

PRACTITIONER GUIDELINES FOR G9686: NURSING FACILITY CONFERENCE

Thank you for being a participating practitioner in the New York–Reducing Avoidable Hospitalizations (NY–RAH) project. Below is the payment code and qualifying criteria to help you provide eligible long stay residents with an annual care conference or following a recent significant acute change that is subject to a payment incentive in this project.

Billing Criteria

The Nursing Facility Conference can be used for any long-stay resident who meets the criteria for the NY-RAH payment incentives. The resident does not need to have a diagnosis of any of the six clinical conditions that are the focus of the Acute Nursing Facility incentive.	HCPCS/CPT Code	Short Descriptor	Long Description
	G9686	Nursing Facility Conference	Participation in an onsite nursing facility conference, 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. This service is for a demonstration project.

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, where the Significant Change in Status Assessment is completed by the facility in the MDS.
- The code can be used for the significant change even if it was already billed in the preceding twelve months.

Billing Process:

- 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.



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Appropriate Discussion Items with Resident:

- Review of the resident's history of present illness and current health status;
- Typical outcomes, scenarios, events, or prognosis for beneficiaries with similar conditions;
- The resident's daily routine (e.g., waking time, eating preferences, other habits, etc.) to help the facility deliver person-centered care;
- Measurable goals agreed to jointly by the resident, representative(s), caregiver(s), and the interdisciplinary care team;
- A description of the resident's risk for hospital admission and emergency department visits and all necessary interventions to address the underlying risk factors;
- Discussion of clinically appropriate preventive services and the facility's capabilities to treat certain conditions in house;
- Development, updating, or confirmation of person-centered care plan, including if possible an interoperable electronic person centered care plan;
- 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;
- Establishment of a health care proxy where necessary.