CMS Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents
Phase 2--Payment Model
The Revolving Door

• One fourth of all nursing home resident go the hospital each year - Some many times

• Number of transfers from nursing home to hospital in 2011
  – 68 percent transferred one time
  – 20 percent transferred two times
  – 7 percent transferred three times
  – 5 percent transferred four or more times.
Many Factors Influence Hospitalization

• Clinical status
• Adequacy of communication systems
• Preferences of resident and family
• Training and number of nursing staff
• Availability and preference of practitioners
• Payment / economic factors.
Factors and Incentives that Influence Decision to Hospitalize LTC Patients

- Medicare Reimbursement Policies for Hospitals, NH, HHA, and MDs
- Patient and Family Preference
- Availability of Individual Patient Advance Care Plans and MD Orders for Palliative or Hospice Care
- Concerns about Legal Liability and Regulatory Sanctions
- ED Time Pressures and Availability of Community-Based Care Options after ED Discharge
- Availability of Trained MDs, NPs, PAs, RNs in LTC settings
- Availability of Diagnostic and Pharmacy Services in LTC Settings
Penalties for Hospitalization

• Re-hospitalization for common conditions
  – Hospitals currently
  – Nursing homes just added

• Bundling payments for common conditions

• ACO models
  – Direct to attributed physician
  – Indirect to home and system
Diagnosis Associated with NH resident Hospitalizations

• Septicemia (13.4%)
• Pneumonia (7%)
• Congestive heart failure (5.8%)
• UTI (5.3%)
• Aspiration pneumonia (4%)
• Acute renal failure (3.9%).
Avoidable NH Hospitalizations

• Up to 60% of all hospitalizations may be avoidable
• 72% of all avoidable hospitalizations are due to 4 common conditions:
  – Pneumonia (30.5%)
  – Congestive heart failure (16.8%)
  – Dehydration (12.9%)
  – UTI (11.7%)
Potential Cost Savings Huge

- Medicare costs hospitalized NH residents
  - Septicemia - $3 billion dollars
    (average $17,000 per case)
  - Pneumonia (all types) - $1.5 billion dollars
    (average $10,000 per case)
- Costs of treating such conditions in NH not well estimated
- Undoubtedly far less than the average Medicare Part A hospital reimbursement
Payment Model

• Six Enhanced Care and Coordination Providers (ECCPs) entered into cooperative agreements with the Centers for Medicare & Medicaid Services (CMS) to test whether a new payment model for long-term care facilities and practitioners will
  – improve quality of care by reducing avoidable hospitalizations
  – lower combined Medicare and Medicaid spending.
Enhanced Care and Coordination Providers (ECCPs)

- Alabama Quality Assurance Foundation - Alabama
- HealthInsight of Nevada - Nevada and Colorado
- Indiana University - Indiana
- The Curators of the University of Missouri - Missouri
- The Greater New York Hospital Foundation, Inc. - New York
- University of Pittsburgh Medical Center (UPMC) Community Provider Services - Pennsylvania
Why Implement Payment Model?

The initial four years of the demonstration project (2012-2016) addressed preventing avoidable hospitalizations through various clinical quality models.
Why Implement Payment Model?

HOWEVER....

the initial demonstration did NOT address the existing payment policies that may be leading to avoidable hospitalizations.
Why Implement Payment Model?

BECAUSE...

• MedPAC has reported it is financially advantageous for LTC facilities to transfer residents to a hospital*

• In decisions regarding provision of care, the focus should always be on providing the best setting for the resident/patient

Why Does This Matter?

At Risk for complications:
- Delirium
- Polypharmacy
- Falls
- Incontinence & Catheter Use
- Hospital acquired infections
- Immobility, deconditioning
- Pressure Ulcers
- Undernutrition
Payment Model

Existing (Group B)
2012-2020
clinical quality model
+ new payment mechanism
Continuing LTC
N=23

New (Group A)
2016-2020
new payment mechanism
New LTC
N=23
Payment Reforms

CMS is adding new codes to the Medicare Part B schedule specifically for this Initiative

- **Facility payment**
  - treatment of six qualifying conditions

- **Practitioner payments**
  - #1 - onsite treatment of six qualifying conditions
  - #2 - care coordination & caregiver engagement
Principal Payment Reform Goal: Six Conditions

