CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-19 Demonstrations	Centers for Medicare & Medicaid Services (CMS)
Transmittal 134	**Date: December 15, 2015**
	Change Request 9136

Transmittal 125, dated October 15, 2015, is being rescinded and replaced by Transmittal 134, dated December 15, 2015, to add sub-requirement (9136.29.2). All other information remains the same.

SUBJECT: Medicare Care Choices Model (MCCM) - Per Beneficiary per Month Payment (PBPM) - Implementation

I. SUMMARY OF CHANGES: This CR is for implementation of system changes required to successfully implement the Medicare Care Choices Model's PBPM for this pre-hospice model as described initially in CR9049. The business rules for system changes in this CR are the result of the analysis and design work conducted under CR9049.

EFFECTIVE DATE: January 1, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 5, 2015 - Analysis and Design for CWF and MACs, and Implementation of Requirements 9136.1 through 9136.1.1.1.1, 9136.2 through 9136.2.1, and 9136.4 through 9136.4.2.1 for FISS. January 4, 2016 – Full Implementation for all Contractors.

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: 134	Date: December 15, 2015	Change Request: 9136

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SUBJECT: Medicare Care Choices Model (MCCM) - Per Beneficiary per Month Payment (PBPM) - Implementation

EFFECTIVE DATE: January 1, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 5, 2015 - Analysis and Design for CWF and MACs, and Implementation of Requirements 9136.1 through 9136.1.1.1.1, 9136.2 through 9136.2.1, and 9136.4 through 9136.4.2.1 for FISS. January 4, 2016 – Full Implementation for all Contractors.

I. GENERAL INFORMATION

A. Background: The services covered by the PBPM fee include services described in the Medicare Hospice Benefit as core services and some non-core services as specified under the hospice Conditions of Participation: 42 CFR §418.64, §418.76, and §418.78 and listed in Section C, of this document; Program Details and Considerations. The hospice CoPs remain in full force and effect in this Model. Further, under section 1115A(d)(1) of the Social Security Act, the Secretary of Health and Human Services may waive such requirements of Titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) as may be necessary solely for purposes of carrying out section 1115A with respect to testing models described in section 1115A(b), we do not currently expect to issue any waivers for this Model.

The methodology for determining the PBPM fee was developed in collaboration with the Center for Medicare (CM) and reviewed by the Office of the Actuary. The methodology accounts for lessons learned from multiple Innovation Center awards and demonstrations with palliative care providers caring for concurrent care populations with advanced illnesses, and research based on managed care programs. The fees in these examples range from $150 - $400 PBPM. Based on the increased services available to beneficiaries proposed in the MCCM, the $400 PBPM fee reasonably reflects the expectations of care the hospices must provide in the Model.

Hospices that participate in the Model will be paid the full $400 PBPM for providing services for 15 or more days per calendar month and $200 PBPM for services provided for less than 15 days in a calendar month, with the exception of the month of discharge which will be paid $400 PBPM.

Total Medicare and Medicaid expenditures for qualifying beneficiaries may be reduced as the result of key aspects of the Model that include pain and symptom management, incorporation of patient-centered goals into the plan of care, care coordination, case management, and shared decision making provided by the MCCM participating hospice. The Model expects to lower expenditures related to emergency department visits, ambulance services, acute care hospital stays, diagnostic tests and procedures.

The CMMI has a growing portfolio testing a variety of payment and service delivery models; the MCCM design focuses on a geographically diverse combination of rural and urban, large and small hospices. Qualifying participants include Medicare beneficiaries eligible for the Medicare hospice benefit, as well as dual eligible beneficiaries enrolled in Medicare fee-for-service and eligible for the Medicaid hospice benefit (collectively these Medicare and dual-eligible beneficiaries are referred to as "Model beneficiaries"). The Model design focuses on certain types of cancer, congestive heart failure (CHF), human immunodeficiency virus (HIV), and chronic obstructive pulmonary disease (COPD). The MCCM will be operational January 1, 2016.

