



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

Practitioner Participation

Last updated June 13, 2016

Computing average panel

1. A practitioner's average panel in the facility was 9 over the last 6 months. The figure of 9 includes 3 short stay patients and 6 long stay residents. Does the practitioner qualify for the payment reform initiative?

A: No, average panel must be at least 7 long-stay patients

2. What if a patient is considered long stay (101+ days) as of March, but in fact was admitted in January and was seen by the same practitioner from admission. Does this resident count in the practitioner's January and February resident count? Or is the resident not counted until March when she became long- stay?

A: The patient may be considered long-stay for the entire duration.

3. If a practitioner sees residents at more than one facility does he have to maintain an average panel of residents at each facility, or just one total?

A: The panel must be seven residents per facility. Nevertheless, we recognize that a panel may fluctuate throughout the period of performance, and CMS will address these fluctuations on a case by case basis

4. If a practitioner is hired and salaried by a facility as an employee as of July 2016, and the practitioner is responsible for 50 long stay residents every day, does the practitioner still have to wait six months – until January 2017 – to participate?

A: In theory, if the practitioner had an average panel of 14 long-stay residents for three months (July-September) and 0 residents for the previous three months (April-June) – resulting in an average of 7 for the six months combined – the practitioner could be eligible in October 2016. However, the practitioner would still need to be vetted and approved by CMS.

Provider eligibility

5. If a non- physician providers (NPs, PAs) are not listed as the provider of record, but works with an enrolled physician, could that NP bill if completing the certification visit on behalf of the physician?



A: Approved practitioners will be identified by individual NPI. Only claims submitted by approved NPIs will be paid.

6. Would a medical resident be able to bill if under the supervision of an enrolled provider? They may not have a panel of patients assigned to them.

A: Approved practitioners will be identified by individual NPI. Only claims submitted by approved NPIs will be paid.

7. Can a separate corporation within a nursing home chain which has nurse practitioners bill for the confirmation and care conferences?

A: Approved practitioners will be identified by individual NPI. Only claims submitted by approved NPIs will be paid.

Nursing Facility Conference

8. What are the documentation requirements for the Nursing Facility Conference for care coordination?

A: Per the FOA, the practitioner must document the conversation in the beneficiary's medical chart. This documentation should address the requirements described in the FOA (i.e. that the beneficiary and/or individual(s) authorized to make health care decisions for the beneficiary (as appropriate) was present; that the conference was for a minimum of 25 minutes; and that at least one member of the LTC facility interdisciplinary team was present.)

9. Given the complex clinical conditions of many of the residents in our facility, we expect that we may have to have a Nursing Facility Conference frequently for some of these residents (for example, if there are six hospital transfers within a six month period, we would want to have the Conference at least six times). Please confirm that assuming all documentation requirements are met, that this would be permissible.

A: Per the FOA, the Conference code can be billed only once per year in the absence of a significant change in condition. The code can also be billed within 14 days of a significant change in condition, which should be documented in the beneficiary's chart and include an MDS assessment (Significant Change in Status Assessment or equivalent).

10. If an approved practitioner comes and sees a resident for a change in condition and it is confirmed to be a qualifying condition; then they see the resident and family later that day with a LTC staff member for a care coordination conference lasting at least 25 minutes, can they bill both codes in the same day?

A: Yes.



Confirming diagnosis for facility payment

11. Is it correct that regardless of a practitioner's participation in Phase Two, they can still provide a confirming diagnosis to initiate facility payment? Must the practitioner be the resident's physician of record (primary care physician) or can this be someone that the home designates to conduct the confirming diagnosis?

A: Any attending practitioner can provide the confirming diagnosis for the purposes of facility payment.

12. If there is a cross-covering practitioner (i.e. weekend coverage) who is **not** an eligible and participating practitioner confirm diagnosis? Can he/she be a "partner" who does not bill but confirms diagnosis for the home to bill? Can we arrange coverage for this with other eligible and participating practitioner, or just use the ECCP staff?

A: Any attending practitioner can provide the confirming diagnosis for the purposes of facility payment.