CMS states that six conditions are linked to approximately 80% of potentially avoidable hospitalizations among nursing facility residents nationally.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia</td>
<td>32.8%</td>
</tr>
<tr>
<td>Urinary tract infection</td>
<td>14.2%</td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>11.6%</td>
</tr>
<tr>
<td>Dehydration</td>
<td>10.3%</td>
</tr>
<tr>
<td>COPD, asthma</td>
<td>6.5%</td>
</tr>
<tr>
<td>Skin ulcers, cellulitis</td>
<td>4.9%</td>
</tr>
</tbody>
</table>
Clinical Goals for Phase 2

- Prevent the 6 conditions
- If you can’t prevent, recognize the signs/symptoms *EARLY*
- Treat in house if possible
- If treatment in house fails, or is not possible, transfer with appropriate documentation
The INTERACT Program: What is It and Why Does It Matter?

("Interventions to Reduce Acute Care Transfers")

Is a **quality improvement program** designed to improve the care of nursing home residents with acute changes in condition
How Does it Work?

• Early identification
• Early assessment
• Improve documentation
• Improve communication
<table>
<thead>
<tr>
<th>Standardized Tools</th>
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</thead>
<tbody>
<tr>
<td><strong>INTERACT</strong></td>
</tr>
<tr>
<td>Quality Improvement Tools</td>
</tr>
<tr>
<td>Communication Tools</td>
</tr>
<tr>
<td>Decision Support Tools</td>
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<tr>
<td>Advance Care Planning Tools</td>
</tr>
</tbody>
</table>
Acute Change in Condition

• **Sudden** and **Clinically Important** deviation from patient’s baseline
• Physical, cognitive, behavioral, or social domains
• A deviation that, without intervention, could result in complications (hospitalization) or death
Recommended Facility Procedures for Ensuring Recognition of ACOC

- Communication of patient information follows defined processes
- All IDT members are expected to report changes in condition
- Roles and responsibilities for identifying, analyzing, managing, and communicating ACOC are clearly assigned
- In-depth discussion of ACOC occurs at specified times
- Responsibility for documenting ACOC is clearly assigned
Stop and Watch

• To guide direct care staff through a brief review of early changes in resident’s condition.

• To improve communication between frontline staff and the nurse in charge about early changes in condition.
Stop and Watch

Early Warning Tool

If you have identified a change while caring for or observing a resident, please circle the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

Seems different than usual
Talks or communicates less
Overall needs more help
Pain – new or worsening; Participated less in activities
Ate less
No bowel movement in 3 days; or diarrhea
Drank less

Weight change
Agitated or nervous more than usual
Tired, weak, confused, or drowsy
Change in skin color or condition
Help with walking, transferring, toileting more than usual

Name of Resident

Your Name

Reported to Date and Time (am/pm)

Nurse’s Name
Purpose of the SBAR

• Improve communication
• Consistent language
• Standardized criteria
• Clear guidelines
• Communication that is efficient
• Communication that is effective
SBAR Communication Form
and Progress Note for RNs/LPN/LVNs

Before Calling the Physician / NP / PA / other Healthcare Professional:
☐ Evaluate the Resident: Complete relevant aspects of the SBAR form below
☐ Check Vital Signs: BP, pulse, and/or apical heart rate, temperature, respiratory rate, O₂ saturation and finger stick glucose for diabetics
☐ Review Records: Recent progress notes, labs, medications, other orders
☐ Review an INTERACT Care Path or Acute Change in Condition File Card, if indicated
☐ Have Relevant Information Available when Reporting
   (i.e., medical record, vital signs, advance directives such as DNR and other care limiting orders, allergies, medication list)

SITUATION
The change in condition, symptoms, or signs observed and evaluated is/are ________________________________________________________________

This started on __________ / __________ / __________ Since this started it has gotten: □ Worse □ Better □ Stayed the same

Things that make the condition or symptom worse are ________________________________________________________________

Things that make the condition or symptom better are ________________________________________________________________

This condition, symptom, or sign has occurred before: □ Yes □ No

Treatment for last episode (if applicable) ________________________________________________________________

Other relevant information ________________________________________________________________

BACKGROUND
Resident Description
This resident is in the facility for: □ Long-Term Care □ Post Acute Care □ Other: __________________________