The Model services are provided in the home based on the Model beneficiary's care needs; CMS does not expect to see claims in the Medicare or Medicaid claims systems for home health services that should be provided by the hospice (ex. skilled nursing and aide services). There may be occasions where necessary home health services require the use of a home health agency that possesses the required skill level (ex. certified enterostomal therapy nurse for new colostomy education). The claims systems will be monitored specifically for use of services provided by home health agencies to Model beneficiaries. MCCM participating hospices will be expected to provide documentation of each use of services by a home health agency for Model beneficiaries.

B. Policy: Hospices that apply and are selected to participate in the MCCM will provide services available under the Medicare hospice benefit for routine home care and in-home respite levels of care that cannot be separately billed under Medicare Parts A, B, and D. CMS will pay a $400 PBPM fee to the MCCM participating hospices for these services. Providers and suppliers furnishing curative services to beneficiaries participating in the MCCM will be able to continue to bill Medicare (A, B, D) for the reasonable and necessary services they furnish.

The hospices will be paid the full $400 PBPM for each eligible beneficiary enrolled in the MCCM for 15 or more days and provides at least one service per calendar month and $200 PBPM for each eligible beneficiary enrolled in the MCCM for less than 15 days and provides at least one service in a calendar month, with the exception of the month of discharge which will be paid $400 PBPM. The PBPM fee would be the total payment for those services for Model beneficiaries. The PBPM fee has no beneficiary co-insurance or deductible.

Note that under the Medicare hospice benefit there are additional items and services that are normally paid through the hospice per diem such as drugs, durable medical equipment, speech language pathology services, and occupational therapy, physical therapy, and ambulance transports. Since patients enrolled in this Model are not receiving the Medicare hospice benefit, if they are in need of any of those items or services, a qualified provider or supplier may furnish them to the MCCM beneficiary and bill the appropriate part of Medicare (A, B, or D) subject to all existing rules and requirements.

While participating in the MCCM, beneficiaries would remain subject to any relevant cost-sharing requirements incurred as a result of curative care treatments. The $400 PBPM fee that is paid to the MCCM participating hospice providing the hospice services has no cost sharing associated with it. Providers furnishing curative services should continue to bill Medicare as they normally would.

Prior to the start of the Model in January 2016, and quarterly thereafter, the MCCM team will submit to the contractors a file via CR of hospices participating in the MCCM. The contractors will be notified via TDL when hospices are terminated from the Model. Only these participating hospices will be eligible to receive payment for this Model.

Eligible hospices may bill once per calendar month per beneficiary. Other practitioners will be eligible to bill Chronic Care Management (CCM) services for the same beneficiary during the same month. In order to determine the effect of the MCCM on total Medicare expenditures, services will be measured through patient population claims comparisons. Claims data from the participating Model beneficiaries will be compared to a control population of non-model Medicare and dual-eligible beneficiaries with similar patient and disease characteristics. Comparing the actual expenditures between these two populations will provide the data to analyze the financial implications of this Model.

The CMMI will review the paid claims for the Model and monitor for overpayment. On a quarterly basis, CMMI will pass through to the MACs a list of PBPM payments which need to be recouped from participating hospices. These overpayments must be reprocessed and recouped.

Program Details and Considerations:

The following assumptions have been identified and must be taken into consideration when analyzing how to implement the PBPM payment for the MCCM:

1. MCCM will last for 5 years.

2. Implementation is set for January 2016.

3. Funding is to come from the Medicare Part A Trust Fund.

4. MCCM will consist of up to 171 participating hospices with up to 71 participating in the first year of the Model and up to 70 additional hospices entering the Model in Year 3. The number may decrease when a hospice chooses to no longer participate or they have been removed from the Model. The target number of beneficiaries over the life of the Model is 150,000.

a. CMMI will send updates if identifying information (e.g., CCN, TIN) changes.

b. CMMI will send updated list of participating hospices.

