



Updated Guidance for Practitioner Participation in the Initiative to Reduce
Avoidable Hospitalizations among Nursing Facility Residents – Payment Reform
Last updated December 10, 2018

CMS is issuing updates and clarification on some of the rules and requirements for practitioner participation in the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents – Payment Reform (the Initiative). This guidance is aimed at practitioners that intend to partner with long-term care (LTC) facilities and awarded enhanced care and coordination providers (ECCPs).

The below guidance provides updates and clarifications from the Funding Opportunity Announcement (FOA) originally issued on August 27, 2015 which can be found at <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NFInitiativePhaseTwoFOA.PDF>.

Updates from previous versions of this Guidance include:

- NFI will cease reimbursement for care conferences as of December 31, 2018. Please see updating billing criteria on the NFI web page for more detail: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/InitiativetoReduceAvoidableHospitalizations/Downloads/NFIHCPCSCodesAndClinicalCriteria_12019.pdf
- We have added revised documentation standards for Acute Nursing Facility Care, effective January 1, 2019

Answers to common questions about practitioner participation may also be found at <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NFGuidancePractitionerParticipationFAQ061316.pdf>

Background: New and Enhanced Payments to Practitioners

- **Evaluation and Management of Beneficiaries (visits)**

This model tests a new payment under the Medicare physician fee schedule that can be billed by a practitioner for an initial visit to treat an acute change in condition in the LTC facility. Payment for the service would be based on the condition of the resident rather than whether the service is furnished in a hospital or LTC facility setting. In other words, when a practitioner sees a beneficiary in the LTC facility for an acute change in condition, the practitioner would be paid for the service at the equivalent of an acute hospital initial visit code.

The requirements are similar to other E&M codes involving moderate to high complexity. The proposed payment code (G9685) and amount will be included in the Medicare physician fee schedule for 2016 and later years and is based on the same Resource Value Units (RVUs) as CPT code 99223 (Initial Hospital Care).

This new code may only be used for the practitioner's first visit in an LTC facility in response to a beneficiary who has experienced an acute change in condition (to confirm and treat the diagnosed conditions). Subsequent visits for the same condition(s) would be billable at current rates using existing codes. In general, the average increase as compared to the existing fee would be approximately \$70. The intent of this payment change is to decrease the financial benefit for a physician to transfer a beneficiary to the hospital, and create an incentive for the physician to visit and treat the beneficiary in the LTC facility, contributing to the reduction of avoidable hospitalizations.¹

Also, a practitioner may bill the new code for this 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.

[NEW] Beginning January 1, 2019, NFI is adopting the simplified documentation standards relating to "Removing Redundancy in E/M Visit Documentation" first proposed by CMS on July 27, 2018 (See [Federal Register, Vol. 83, No. 145](#), page 35838) and [finalized on November 1](#). Effective January 1, 2019, for established patient office and outpatient E/M codes, for the comprehensive patient history and examination, when relevant information is already contained in the medical record, practitioners will only be required to focus their documentation on what has changed since the last visit or on pertinent items that have not changed, rather than re-documenting a defined list of required elements such as review of a specified number of systems and family/social history. We expect that practitioners will still conduct clinically relevant and medically necessary elements of history and physical exam, and conform to the general principles of medical record documentation for E/M codes. However, practitioners will not need to

¹ Note: ECCP staff are not permitted to bill Medicare for services provided as a part of this Initiative. Non-ECCP practitioners may still bill the new codes for their first visit even if the beneficiary was already seen and diagnosed by an ECCP clinician.

re-record these elements (or parts thereof) if there is evidence that the practitioner reviewed and updated the previous information.

Although the finalized CMS policy described above applies only to office and outpatient E/M codes, we believe that these standards are also appropriate for the subset of practitioner visits described by HCPCS code G9685 associated with this time-limited demonstration. As such, effective January 1, 2019, we are applying this new documentation standard to NFI demonstration HCPCS code G9685.