Primary diagnoses ________________________________________________________________

Other pertinent history (e.g., medical diagnosis of CHF, DM, COPD) ________________________________________________________________

Medication Alerts
☐ Changes in the last week (describe) ________________________________________________________________

☐ Resident is on Warfarin/Coumadin: Result of last INR: __________ Date __________ / __________ / __________

☐ Resident is on an anticoagulant (direct thrombin inhibitor or platelet inhibitor)

Resident is on: □ Hypoglycemic medication(s) □ Insulin □ Digoxin

Allergies ________________________________________________________________

Vital Signs
BP __________ Pulse __________ (or Apical HR __________) RR __________ Temp __________ Weight __________ lbs (date __________ / __________ / __________)

For CHF, edema, or weight loss: last weight before the current one was ________________________________________________________________

Pulse Oximetry (if indicated) __________ % on □ Room Air □ O₂ (______________)

Blood Sugar (Diabetics) ________________________________________________________________

Resident / Patient Name ____________________________ (continued)
Decision Support Tools

Change in Condition File Cards
   Based on AMDA Clinical Practice Guideline
   Meant to be used to reference when to notify a physician

Care Paths
   Provide guidance on when to notify the MD/NP/PA
   Suggest evaluation strategies
   Provide recommendations for management and monitoring in the facility
   Educational tool
Care Paths

• Acute Mental Status Change/Behaviors
• Dehydration
• Fever
• Falls
• GI (N/V/D)
• Shortness of Breath
• Symptoms of CHF
• Symptoms of Lower Respiratory Illness
• Symptoms of UTI
Case Study

• 90 yo WF long term resident with severe osteoarthritis, history of falls, gait disturbance
• Staff notices she is “leaning to the right” in her chair and “does not seem to be her usual self”
• What to do?
Initial Assessment

• Vital Signs:
  • BP 100/60
  • HR 109
  • RR 24
  • Temp 97.7
  • O2 sat 90%
<table>
<thead>
<tr>
<th>Sign/Symptom</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent falls</td>
<td>10%</td>
</tr>
<tr>
<td>Tachycardia</td>
<td>10-15%</td>
</tr>
<tr>
<td>Tachypnea (RR&gt;30)</td>
<td>26-75%</td>
</tr>
<tr>
<td>Change in mental status/confusion</td>
<td>33-60%</td>
</tr>
<tr>
<td>History of cough, fever, or dyspnea</td>
<td>44%</td>
</tr>
</tbody>
</table>
No CHF, COPD diagnosis
Never happened before
No med changes
Other info?

Aspiration

Dysphagia

Poor cough reflex

Silent aspiration

Oropharyngeal secretion

Bacterial contamination

Gastric secretion

GER

Pneumonia
## Nursing Home 1

<table>
<thead>
<tr>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>CNA tells nurse about change, but nurse doesn’t think the patient is different and does nothing</td>
<td>CNA tells nurse resident is worse, nurse does assessment, but gets sidetracked and doesn’t call provider. Leaves it to next shift</td>
<td>Provider orders CXR, lab. CXR comes back on night shift w/ pneumonia. Provider is called at midnight but doesn’t answer.</td>
<td>Patient has O2 sat of 75% and is in respiratory distress—provider is called and orders patient to hospital for treatment of pneumonia.</td>
</tr>
</tbody>
</table>
### Nursing Home 2

<table>
<thead>
<tr>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>CNA tells nurse about change in condition. Nurse jumps on it, does assessment. Does SBAR and calls provider. Provider orders CXR and lab. CXR comes back with pneumonia and provider is called and orders oral antibiotic.</td>
<td>Facility “escalates care”—resident is put on “watch list” with frequent rounding and vital signs. All staff know resident is sick—dietary brings his favorite foods and increased fluids. CNAs and nurses watching for any worseining. Family is confident facility is “on top of it” and are happy the resident can “stay at home.”</td>
<td>Resident improving.</td>
<td>Resident continues to improve.</td>
</tr>
</tbody>
</table>
Congestive Heart Failure
Shortness of breath
Swelling of feet & legs
Chronic lack of energy
Difficulty sleeping at night due to breathing problems
Swollen or tender abdomen with loss of appetite
Cough with frothy sputum
Increased urination at night
Confusion and/or impaired memory
Heart Failure Zones

**EVERY DAY**
- Weigh yourself in the morning after you go to the bathroom and before breakfast and write down your weight.
- Take your medicine as prescribed.
- Check for swelling in your feet, ankles, hands and stomach.
- Eat a diet low in sodium and aim for less than 2,000mg of salt daily.
- Balance activity and rest periods.
- Limit alcohol and avoid smoking.