5. A beneficiary would be considered eligible if he/she meets all of the following criteria.

a. Medicare Part A has been primary for at least 24 continuous months and is currently enrolled in Part B; and,

b. Is not enrolled in a Medicare managed care organization; and,

c. Has a diagnosis as indicated by certain ICD-9/10 codes for cancer, COPD, HIV, or CHF (a crosswalk will be provided); and,

d. Has had at least two hospitalizations in the last 12 months which were related to his/her MCCM qualifying diagnosis; and,

f. Has had at least three office visits with his/her Medicare enrolled healthcare provider (defined as primary care or specialist provider) within the last 12 months which were related to his/her MCCM qualifying diagnosis; and,

g. Meets hospice eligibility and admission criteria as stated in 42 CFR §418.20, Eligibility requirements, and §418.25, Admission to hospice care; and,

h. Has not elected the Medicare Hospice Benefit or Medicaid Hospice Benefit within the last 30 days prior to their participation in the MCCM.

6. MCCM-specific Notice of Election will not turn off Part A, B, and D coverage so other providers can bill for related curative services. Model services covered by the PBPM fee include: counseling services to the beneficiary and family (bereavement, spiritual, dietary); family support; psycho-social assessment; nursing services; medical social services; hospice aide and homemaker services; volunteer services; comprehensive assessment; plan of care; interdisciplinary team (IDG); care coordination/case management services; and in-home respite care. Those services that can be billed as a separate claim under Parts A, B, or D include: physical or occupational therapy; speech language pathology services; drugs for the management of pain or other symptoms from the terminal illness or related conditions; medical equipment and supplies; physician services; and short-term inpatient care for pain or symptom management which cannot be managed in the home environment including other services that are specified in the patient's plan of care for which payment may otherwise be made under Medicare (for example, ambulance transports).

7. Other providers may continue to bill CCM/care transitions codes.

8. If, during the course of participation in the Model, a beneficiary chooses to seek only hospice care under the Medicare hospice benefit, the beneficiary would sign a hospice Notice of Election, 42 CFR 418.24 and would not be eligible to continue participating in the Model.

9. A beneficiary who leaves the Model for any reason would not be eligible to return to the Model at a later date.

10. The PBPM payment is $400 for each eligible beneficiary enrolled in the Model for 15 or more days as long as the participating hospice provides at least one service per calendar month and $200 for each eligible beneficiary enrolled in the Model for less than 15 days and the participating hospice provides at least one service in a calendar month. When identified, monies paid erroneously to providers will be recouped through the normal overpayment process.

12. Claims will be paid according to dates of service. Participating hospices will receive payment if they were on the list of approved participating hospices at the time services were rendered. Thus, if a quarterly update of participating providers is received and the provider is no longer on the list then he/she would receive the PBPM payment for dates of service prior to the quarterly update.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9136.1	CMS shall provide FISS the initial file with information on hospices participating in this Model prior to the start of the MCCM. All participating providers will be Medicare certified and enrolled.					X				CMS
9136.1.1	For each participating hospice providing services under the MCCM, the information shall include the following fields: 1. CCN 2. NPI 3. Effective start date of participation for this Model 4. Effective termination date of participation for this Model					X				CMS
9136.1.1.1	FISS shall provide CMS with the file format.					X				CMS
9136.1.1.1.1	FISS shall provide the file to VDCs who shall make available to the MACs online.			X		X				VDCs
9136.2	CMS shall provide the MACs a TDL when			X		X				CMS