- **[2016-2018 ONLY] Practitioner payment for care coordination and caregiver engagement**

To increase practitioner involvement in person-centered care coordination with beneficiaries (and/or engagement with the individual(s) authorized to make health care decisions on their behalf), this model also includes a payment to create an incentive for practitioners to participate in nursing facility conferences that engage in care coordination discussions with beneficiaries, their caregivers, and the LTC facility interdisciplinary team. Examples of care coordination discussions include the following:

1. Review of the resident's history of present illness and current health status;
2. Typical outcomes, scenarios, events, or prognosis for beneficiaries with similar conditions;
3. The resident's daily routine (e.g., waking time, eating preferences, other habits, etc.) to help the facility deliver person-centered care;
4. Measurable goals agreed to jointly by the resident, representative(s), caregiver(s), and the interdisciplinary care team;
5. A description of the resident's risk for hospital admission and emergency department visits and all necessary interventions to address the underlying risk factors;
6. Discussion of clinically appropriate preventive services and the facility's capabilities to treat certain conditions in house
7. The development, updating, or confirmation of a person-centered care plan, including if possible an interoperable electronic person centered care plan.
8. Discussion with the resident, family, and/or other legally responsible individual about the resources that would be needed, and the residents ability to potentially be discharged to the community
9. Establishment of a health care proxy where necessary.

In order to bill code G9686 for this service, the practitioner must conduct the discussion:

- with the beneficiary (and/or individual(s) authorized to make health care decisions for the beneficiary, as appropriate)² and at least one member of the LTC facility interdisciplinary team present;
- 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)

The practitioner must also document the conversation in the beneficiary's medical chart. This documentation should include information on the above requirements of the conversation. Where possible, the documentation could be created electronically in the LTC facility's EHR and electronically exchanged with the practitioner and other members of the interdisciplinary team.

The amount for physicians to furnish this activity will be included in the Medicare physician fee schedule in 2016 and later years and is based on the same RVUs as CPT code 99214 (Office or other outpatient visit for established patient).

The code can be billed only once per year in the absence of a significant change in status. The code can also be billed within 14 days of a significant change in status that increases the likelihood of a hospital admission; in that case, the significant change must be documented in the beneficiary's chart and be reflected in a comprehensive MDS assessment.

Detailed billing criteria for both facility and practitioner codes can be found on the NFI web site:

https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/InitiativeToReduceAvoidableHospitalizations/Downloads/NFIHCPCSCodesAndClinicalCriteria_12019.pdf

Original criteria for services on or before December 31, 2018 can be found below **for reference only**.

² In general, the conference should be face-to-face with either the beneficiary or at least one authorized representative. In unusual circumstances – i.e., the beneficiary is incapacitated or incompetent and no authorized representatives are nearby – telephone participation is acceptable as long as the practitioner has an existing treatment relationship with the beneficiary. The practitioner should document these unusual circumstances in the beneficiary's medical record.

<i>Purpose</i>	<i>Description</i>	<i>Practitioner Clinical Criteria (2016-2018 ONLY)</i>
<i>Acute Nursing Facility Care (G9685)</i>	Physician or other qualified health care professional service for the evaluation and management of a beneficiary's acute change in condition in a nursing facility.	<p><u>Key Components Required:</u></p> <ul style="list-style-type: none"> • A comprehensive review of the beneficiary's history • A comprehensive examination • Medical decision making of moderate to high complexity. • 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. <p><u>Maximum Benefit Period:</u> Code can be billed once per day for a single beneficiary.</p>
<i>Nursing Facility Conference (G9686)</i>	Participation in an onsite nursing facility conference with the resident and/or resident's representative, that is separate and distinct from an evaluation and management visit, including a physician, or other qualified health care professional and at least one member of the nursing facility interdisciplinary care team.	<p><u>Qualification Criteria</u></p> <p>In order to qualify for payment, the practitioner must conduct the discussion:</p> <ul style="list-style-type: none"> • 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 • Include at least one member of the LTC facility interdisciplinary team. • The practitioner must also document the conversation in the beneficiary's medical chart. • The acute change in condition should be documented in the beneficiary's chart. <p><u>Maximum Benefit Period:</u> The code can be billed only once per year. Exception: The code can also be billed within 14 days of a significant change in condition that increases the likelihood of a hospital admission, even if the code had already been billed in the preceding twelve months; in this case, a Significant Change in Status Assessment is required.</p>

Practitioner Vetting and Continued Program Participation

CMS retains the right to modify or waive any of the required criteria for participation and the right to approve or terminate any practitioner's participation in the Initiative.