**GOAL ZONE**

- Your condition is under control if you have:
  - No shortness of breath.
  - Weight gain of no more than 2 pounds.
  - No swelling of your feet, ankles, hands or stomach.
  - The ability to maintain your activity level.
  - No chest pain.

**WARNING ZONE**

- Call your doctor if you have any of the following symptoms:
  - Weight gain of 3 pounds in 1 day, or 5 pounds in 1 week.
  - Shortness of breath or a dry, hacking cough.
  - Difficulty breathing when lying down, or you need to sleep sitting up in a chair.
  - Swelling of your feet, ankles, hands or stomach.
  - Fatigue or no energy.
  - New or increased chest pain.
  - An uneasy feeling; you know something is not right.

**EMERGENCY**

- If you experience any of the following symptoms:
  - Struggling to breathe or unrelieved shortness of breath while resting.
  - Chest pain.
  - Confusion or can’t think clearly.

Have someone take you to the nearest Emergency Department or call 911!
Instructions: “A NEW LEAF” pocket card is used by direct caregivers to screen for symptoms of heart failure exacerbation. The pocket card, carried by facility nursing assistants, serves as a reference for the signs and symptoms of heart failure exacerbation during routine daily resident care. Upon recognition of any of the symptoms, the certified nursing assistant should notify the primary nurse for further assessment and follow up.

“A NEW LEAF”
Screening Tool for Direct Caregivers

A: Acute Agitation/Anxiety

N: Nighttime shortness of breath or increased nighttime urination

E: Edema in lower extremities

W: Weight gain (2 to 4 pounds per week)

L: Lightheadedness

E: Extreme shortness of breath lying down

A: Abdominal symptoms (nausea, pain, decreased appetite, distension)

F: Fatigue
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<td>CNA notices patient seems more fatigued than usual. He wasn’t able to pull his pants up or do his buttons and usually can. CNA fills out stop and watch and circles seems more tired and needs more help. Nurse leaves on med cart and doesn’t address.</td>
<td>CNA reminds nurse about patient and remarks that he seems worse today. CNA weighs patient today and notes weight gain of 5 lbs. Tells nurse. 3-11 nurse finally does assessment. Vital Signs: BP 150/70, HR 100, RR 24, O2 sat 91%. Calls on-call doctor who orders lab for AM, CXR</td>
<td>Lab is drawn, CXR done. Results come back on 3-11 shift. CXR looks like early CHF. No further VS have been done. CXR faxed to MD.</td>
<td>Patient noted to be very SOB. O2 sat 80%. Daughter in to check on him and demands he be sent to hospital.</td>
</tr>
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</table>
**Nursing Home 2**

<table>
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<tr>
<td>CNA notes change in condition. Nurse promptly does assessment. Notes weight increase over past 2 weeks. Get weight and notes 5 lb increase over 2 days. Fills out SBAR, calls MD with information. Stat CXR, lab, BNP ordered. Results called to on-call provider who is “on-board” with efforts to treat in facility and orders 40 mg Lasix IV and F/U lab</td>
<td>Facility “escalates care”—resident is put on “watch list” with frequent rounding and vital signs. All staff aware that resident having exacerbation of CHF. Family is confident facility is “on top of it” and are happy the resident can “stay at home.” Weights and lab are followed daily and provider adjusts medications as needed.</td>
<td>Resident improving.</td>
<td>Resident continues to improve.</td>
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</table>
Requirements—Readiness Review

- 24 hour availability of key staff—Administrator, DON, Med Director
- Implementation of INTERACT
- Availability of RN 24/7, preferably onsite
- EKG/CXR within 4 hours
- Ability to start and maintain parenteral medications and fluids 24/7
- Ability to deliver respiratory therapy (nebulizer) and oxygen 24/7
- Ability to debride wounds in-house
- Policies and procedures in place regarding prevention
ECCP* Eligible Residents