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
	hospices are terminated from the Model.									
9136.2.1	The term date on the hospice demo file shall be accessible to the MACs so the list of participating hospices can be updated upon receipt of the TDL.			X		X				
9136.2.2	FISS shall reject MCCM-specific NOEs and claims for providers who are no longer a MCCM-participating provider using Group Code = CO; CARC = 132.			X		X				
9136.3	FISS shall reject MCCM-specific NOEs and claims for providers that are no longer eligible to receive Medicare payments (those hospices with terminated CCNs) using Group Code = CO; CARC = B7; and, RARC = 570. Normal processes shall be followed.					X				
9136.3.1	Contractors shall follow standard recoupment processes if a participating provider's CCN is terminated.			X		X				HIGLAS
9136.4	CMS shall provide SSMs a file that contains all ICD9/10 codes that are eligible for payment under this Model prior to the start of the MCCM.					X			X	CMS
9136.4.1	FISS shall provide CMS with the file format.					X				CMS
9136.4.2	FISS shall validate that file submitted contains valid diagnosis codes, valid effective/termination dates, and that diagnosis codes are present for both ICD9 and ICD10.					X				
9136.4.2.1	FISS shall send a report to CMS listing any invalid ICD9/10 information for correction. A file will be returned to FISS with the corrected information.					X				CMS
9136.5	ICD9/10 Codes may be added or removed during the course of the Model. The contractor shall be able to update the list no more than quarterly based on the information provided by CMS.					X			X	
9136.5.1	The contractors and SSMs shall not look at eligibility retroactively when there are changes to the ICD9/10 file.					X			X	
9136.5.2	FISS shall make necessary changes so providers can submit MCCM-specific TOBs via hardcopy					X				

Number	Requirement	Responsibility: A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	and DDE.									
9136.6	The contractors shall ensure that participating hospices submit a MCCM-specific Notice of Election (NOE) on bill type 81A and 82A.			X		X				
9136.7	CWF shall carry the demo code “73” on the MCCM-specific NOE, and the existing fields used on Notice of Elections. Those fields shall be carried on the NOE transmit record using Hospice record type (HUHC). The demo code "73" shall carry in the existing 1st demo code field on the HUHC record for the NOE.			X		X			X	
9136.7.1	FISS shall recognize the demonstration code “73” when submitted in FL 63 (or equivalent) – Treatment Authorization Code. Occurrence code 27 shall not be required for MCCM-specific NOE.			X		X				
9136.7.1.1	CWF shall reject and FISS and MACs shall return to provider all MCCM-specific NOEs that carry both the demo code "73" and the occurrence code "27" using Group Code = CO; CARC = 16; and, RARC = M45.			X		X			X	
9136.7.1.2	FISS shall reject any MCCM-specific NOE that is submitted by a non-participating hospice provider using Group Code = CO; CARC =132.					X				
9136.8	Upon receipt of the MCCM-specific NOE, FISS shall verify that for the beneficiary, there is an MCCM approved ICD-9/10 code; if not, return to provider using Group Code = CO; CARC =96; and, RARC = N564.					X				
9136.9	Upon receipt of the MCCM-specific NOE, the CWF shall verify that for the beneficiary: 1. has had Medicare Part A for 24 months or more and has been primary for all services (excluding worker's comp, auto, and 3rd party liability and other diagnosis-specific coverage) for at least 24 continuous months; CWF shall reject and the contractor shall RTP with the CWF reject when the NOE’s From date is not greater than 24 months from the last MSP period using Group Code								X	