13. Will a provider, who is not enrolled/ eligible in the project, be required to complete training to be informed and to comply with requirements for certification for the facility to be eligible to bill for services?

A: No, facilities may make whatever arrangements they deem appropriate to obtain a confirming diagnosis.

Miscellaneous

14. Does a practitioner's participation in Phase Two of the NFI qualify as an Alternative Payment Model (APM) as that term is used in the Medicare Access and CHIP Reauthorization Act (MACRA)?

A: No, NFI is not an eligible APM for the purposes of MACRA requirements.

15. Would a separate facility specific provider LOI be needed if an eligible provider works at several buildings and meets all of the eligibility criteria?

A: A single LOI is acceptable as long as the LOI identifies the facilities where the practitioner would be eligible.

16. The practitioner has the ability to perform a telemedicine visit; is the reimbursement the same for a telemedicine visit? (Assuming documentation of this visit is done).

A: Yes, standard CMS rules for telemedicine would still apply.



Confirmation diagnosis

17. We have been under the assumption that our ECCP staff or a Telemedicine visit can confirm a diagnosis for facility payment and if the Practitioner who is approved for Phase Two sees a resident for a Face-to-Face within 48 hours can still bill at the increased Initial visit rate. A prime example of this would be if we saw a resident on the weekend via Telly and on Monday the practitioner assesses the resident for the change in condition that was being reported.

A: This is correct, as long as the practitioner visit occurs within two days of the change in condition.

18. What does the flow chart look like – does the facility have to raise a flag first that the 6 conditions are being considered, starting the 2 day clock?

- a. Could every acute change in condition visit be billed under this new code? That's not the intent, but you could argue that one of the six conditions could be on the differential for a whole range of chief complaints.
- b. What if the provider is in the building when the change is noted and the nurse taps the doctor on the shoulder to see the patient – there wouldn't be a paper trail in that case of the facility alerting the provider it might be one of the six conditions, etc.

A: The facility may not bill unless the diagnosis has been confirmed. If treatment for the condition begins before the official confirmation, the facility may bill retroactive to the start of treatment as long as the confirmation occurs no more than two days afterward.

Documentation and reporting

19. What are the documentation requirements for the new practitioner's Acute Nursing Facility Care code? Are they the same as the requirements for an initial SNF visit of high complexity, or a follow up?

A: The new code essentially substitutes for CPT code 99310 and the same documentation requirements would generally apply. The patient record should either reflect a diagnosis of one of the six targeted conditions, or state that one (or more) of the six conditions was suspected, considered, or ruled out. Per the FOA: *Also, a practitioner may bill for the "Acute nursing facility care" service even if the service is furnished because a LTC facility suspects that a beneficiary has one of the six targeted conditions, but upon examination it turns out that the beneficiary does not have such a condition.*

20. Will provider be required to provide specific data when triggering the billing code?

A: No, the provider would bill the same way they bill all other Medicare fee-for-service claims. However, there will be separate requirements for providers to submit other data to CMS (via the



ECCP), pertaining to demonstration activities, on a regular basis; further information on data submission requirements will follow at a later date.

Practitioner billing

21. The 2017 Medicare Physician Fee Schedule (PFS) notice of proposed rulemaking (NPRM) is expected to be released in late June/early July, finalized on or about November 1, and go into effect January 1, 2017. We understand that the new code numbers and policies associated with the Nursing Facility Initiative (NFI) will be included in the 2017 PFS NPRM. Given the effective date for new billing under the NFI is October 1, 2016, how does CMS plan to ensure that practitioners and skilled nursing facilities participating in the NFI will be able to start billing under the newly established codes as of October 1, 2016? Will CMS issue a One-Time Notification (OTN) to the relevant carriers to make them aware of the new codes that will become effective as of October 1, 2016? If so, when will that OTN be issued?

A: The codes and instructions will be released in October as part of the quarterly update to the Physician Fee Schedule.

22. Can a separate corporation within a nursing home chain which has nurse practitioners bill for the confirmation and care conferences? If the NP within this separate corporation is currently billing for the services they provide in a nursing home, does this trump that billing?

A: Providers may not bill twice for the same service. Only participating providers (as identified by individual NPI) are permitted to bill the new codes.