• Have resided in the LTC facility for ≥101 cumulative days from the resident’s admission date to that LTC
• Are enrolled in Medicare (Part A and Part B FFS) and Medicaid, or Medicare (Part A and Part B FFS) only
• Have NOT opted-out of participating in the Initiative

* Enhanced Care and Coordination Providers
ECCP Eligible Residents (cont’d)

- Reside in Medicare or Medicaid certified LTC bed
- Are NOT enrolled in a Medicare Advantage plan
- Are NOT receiving Medicare through the Railroad Retirement Board
- Have NOT elected Medicare hospice benefit
- Resident’s eligibility must be renewed if discharged to the community for more than 60 days.
Facility Payment for Six Qualifying Conditions

Purpose

- Create incentive for facility to enhance staff skills to provide higher level of service in-house

Payment

- “Onsite Acute Care”
- Limited to 5-7 days, based on qualifying condition
- Limited to residents not on a covered Medicare Part A SNF stay and who meet the long stay criteria
Facility Payment for Six Qualifying Conditions

• The six conditions have very specific, detailed qualifying criteria that could trigger the benefit
  – **Detection** of acute change of condition documented in the medical record by a physician or a nurse at the LPN level or higher
  – STOP AND WATCH tool, SBAR, free text note, structured clinical documentation are acceptable formats as long as they are part of the medical records
Facility Payment for Six Qualifying Conditions

• Qualifying criteria that could trigger the benefit
  – MD, NP or PA must confirm qualifying diagnosis through in-person evaluation by the end of the 2nd day following the change in condition
  – ANY attending practitioner can provide confirming diagnosis for the purposes of facility payment
Facility Payment for Six Qualifying Conditions

• If, after the nursing facility’s maximum benefit period, it is suspected that the beneficiary continues to meet the qualifying criteria, a new practitioner assessment is required.
Facility Payment for Six Qualifying Conditions

Medicaid Nursing Facility Daily Rate + Allowable Medicare Part D payment + Allowable Medicare Part B payment + NEW Medicare Part B Payment = Total Facility Payment/Day

New code added for the participating nursing facilities
Example of Facility Payment

- Resident is diagnosed with qualifying criteria for one of the specific conditions and treatment begins.
- Condition no longer meets qualifying criteria requiring elevated level of treatment.

- Medicare Payments (Part B – New Code)
- Medicaid Payments (Nursing Facility)
- Medicare Payments (Part D – Medications)
Practitioner Payment #1 for Six Qualifying Conditions

Purpose

• Create incentive for practitioner to conduct nursing facility resident visits to treat acute change in condition
• Equalize payment for acute change of condition visit regardless of location of service

Payment

• Billing Code G9685; Acute Nursing Facility Care
• Payment will be equivalent to what would be received for a comparable visit in a hospital.
• Limited to first visit in response to a beneficiary who has experienced an acute change in condition (to confirm and treat the diagnosed condition)
• NPs & PAs reimbursed at 85% of physician
Practitioner Payment #1 for Six Qualifying Conditions (cont’d)

Current LTC Facility Visit CPT Code 99310

Equivalent Hospital Visit CPT Code 99223

Acute Nursing Facility Care Code G9685

New code added for the participating practitioners
Acute NURSING FACILITY CARE

Physician service or other qualified health care professional for the evaluation and management of a beneficiary’s acute change in condition in a nursing facility. (Beneficiary must meet required clinical criteria). This service is for a demonstration project.

Key Components Required:

• 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.

Maximum Benefit Period: Code can be billed once per day for a single beneficiary.
Resident appropriately managed in facility per CMS guidelines

Resident experiences suspected qualifying acute change of condition

Resident provided with in-person evaluation by CMS-approved practitioner by the end of the second day after the change in condition

Resident provided with in-person evaluation by UNAPPROVED practitioner at any time

Resident is on a covered Medicare Part A SNF stay

Resident is not on a covered Medicare Part A SNF stay

Practitioner can bill new code

Practitioner cannot bill new code
In decisions regarding provision of care, the focus should always be on providing the best setting for the resident/patient.

