DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

MLN Matters® Number: SE1626

Related Change Request (CR) #: N/A

Article Release Date: December 9, 2016

Effective Date: N/A

Related CR Transmittal #: N/A

Implementation N/A

Comprehensive Care for Joint Replacement (CJR) Model: Skilled Nursing Facility (SNF) 3-Day Rule Waiver

Provider Types Affected

This MLN Matters® Article is intended for Skilled Nursing Facilities (SNFs) submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries in the Comprehensive Care for Joint Replacement (CRJ) model.

What You Need to Know

This purpose of this article is to inform SNFs of the policies surrounding use of the 3-day stay waiver available for use under the CJR Model and to provide instructions on using the demonstration code 75 on applicable CJR claims submitted on or after January 1, 2017. Make sure that your billing staffs are aware of these changes.

Background

Section 1115A of the Social Security Act authorizes the Centers for Medicare & Medicaid Services (CMS) to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to Medicare, Medicaid, and Children's Health Insurance Program beneficiaries. In accordance with this statutory authority, in November 2015 CMS published a final rule for the creation and testing of a new bundled payment model called the CJR model. The CJR model tests bundled payments for Lower Extremity Joint Replacement (LEJR) episodes at acute care hospitals located in multiple geographic areas. The intent of the model is to promote quality

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2015 American Medical Association. All rights reserved.

and financial accountability for episodes of care surrounding a LEJR procedure, hereafter referred to as LEJR episodes. The CJR model will test whether bundled payments to acute care hospitals for LEJR episodes of care can reduce Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries. CMS is testing the CJR model over a period of 5 performance years. The CJR model, began April 1, 2016, and will run through December 31, 2020.

Key Points

Under the CJR model, acute care hospitals in certain selected geographic areas take on quality and payment accountability for retrospectively calculated bundled payments for LEJR episodes. All related care within 90 days of hospital discharge from the LEJR procedure is included in the episode of care.

CJR Episodes of Care
Medicare currently pays for LEJR procedures under the Inpatient Prospective Payment System (IPPS) through one of two Medicare Severity Diagnosis Related Groups (MS-DRGs): MS-DRG 469 (major joint replacement or reattachment of lower extremity with major complications or comorbidities (MCC)) or MS-DRG 470 (major joint replacement or reattachment of lower extremity without MCC). Under the CJR model, episodes begin with admission to an acute care hospital for an LEJR procedure that is assigned to MS-DRG 469 or 470 upon beneficiary discharge and paid under the IPPS. Episodes end 90 days after the date of discharge from the acute care hospital. The episode includes the LEJR procedure, inpatient stay, and all related care as defined under the model that is covered under Medicare Parts A and B within the 90 days after discharge, including hospital care, post-acute care, and physician services.

CJR Participant Hospitals
Participant hospitals are the episode initiators (that is, the entity where the episode begins) and bear quality and episode payment accountability under the CJR model. CMS requires all hospitals paid under the IPPS and located in selected geographic areas to participate in the CJR model, with limited exceptions for those hospitals currently participating in Bundled Payments for Care Improvement (BPCI) Models for the LEJR BPCI clinical episodes.

CJR Model Beneficiary Inclusion Criteria
Medicare beneficiaries whose care is included in the CJR model must meet the following criteria upon admission to the anchor hospitalization:

- The beneficiary is enrolled in Medicare Part A and Part B throughout the duration of the episode.
- The beneficiary's eligibility for Medicare is not on the basis of the End Stage Renal Disease benefit.
- The beneficiary is not enrolled in any managed care plan.
- The beneficiary is not covered under a United Mine Workers of America health plan.
- Medicare is the primary payer.

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2015 American Medical Association. All rights reserved.