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
	= CO; CARC = 96; and, RARC = N564. 2. he/she has Medicare Part B currently (no length of time requirement); CWF shall reject and the contractors shall RTP with the CWF reject when the NOE's From Date is not enrolled in both Part A and Part B using Group Code = CO; CARC = 109; and, RARC = N216. 3. he/she is not enrolled in a Medicare managed care organization, including but not limited to Medicare Advantage plans; CWF shall reject and the contractors shall RTP from the CWF reject when the NOE's From Date is during enrollment in a Medicare Advantage Plan using Group Code = CO; CARC = 96; and, RARC = MA73. 4. the Medicare Hospice Benefit has not been active within the last 30 days (the term date of the last Medicare Hospice period is greater than 30 days); if no, CWF shall reject and the contractors shall RTP with the CWF reject when an MHB has been active in the last 30 days using Group Code = CO; CARC = B9. 5. there is no previous MCCM-specific NOE; CWF shall reject and the contractors shall RTP with the CWF reject when there is a previous MCCM-specific NOE (81A or 82A with demo code 73) using Group Code = OA; CARC = 18; and, RARC = N111.									
9136.9.1	Upon receipt of the MCCM-specific NOE, the CWF shall also verify that for the beneficiary: 1. there have been 3 office visits with the same Medicare enrolled healthcare provider (not to exclude FQHC, RHC, CAH affiliated primary care sites) for a MCCM approved ICD-9/10 in the last 12 months; CWF will reject and the contractors shall return to provider if there are not 3 Part B office visits with applicable ICD-9/10 codes in the system using Group Code = CO; CARC = 132.			X					X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• Provider can be a physician or Advanced Practice Nurse; primary care or specialist; rendering or referring • Claims can be paid or denied • Establish an override code for the contractor • CWF shall allow the reject to be overridable 2. there have been 2 acute care hospitalizations (not to exclude Maryland, nationwide cancer hospitals, etc. that receive Medicare payments under a unique system) in the last 12 months for an MCCM approved ICD-9/10; CWF will reject and the contractors shall return to provider if there are not 2 hospital admissions with applicable ICD9/10 codes in the system using Group Code = CO; CARC =A6. • Hospitalizations must be counted as admissions and billable to Inpatient PPS • Claims can be paid or denied • Establish an override code for the contractor • CWF shall allow the reject to be overridable									
9136.9.1.1	CWF shall create the rejects and FISS shall perform system modifications to incorporate the CWF rejects/overrides.					X			X	
9136.10	FISS shall use overrides in the header when an MCCM-specific NOE is RTP'd and contains remarks from the provider acknowledging that they have verified the following information: 1. there have been 3 office visits with the same Medicare enrolled healthcare provider with an MCCM approved ICD-9/10 2. there have been 2 hospitalizations in the last 12 months with an MCCM approved ICD-9/10 code			X		X				
9136.10.1	Contractors shall not require an appeals process to			X		X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	utilize overrides.									
9136.11	Upon receipt of the MCCM-specific NOE or claim, CWF shall not update a Medicare Hospice Benefit period.								X	
9136.12	CWF will ensure NOE and claims with demo code “73” bypass standard hospice edits.								X	
9136.13	CWF shall create an MCCM auxiliary history record from the MCCM-specific NOE.								X	
9136.13.1	The MCCM auxiliary history record will carry start and discharge dates as well as claims data.								X	
9136.14	Contractors shall recognize bill type 81B and 82B with demo code "73" as the notice of termination/revocation (NOTR) and will post termination date on the MCCM Auxiliary file. CWF shall reject if bill type 81B or 82B (termination/revocation) is received if no election period has been established using Group Code = CO; CARC =132.			X		X			X	
9136.15	CWF shall process the MCCM NOTR (81B or 82B) with demo code "73" to terminate the MCCM period.								X	
9136.15.1	If a MCCM claim has processed with Dates of Service after the termination date, CWF shall initiate a ‘look back' (IUR) to identify the MCCM claims that processed after the termination date.								X	
9136.15.1.1	FISS shall initiate an adjustment based on the IUR sent from CWF. This will initiate the standard debit/credit procedures.					X				