Six conditions have qualifying criteria:

- MD, NP or PA must confirm qualifying diagnosis through in-person evaluation.
- Evaluation or assessment must occur by end of the 2nd day after acute change in condition.
- Evaluation documented in resident’s medical record.
Practitioner Payment #1 for Six Qualifying Conditions (cont’d)

• The new code can be billed even if the exam reveals that the resident does NOT have one of the six qualifying conditions.
Responsibility for triggering actual payment code (G9685) is with the practitioner.

Code may be billed only once for a single beneficiary, even if beneficiary has more than one of the six conditions.
Practitioner Payment #1 for Six Qualifying Conditions (cont’d)

• Practitioner may bill the new code even if upon examination it turns out a beneficiary does not have one of the six conditions.
• CMS intends to waive any requirement for a 20% beneficiary coinsurance or payment of deductible.
• Subsequent visits would be billable at current rates using existing codes.
Acute Care PNEUMONIA

Facility service(s) for onsite acute care treatment of a nursing facility resident with pneumonia. (May only be billed once per day per beneficiary). This service is for a demonstration project.

Qualifying Diagnosis:

- Chest x-ray confirmation of a new pulmonary infiltrate

OR TWO or more of the following:

- Fever >100°F (oral) or two degrees above baseline
- Blood Oxygen saturation level < 92% on room air or on usual O2 settings in patients with chronic oxygen requirements.
- Respiratory rate above 24 breaths/minute
- Evidence of focal pulmonary consolidation on exam, including rales, rhonchi, decreased breathe sounds, or dullness to percussion

Symptomatic guidance: Productive cough, increased functional decline, increase dependence in ADLS, reduced oral intake, or increased lethargy, altered mental status, dyspnea

Treatment: Antibiotic therapy (oral or parenteral), hydration (oral, sc, or IV), oxygen therapy, and/or bronchodilator treatments. Additional nursing supervision for symptom assessment and management (vital sign monitoring, lab/diagnostic test coordination and reporting)

Maximum Benefit Period: 7 days.
Acute Care CHF

Facility service(s) for onsite acute care treatment of a nursing facility resident with Congestive Heart Failure, (CHF). (May only be billed once per day per beneficiary). This service is for a demonstration project.

Qualifying Diagnosis:

• Chest x-ray confirmation of a new pulmonary congestion

OR TWO or more of the following:

• Blood Oxygen saturation level below 92% on room air or on usual O2 settings in patients with chronic oxygen requirements.
  **New or worsening pulmonary rales**
  **New or worsening edema**
  **New or increased jugulo-venous distension**
  **BNP > 300**

Symptomatic Guidance: Acute onset of dyspnea (shortness of breath), orthopnea (SOB when lying down), paroxysmal nocturnal dyspnea (SOB waking the patient at night), new or increased leg or presacral edema, and/or unexpected weight gain.

Treatment: Increased diuretic therapy, obtain EKG to rule out cardiac ischemia or arrhythmias such as atrial fibrillation that could precipitate heart failure, vital sign or cardiac monitoring every shift, daily weights, oxygen therapy, low salt diet, and review of medications, including beta-blockers, ACE inhibitors, ARBS, aspirin, spironolactone, and statins, monitoring renal function, laboratory and radiologic monitoring. If new diagnosis, additional tests may be needed to detect cause.

Maximum Benefit Period 7 days
Acute Care COPD/ASTHMA

Qualifying Diagnosis:

- Known diagnosis of COPD/Asthma or CXR showing COPD with hyper inflamed lungs and no infiltrates

**AND TWO or more of the following:**

- Symptoms of wheezing, shortness of breath, or increased sputum production
- Blood Oxygen saturation level below 92% on room air or on usual O2 settings in patients with chronic oxygen requirements
- Acute reduction in Peak Flow or FEV1 on spirometry
- Respiratory rate > 24 breaths/minute

**Treatment:** Increased Bronchodilator therapy, usually with a nebulizer, IV or oral steroids, oxygen, and sometimes antibiotics.

**Maximum Benefit Period:** 7 days
<table>
<thead>
<tr>
<th>Qualifying Diagnosis:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• New onset of painful, warm and/or swollen/indurated skin infection requiring oral or parenteral antibiotic therapy</td>
</tr>
<tr>
<td>• If associated with a skin ulcer or wound there is an acute change in condition with signs of infection such as purulence, exudate, fever, new onset of pain, and/or induration.</td>
</tr>
</tbody>
</table>

**Treatment:** Frequent turning, nutritional assessment and/or supplementation, at least daily wound inspection and/or periodic wound debridement, cleansing, dressing changes, and antibiotics (oral or parenteral).

