in these situations, billing for skin infections can only begin on the day the practitioner prescribes the oral or parenteral antibiotic (or antiviral) therapy, not necessarily when the resident began showing symptoms.

Scenario 7: Skin Infection Requiring Antibiotic or Antiviral Therapy

	Day One	Day Two	Day Three	Day Four	Day Five	Day Six	Day Seven
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Monday
Practitioner confirmation visit occurs in this window, confirmation occurs no later than Day Two							
Eligible resident presents with skin infection symptoms Enhanced treatment begins	Practitioner prescribes oral or parenteral antibiotic/antiviral therapy for the skin infection Enhanced treatment continues	Enhanced treatment continues	Enhanced treatment continues	Enhanced treatment continues	Enhanced treatment continues	Enhanced treatment continues	Last billable day for episode**Ŧ**
Facility does not bill G9682 because antibiotic or antiviral therapy has not begun as required in the qualifying diagnosis criteria	Facility eligible to bill for G9682	Facility eligible to bill for G9682	Facility eligible to bill for G9682	Facility eligible to bill for G9682	Facility eligible to bill for G9682	Facility eligible to bill for G9682	Last day facility is eligible to bill G9679
Ŧ Because the skin infection qualifying diagnosis criteria requires a **NEW** infection, it is not possible to recertify the same skin infection for an additional episode of care.							