9136.15.2	CWF shall create a new reject to not allow incoming claims with demo code "73" for same provider after the termination date for that beneficiary allowing the MACs to reject these claims. Use Group Code = CO; CARC = 96; and, RARC = M138.			X					X	
9136.15.2.1	FISS shall perform system modifications to incorporate the CWF rejects.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9136.16	Contractors shall recognize bill type 81D and 82D with demo code "73" as the notice of cancellation and will remove the MCCM Auxiliary file. CWF shall reject if a bill type 81D or 82D (notice of cancellation) for the following 2 conditions: (a) If no election period has been received (b) If the cancellation date is received and a MCCM claim has processed. Use Group Code = CO; CARC = 96; and, RARC = M138.			X		X			X	
9136.17	Contractors shall recognize bill type 81C and 82C with demo code "73" as the MCCM notice of transfer from one participating hospice to another participating hospice and shall post transfer date on the MCCM Aux file. CWF shall reject if bill type 81C or 82C (notice of transfer) is received if no election period has been established. Use Group Code = CO; CARC = 96; and, RARC = M138.			X		X			X	
9136.17.1	CWF shall create a new reject to not allow incoming claims with demo code "73" for the previous provider with service dates after the transfer date. If the transferring participating hospice participant submits a MCCM claim with service dates after the transfer NOE (8XC) is submitted by the admitting participating hospice, CWF shall reject that claim and contractors shall return to provider. (Group code = CO; CARC=96; RARC=138).								X	
9136.17.2	CWF shall reject the Transfer NOE (8XC) if claims have already processed for dates of service after the transfer date. (Group code = CO; CARC=96; RARC=138).								X	
9136.17.3	FISS shall perform system modifications to incorporate the CWF rejects.					X				
9136.18	Contractors shall recognize all MCCM claims as PBPM when bill type 81X or 82X carries Demo Code ‘73’ in FL 63 (or equivalent).			X		X			X	HIGLAS
9136.18.1	PIP providers shall not be paid on an "as claim" basis; payments will be included in the normal PIP cycle.			X		X				HIGLAS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9136.19	CWF shall carry demonstration code in the existing 1st demo code field on the HUHC record.								X	
9136.20	Claims for demonstration services without demonstration code "73" shall be returned to provider. Use Group Code = CO; CARC = 16; and, RARC = M62.			X		X				
9136.21	The contractor shall reject any MCCM-specific claim that is submitted by a non-participating hospice provider. Use Group Code = CO; CARC = 132.					X				
9136.22	Upon receipt of the MCCM-specific claim, FISS shall verify that for the beneficiary, there is an MCCM approved ICD-9/10 code; if not, return to provider. Use Group Code = CO; CARC = 96; and, RARC = N564.					X				
9136.23	FISS shall bypass the Hospice Pricer and regular hospice edits when demo code "73" is present on Model claims.					X				
9136.24	FISS shall verify that all Model claims are submitted with: 1. Demo code 73 and without occurrence code 27; and 2. Revenue Code 0659 in one claim line with one of the approved HCPCs identified in this CR, and a covered charge amount to indicate they are associated with the MCCM. (Note: This is to distinguish the lines from billings for denial for room & board services.) Claims without this shall be returned to provider for re-billing. Use Group Code = CO; CARC = 132.			X		X				
9136.25	FISS shall recognize that the acceptable revenue codes for Model claims are limited to 0551, 0561, 0569, 0571, and 0659. 1. Claims without a revenue code shall be returned to provider for re-billing. Use Group Code = CO; CARC = 16; and,			X		X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	RARC = M50. 2. Claims with revenue codes other than these shall be returned to provider for re-billing. Use Group Code = CO; CARC = 16; and, RARC = M50. 3. Note: the lines of service are for data purposes only, not for payment.									
9136.26	FISS shall recognize that the acceptable HCPCS for Model claims are limited to G0299, G0300, G0155, G0156, G9473, G9474, G9475, G9476, G9477, G9478, G9479, and G9480 and that payment shall be paid if one 15 minute increment is present and the corresponding revenue code is present. If not present, return to provider for re-billing using Group Code = CO; CARC = 16; and, RARC = M51 or M53. G0299 and G0300 (Revenue code 0551) G0155 (Revenue code 0561 or 0569) G0156 (Revenue code 0571) G9473, G9474, G9475, G9476, G9477, G9478, G9479, and G9480 (Revenue code 0659)			X		X				
