CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-19 Demonstrations	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 118	**Date: May 8, 2015**
	Change Request 8926

SUBJECT: Updates to the Model 4 Bundled Payments for Care Improvement (BPCI) Initiative to Clarify the Payment Calculation to Include New Technology Add-On Payments, Validate Only Claims with Medicare as Primary Payer, Allowing Medical Necessity Denial Claims to Process Effectively, and Correct Processing of Claims Submitted as Model 4 for Beneficiaries Determined to be Ineligible.

I. SUMMARY OF CHANGES: This Change Request will correct the calculation used to determine payments to Model 4 Bundled Payment for Care Improvement (BPCI) Awardees.

EFFECTIVE DATE: October 1, 2013
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 5, 2015

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Demonstrations

Attachment - Demonstrations

Pub. 100-19	Transmittal: 118	Date: May 8, 2015	Change Request: 8926

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I. GENERAL INFORMATION

A. Background: Model 4 of the BPCI provides a prospectively determined bundled payment to the hospital that encompasses all services furnished during the inpatient stay by the hospital, physicians, and other practitioners. Indirect Medical Education (IME), Disproportionate Share Hospitals (DSH), uncompensated care payments to DSH eligible hospitals, outlier and hospital capital IPPS payments are added to the prospectively determined bundled payment.

Currently, when an inpatient claim with demo number 64 is denied as not medically necessary, it will not include value codes Y1-Y4 and will edit in CWF with 46#S and will not finalize. Edit 46#S requires that value codes Y1-Y4 be present on Model 4 claims. In addition, claims submitted as Model 4 for beneficiaries who are determined to be ineligible for Model 4 BPCI are rejecting instead of processing as they would in the absence of Model 4.

B. Policy: In addition to the payments outlined above, New Technology Add-On payments will also be added to the prospectively determined bundled payment.

To prevent unnecessary claims processing, this Change Request will update policies outlined in CR 7887, which states that all IPPS inpatient claims with an admission date on or after 01/01/13 shall be validated against the list of Model 4 hospitals and selected DRGs (provided by CMS).

In order for Part B claims to be processed correctly when the associated Part A claim has been denied as not medically necessary, this CR will instruct FISS to remove the demonstration code 64 so that the claim will process, close out the Model 4 episode, and allow the Part B claims to process.

This CR corrects processing of Model 4 claims to be processed as they would in the absence of Model 4 when a beneficiary is found to be ineligible for Model 4.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8926.1	Medicare contractor shall add CWF consistency edit E46#T to the list of CWF codes that will automatically assign condition code B1 and remove all associated Model 4 coding.					X				
8926.2	Medicare contractor shall exclude claims medically denied in full from the Model 4 process.					X				
8926.3	Medicare contractor shall calculate the net reimbursement for a Model 4 BPCI (demo code 64 present) **PIP or non-PIP** claim that has an NOA as follows: (Part A Demonstration Amount + Part B Demonstration Amount) – Part A deductions – Part B deductions + IME + DSH + Total capital + Outlier + New Technology + Hemophilia + UCP – sequestration amount - $500.00 Note: Part A deductions: cash deductible, blood deductible, coinsurance and LTR amount Part B deductions: cash deductible and copayment					X				
8926.4	Medicare contractor shall calculate the net reimbursement for a Model 4 BPCI (demo code 64 present) **PIP or non-PIP** claim that does not have an NOA as follows: (Part A Demonstration Amount + Part B Demonstration Amount) – Part A deductions – Part B deductions + IME + DSH + Total capital + Outlier + New Technology + Hemophilia + UCP –sequestration amount. Note: Part A deductions: cash deductible, blood deductible, coinsurance and LTR amount Part B deductions: cash deductible and copayment					X				
8926.5	Medicare contractor shall calculate the net reimbursement for **PIP or non-PIP** Model 4 Related Readmission as follows: (IME + DSH + Total Capital + Outlier + New Technology + Hemophilia + UCP) – Part A deductions) – sequestration amount					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Note: Part A deductions: cash deductible, blood deductible, coinsurance and LTR amount.									
8926.6	Medicare contractors shall identify, reprocess and/or adjust Model 4 claims eligible for New Technology add-on payments that did not receive New Technology add-on payments.	X								
8926.7	Medicare contractor shall remove Model 4 information from the claim and re-price in the absence of Model 4 when edit 5244 is received from BDS.					X				
8926.8	Medicare contractor shall create a new edit to prevent an adjustment to change a non-Model 4 claim/adjustment to a Model 4 claim.					X				
8926.9	Medicare contractor shall RTP the claim/adjustment with the new edit in BR 8926.8 instructing the provider to cancel the original non-Model 4 claim and resubmit a new claim to be processed as Model 4.	X								
8926.10	Medicare contractor shall apply the readmission indicator '1' on an incoming IPPS claim if all of the following are met even if PRICER Return code equals 03, 05, 06, 10, 12, 33, 42, or 40: • The incoming IPPS claim is from a Model 4 provider • The admission date of the incoming IPPS claim is within 30 days after the discharge from the same provider which was processed under Model 4 • The DRG on the incoming IPPS claim does not match a DRG on the unrelated admissions DRG list FISS shall add a new 1-byte field to the header claim level to carry one of the following Model 4 BPCI readmission indicators: • '1'- claim is a related readmission to a Model 4 BPCI claim, shall pay IME, DSH & Capital only.					X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
8926.7	Please review QCNs 140730020, 140904017 and 140910008 for more information on the BDS issue.

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Adam Conway, 410-786-2455 or adam.conway@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0