To protect the integrity of program and safeguard beneficiaries, CMS will implement periodic vetting checks of participating practitioners. For example, if a practitioner has had licensure or certification suspended; if a practitioner has had any sanctions, indictments, probations, corrective action plans, or judgments imposed in the last three years relating to fraudulent or abusive billing practices; or if a practitioner has been excluded from participation in the Medicare or Medicaid, CMS will reconsider whether the practitioner should continue to participate in the Initiative.

CMS retains the right to take action (e.g. termination, suspension, withholding payments) at any time throughout the Initiative if CMS believes that improper practices are occurring or beneficiaries are not receiving the enhanced care expected under this model.

Phase II Data Elements for Collection from Groups A and B Nursing Facilities

To participate in the Initiative, all practitioners must agree to coordinate with partnering ECCPs on sharing data and information, in compliance with applicable privacy requirements, necessary for the operations and evaluation of the Initiative and the care of beneficiaries in accordance with regulations governing CMS payment and service delivery models ([42 CFR 403.1110](#)).

Data collection is a necessary component of program oversight, monitoring, evaluation, and integrity and is required by regulation. CMS will prescribe the required data elements to be collected by practitioners prior to the start of the program on October 1, 2016. Practitioners and ECCPs should work together to determine the most efficient method of data collection. This includes signing all necessary legal agreements for the sharing of beneficiary data. CMS currently expects that ECCPs will be responsible for compiling and reporting the data to the CMS operations support contractor; further details will be provided at a later date.

Failure to comply with data collection standards under 42 CFR 403.1110 may result in termination from the Initiative.

Operations Support Contract Site Visits and Chart Reviews

Participating nursing facilities will also agree to respond to requests from CMS or its contractors (operations support contractor or evaluation contractor) for the purpose of oversight, monitoring, or evaluation. This may include requests to participate in conference calls, submit data, conduct chart reviews, conduct site visits, and/or participate in surveys.

As part of program monitoring and to ensure integrity of the program, the operations support contractor will conduct yearly site visits to select nursing facilities to conduct chart reviews. These chart reviews will determine whether a beneficiary was eligible for billings, whether the nursing facility and practitioner followed the clinical criteria and recommendations, and whether each beneficiary received appropriate care in the appropriate setting. Claims data will be used in conjunction with site visits for program monitoring.

Practitioners may be interviewed or asked to participate with contactors during site visits and chart reviews. Failure to comply may result in termination from the Initiative.

Practitioner Regulatory and Demographic Criteria

In order for practitioners (i.e., MD, NP, PA) to participate, they must follow the below criteria:

- Have carried an average panel (daily census of beneficiaries) of at least seven long-stay FFS Medicare beneficiaries in the affiliated participating LTC facility over the most recent six months;
- Have all licensure and certification in good standing;
- Not have had any sanctions, indictments, probations, corrective action plans, or judgments imposed in the last three years relating to fraudulent or abusive billing practices; and
- Not be excluded from participation in the Medicare or Medicaid programs.

Note that ECCPs shall give preference to recruiting practitioners that use technology to support interoperable health information exchange (for example use technology that supports the creation and exchange of electronic care plans and creation and exchange of interoperable transition of care summary documents)

Practitioner Recruitment after Initial Launch

For practitioners not on the initial ECCP lists of proposed participants, CMS will accept new practitioner Letters of Intent (LOIs) from ECCPs on a monthly basis, beginning September 15, 2016. Please allow a minimum of three months following submission for CMS approval.

Each LOI should clearly state that if the practitioner were selected and approved for participation, he/she would adhere to the following attestations (at a minimum):