**Maximum Benefit Period:** 7 days
Facility service(s) for the onsite acute care treatment of a nursing facility resident with fluid or electrolyte disorder or dehydration (May only be billed once per day per beneficiary). This service is for a demonstration project.

**Qualifying Diagnosis:**

- Any acute change in condition

AND TWO or more of the following:

- Reduced urine output in 24 hours or reduced oral intake by approximately 25% or more of average intake for 3 consecutive days
- New onset of Systolic BP < 100 mm Hg (Lying, sitting or standing)
- 20% increase in Blood Urea nitrogen (e.g. from 20 to 24) OR 20% increase in Serum Creatinine (e.g. from 1.0 to 1.2)
- sodium > 145 or < 135
- Orthostatic drop in systolic BP of 20 mmHg or more going from supine to sitting or standing.

Treatment: Parenteral (IV or clysis) fluids, lab/diagnostic test coordination and reporting, and careful evaluation for the underlying cause, including assessment of oral intake, medications (diuretics or renal toxins), infection, shock, heart failure, and kidney failure.

**Maximum Benefit Period: 7 days**
Facility service(s) for the onsite acute care treatment of a nursing facility resident for a urinary tract infection (UTI). (May only be billed once per day per beneficiary). This service is for a demonstration project.

Qualifying Diagnosis:

• >100,000 colonies of bacteria growing in the urine with no more than 2 species of microorganisms.

AND One or more of the following:

• Fever > 100°F (oral) or two degrees above baseline.
• Peripheral WBC count > 14,000.

Symptoms of: dysuria, new or increased urinary frequency, new or increased urinary incontinence, altered mental status, gross hematuria, or acute costovertebral angle pain or tenderness

Symptomatic Guidance: Dysuria, frequency, new incontinence, altered mental status, hematuria, CVA tenderness.

Treatment: Oral or parenteral antibiotics, lab/diagnostic test coordination and reporting, monitoring and management of urinary frequency, incontinence, agitation and other adverse effects.

Maximum Benefit Period: 7
Purpose

• Payment to create incentive for practitioners to participate in nursing facility conferences, and engage in care coordination discussions with beneficiaries, their caregivers, and LTC facility interdisciplinary team.

Payment

• Billing Code G9686; Nursing Facility Conference
Practitioner Payment #2 for Care Coordination (cont’d)

Conference must: be a minimum of 25 minutes
Conference must not: include a clinical examination during the discussion

Discussion may include:
1. Review of history and current health status;
2. Typical prognosis for beneficiaries with similar conditions;
3. The resident’s daily routine
4. Measurable goals agreed to by all
5. Necessary interventions to address risk for hospitalization
6. Discussion of preventive services available in house
7. Development or updating, of person-centered care plan,
8. Discussion of potential discharge to the community.
9. Establishment of health care proxy

Discussion must be documented in the medical chart

Practitioner can bill new code
Practitioner Payment #2 for Care Coordination (*cont’d*)

• Code can be billed within 14 days of significant change in condition that increases likelihood of hospital admission.

• If billed, change in condition must be documented in beneficiary’s chart. MDS assessment for significant change MAY be required if meets RAI criteria.
Practitioner Payment #2 for Care Coordination (cont’d)

• If billed following a MDS significant change in condition, G9686 MUST be billed with a KX modifier.
Practitioner Payment #2 for Care Coordination (cont’d)

• CMS intends to waive any requirement for 20% beneficiary coinsurance or payment of deductible under the model.

• Code can be billed for beneficiaries in the target population when on a covered Medicare Part A SNF stay, as long as requirements listed above are met.
## Qualification Criteria

In order to qualify for payment, 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
- 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 change in condition should be documented in the beneficiary's chart and include a Minimum Data Set (MDS) assessment.

**Maximum Benefit Period:** The code can be billed only once per year or within 14 days of a significant change in condition that increases the likelihood of a hospital admission. Subsequent billing of this code after the first time must include a –KX modifier when processed. Failure to meet the significant change in condition threshold and include the –KX modifier will result in denial of subsequent claims.