Skilled Nursing Facility Three-Day Waiver

The CJR model waives certain existing payment system requirements to provide additional flexibilities to hospitals participating in CJR, as well as other providers that furnish services to beneficiaries in CJR episodes. The purpose of such flexibilities is to increase LEJR episode quality and decrease episode spending or provider and supplier internal costs, or both, and to provide better, more coordinated care for beneficiaries and improved financial efficiencies for Medicare, providers, and beneficiaries.

In order to provide more comprehensive care across the post-acute spectrum and support the ability of participant hospitals to coordinate the care of beneficiaries, CMS will conditionally waive the 3-day stay requirement for covered SNF services for beneficiaries in CJR episodes in performance years 2 through 5 of the CJR model (i.e. on or after January 1, 2017).

Under Medicare rules, in order for Medicare to pay for SNF services, a beneficiary must have a qualifying hospital stay of at least 3 consecutive days (counting the day of hospital admission but not the day of discharge). Additional information regarding the Skilled Nursing Facility benefit is available in the "Medicare Benefit Manual" (Pub 100–02), Chapter 8.

CMS waives the SNF 3-day rule for coverage of a SNF stay for a CJR beneficiary following the anchor hospitalization, only if the SNF is identified on the applicable calendar quarter list of qualified SNFs at the time of CJR beneficiary admission to the SNF. CMS will determine all the qualified SNFs for each calendar quarter based on a review of the most recent rolling 12 months of overall star ratings on the Five-Star Quality Rating System for SNFs on the Nursing Home Compare website. All other Medicare rules for coverage and payment of Part A-covered SNF services continue to apply. This will allow payment of claims for SNF services delivered to beneficiaries at eligible sites.

When submitting claims to Medicare that require a waiver of the 3-day hospital stay requirement for Part A SNF coverage, SNF billing staff must enter a "75" in the Treatment Authorization Code Field. This allows MACs to appropriately pay SNFs treating beneficiaries during CJR Model episodes. In order to determine if use of the demonstration code "75" is appropriate, the following circumstances must be met:

- The hospitalization does not meet the prerequisite hospital stay of at least 3 consecutive days for Part A coverage of ''extended care'' services in a SNF. If the hospital stay would lead to covered SNF services in the absence of the waiver, then the waiver is not necessary for the stay.
- The discharge is from a participant hospital in the CJR model. Participant hospitals are listed on the CMS website this list is shared with the MACs on a monthly basis.
- The beneficiary must have been discharged from the CJR model participant hospital for one of the two specified MS–DRGs (469 or 470) within 30 days prior to the initiation of SNF services.
- The beneficiary meets the criteria for inclusion in the CJR model at the time of SNF admission: That is, he or she is enrolled in Part A and Part B, eligibility is not on the

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2015 American Medical Association. All rights reserved.

basis of ESRD, is not enrolled in any managed care plan, is not covered under a United Mine Workers of American health plan, and Medicare is the primary payer.

- The waiver will apply if the SNF is qualified to admit CJR model beneficiaries under the waiver. A list of qualified SNFs will be sent to the MACs and Medicare Shared Systems Maintainers via a quarterly list, developed by CMS and posted to the CMS website on a quarterly basis. The list will contain those SNFs with an overall star rating of three stars or better for at least 7 of the preceding 12 months of the rolling data used to create the quarterly list.
- **The SNF must include Demonstration Code 75 in the Treatment Authorization field when submitting claims that qualify for the SNF waiver under the CJR model.** Note: The waiver is not valid for swing bed (TOB 18X) stays or Critical Access Hospitals (CAHs).
- All other Medicare rules for coverage and payment of Part A-covered SNF services continue to apply.

Additional Information

If you have any questions, please contact your MAC at their toll-free number. That number is available at **https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/**.

The "Medicare Benefit Policy Manual," Chapter 8, on SNF services is available at **https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf**.

More information on the CJR model is available at **https://innovation.cms.gov/initiatives/CJR**. At this page, one can scroll down and open a list of the hospitals participating in this model.

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2015 American Medical Association. All rights reserved.