- a) An attestation that the practitioner meets all the regulatory and demographic criteria listed above. This should include the practitioner's average panel (daily census of beneficiaries) of long-stay FFS Medicare beneficiaries in the corresponding participating LTC facility over the most recent six months.
- b) A statement agreeing to adhere to the requirements and qualifying criteria listed above to receive payment under this Initiative.
- c) A statement agreeing to participate with the learning community for the Initiative (e.g., attend events, webinars, etc.).
- d) A statement agreeing to participant reporting requirements outlined by 42 CFR 403.1110). This includes responding to requests from the ECCP, CMS, or its contractors for the purposes of oversight, monitoring, or evaluation, such as requests to participate in conference calls, submit data, conduct chart reviews, conduct site visits, and/or participate in surveys (e.g., phone or internet).
- e) A statement committing to make the best available decisions for care for beneficiaries at all times regardless of payments received through the Initiative. There shall be no withholding of care or services in lieu of payments. Beneficiaries' freedom of choice shall not be restricted.
- f) (For ECCP+Payment Group) A statement committing to continue to partner with the ECCP on all relevant aspects of the clinical interventions. This includes regular communication, coordinating care, adhering to previous commitments or agreements, or any other activities that are part of the original ECCP's interventions' design.
- g) A statement agreeing to apply the payment model under this Initiative exclusively to the target population.
- h) A statement of the practitioner's commitment to meeting³ and maintaining adherence to the above criteria through the end of the Initiative. (We note that a practitioner's ability to maintain adherence to the demographic criteria, such as an average panel of seven residents in the target population over the most recent six months, may be outside of the practitioner's control and may fluctuate throughout the period of performance. CMS will address these fluctuations on a case by case basis).
- i) A statement accepting the Medicare waivers that would apply to the Initiative (see below).
- j) A statement regarding whether the practitioner uses an ONC-certified EHR and whether the practitioner uses health IT for care planning or the creation and exchange of transition of care documents.

³ Practitioners may submit LOIs before fully meeting all demographic and regulatory criteria. In that case, the LOI should state when practitioner expects to meet all criteria, and ECCPs are responsible for verifying that this occurs before final approval for participation.

- k) A commitment to promptly communicate any changes in the practitioner's information to the ECCP and CMS or its contractors (e.g., change of practice ownership, TIN, NPI, CCN, etc.).

ECCPs are responsible for screening practitioners and verifying facility support before submitting new practitioner LOIs.

On or before the 15th of each month, beginning in September 2016, ECCPs should submit LOIs to CMS for each newly-proposed participant, ECCPs should also include a practitioner submission grid (FOA Appendix C) with complete information on the newly-recruited practitioners who have submitted signed LOIs to be considered for participation. Upon preliminary CMS approval of the lists, CMS will begin the vetting process.

After practitioners have undergone both CMS and law enforcement vetting, CMS will notify each ECCP of the practitioners that have passed vetting and are approved to become participants. This will include the CMS decision date and the effective start date for the practitioner.

Practitioners will be notified when CMS approves or disapproves each practitioner's participation and will receive further instructions at that time.

Questions about claims

Practitioners seeking assistance with specific claims should contact their local Medicare Administrative Contractor (MAC). A list of MACs operating in the states served by the Initiative can be found below. Practitioners may wish to reference Change Request 8809. Practitioners who do not get a satisfactory answer from the MAC should contact their ECCP.

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>

Also, please see the following Medicare Learning Network articles:

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9749.pdf>

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1636.pdf>

Medicare Payment Policy Waivers

In accordance with section 1115A(d)(1) of the Social Security Act (the Act), CMS finds that it is necessary for purposes of testing the Initiative to waive certain payment provisions. CMS may also determine, in its sole discretion, that it is necessary to waive other Medicare payment provisions for purposes of testing this model. CMS reserves the right to reconsider these waivers and to modify or terminate the waivers at any time.

Waivers are described below for reference only.

Treatment for six designated conditions

Section 1861(s) of the Act defines the “medical and other health services” payable under Medicare Part B. CMS waives the locational requirement for the medical and other health services described in section 1861(s)(2)(B) to allow for acute nursing services furnished by participating nursing facilities to be paid for under Part B.

Physician Fee Schedule

Section 1848(a)(1) of the Act requires that payment amounts for physicians’ services be determined under the Physician Fee Schedule (PFS). CMS waives this requirement to allow payment to be made as described in the FOA for this Payment Reform Initiative. CMS may adjust the payment amounts specified in the FOA on an annual basis, including payments both to practitioners and to nursing facilities. These updates would occur through a process that would parallel the annual PFS updates. As part of this process, CMS will notify all NFI participants in advance of any such adjustment and provide an opportunity for comment.

Coinsurance

Section 1833(a)(1)(N) of the Act requires beneficiary coinsurance for physicians’ services by setting payment at 80 percent of the Medicare rate. CMS waives that requirement for the new payments described in the FOA for this Payment Reform Initiative.

Deductible

Section 1833(b) of the Social Security Act requires that Part B services be subject to a deductible. CMS waives that requirement for the new payments described in the FOA for this Payment Reform Initiative.