Monitoring

23. Is the ECCP and/or facility required to monitor dates of licensure and report them to the CMS Operations Subcontractor (OSC)? If a practitioner's license is scheduled to expire in the upcoming month, is the ECCP expected to alert the practitioner, facility, CMS, or the OSC?

A: There is no requirement or expectation. CMS conducts routine licensing checks on all providers. However, if ECCP staff become aware of any licensing issues during the Initiative, the ECCP should discuss with CMS.



Resident panel

24. A practitioner's total long-stay resident panel for all the months for the prior six months was 39, yielding an average resident panel per month of 6.5. Does the practitioner qualify for the payment reform initiative?

A: No, average resident panel across the six month period must be 7 or more.

25. Regarding the stipulation that practitioners have at least 7 residents - can that be cumulative over all homes in the project instead of a 7 at each facility? If so, can the residents be across both Group A and Group B facilities?

A: The panel must be seven residents per facility.

26. A provider's patient load is changing daily due to admissions and discharges. Since this is not a static number throughout a calendar month, how will this be viewed regarding billing submissions?

A: Routine fluctuations in caseload would not affect practitioner eligibility. We would only ask ECCPs and NFs to notify CMS if there are major declines in a practitioner's panel beyond routine fluctuations. Regardless, ECCPs should verify that each practitioner's panel meets the Initiative's requirements at least once per year.

27. How do we enroll large provider group who all see the same panel of residents, and may not be listed as separate patient panels. How can they bill for the certification visit.

A: Residents may count toward more than one practitioner's panel. However, practitioners are enrolled on an individual level, and provider eligibility will be tracked by NPI not by group.

28. Can CMS generally provide more detailed information about how it expects a participating facility to determine when a resident is considered to be part of a practitioner's panel for purposes of participating in the payment reform initiative? Is it up to the facility to make that determination? Is it based on chart documentation?

A: Generally, CMS expects each practitioner would be able to demonstrate a treatment relationship with at least seven residents over time. This relationship may be documented in the residents' chart, recorded via notes or lab orders, or listed as billing for services provided to the resident. It will be incumbent upon the facilities and practitioners to attest that the practitioners have an established panel of residents, even if the practitioner is not formally listed as the practitioner of record. As noted above, a resident may count toward more than one practitioner's "panel".

29. In some facilities, the "physician of record" (and therefore who would count in the census for purposes of our program) is the facility medical director. However, the medical director may not actually see any of the patients and instead of physicians may have more care responsibilities for that person. However, because the medical director is the



officially listed person, there isn't really a way to "prove/show" that these other physicians may actually carry a panel of 7 or more patients (because they're all attributed to the medical director). I think the question here is can they look at charts to see if physicians have treated 7+ people in the facility in order to qualify or do we have to follow who is officially listed in their chart?

A: See response to previous question.

30. In many facility when a PA or NP treats to the patient, the chart/responsibility is actually accredited to the patient's physicians and not to the NP/PA. In this way, they always list the doctor on things. For purposes of this demo, how can the NPs/PAs be included if the official records all attribute care to the physician (how can they show the patient panel of 7+ when all official records are listed with the physician even is she/he didn't provide care).

A: See response to previous question.

31. If Dr. Y cross-covers Dr. X on weekends and Dr. Y visits several of Dr. X's residents in response to an acute change of condition, please confirm that those residents can now count toward Dr. Y's resident panel.

A: If Dr. Y is not already participating in the model, the ECCP will need to submit a signed Letter of Intent for CMS consideration. It is incumbent upon the facilities and practitioners to attest that each practitioner has maintained relationships with an established panel of residents. These treatment relationships should persist over a period of time, not just be a one-time visit.

32. If Dr. Y cross-covers Dr. X on weekends and Dr. X has wound up visiting a resident less frequently than Dr. Y, please confirm that the applicable resident can still count on both practitioner's panels for purposes of calculating an average daily census for the payment reform initiative.

A: Yes, residents may count toward more than one practitioner's panel. Relative frequencies of visits do not matter as long as both practitioners maintain a treatment relationship with the resident over a period of time.