9136.27	Claims for demonstration services which are included on the same claim as non-Model services shall be returned for re-billing by FISS and direct providers to submit Model services on a separate claim form. Use Group Code = CO; CARC = 267; and, RARC = N74.			X		X				
9136.28	The contractors shall only pay Model claims submitted by Hospices participating in the MCCM.			X		X				
9136.29	Based on from and through dates, the contractors shall pay $200 if less than 15 days; and, $400 if 15 or more days.			X		X				HIGLAS
9136.29.1	The contractors shall pay $400 for discharge claims (TOB 8X1 and 8X4). This applies even if the day of discharge is the only day of service that month.			X		X				HIGLAS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9136.29.2	The contractors shall use Group Code “CO” and CARC “132” to identify the MCCM payments.			X		X				
9136.30	Contractors shall not pay claims that have overlapping service dates.			X		X				
9136.30.1	FISS shall create an edit that only one claim per month per provider with demo code "73" will be paid and additional claims per month per provider will be returned to provider. Use Group Code = CO; CARC = 267; and, RARC = N74.			X		X				
9136.31	FISS shall not apply a copay or deductible to for Model services. All MCCM claims shall be paid at 100% of the allowable.			X		X				
9136.32	When adjudicating claims for Model services, the contractor shall not pay for services for beneficiaries meeting the following criteria on the dates of service. CWF shall apply the same rejects as the NOE. 1. Beneficiaries that are deceased prior to the service from date. Use Group Code = CO; CARC = 13. 2. Beneficiaries not having both Medicare Part A as primary (for 24 continuous months) and Part B. Use Group Code = CO; CARC = 109. 3. Beneficiaries enrolled in a Medicare managed care organization, including but not limited to Medicare Advantage plans. Use Group Code = CO; CARC = 96; and, RARC = MA73. 4. Beneficiaries that are in a current Medicare Hospice Benefit period. Use Group Code = CO; CARC = B9. 5. Beneficiaries who do not have a current MCCM-specific NOE. Use Group Code = CO; CARC = 96; and, RARC = M138.								X	
9136.32.1	The MCCM-specific NOE shall be terminated retroactive to the dates related to the reason for the								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	above reject. a. date of death b. date when Part A is terminated c. date when Part B is terminated d. date of enrollment in a Medicare managed care organization, including but not limited to Medicare Advantage plans e. date of election of the Medicare Hospice Benefit (one day prior to the start of the current Medicare Hospice period)									
9136.33	FISS shall map the Model Claim, TOB 81X and 82X with demo code "73" present to the Medicare Part A Trust Fund.					X				HIGLAS
9136.34	If a Model claim is submitted for a beneficiary that is also in a home health episode of care, the Model claim shall be paid.			X		X				
9136.34.1	The contractor shall not reject home health claims just because the beneficiary is in the MCCM.					X				
9136.34.1.1	If a Model claim is submitted for a beneficiary that is currently in an SNF or hospital, the Model claim shall be paid.					X				
9136.35	FISS and CWF will recognize a Model claim TOB 8X1 or 8X4 submitted using the established patient status codes (01, 40, 41, 42, 50, 51) and established condition codes (52, H2) as the final claim and shall terminate the MCCM-specific NOE.			X		X			X	HIGLAS
9136.36	When Model claims are rejected for any reason, the contractor shall use Group Code "CO" and identified CARC and RARC's; and the beneficiary shall not be liable for any payments.			X		X				
9136.37	There shall not be limitations on the number of months a beneficiary is enrolled in the Model; or amount of services billed associated with this Model. There may be several lines of services on the claim; however, the payment is determined by			X		X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	the service thru dates.									
9136.38	The contractor shall not publish provider billing instructions for the Model. CMS will release all necessary information regarding how participating providers should submit claims.			X						
9136.39	PS&R shall perform system modifications to ensure that reimbursement and beneficiary counts are excluded from the hospice CAP reporting.									PS&R
9136.40	PS&R shall perform system modifications to ensure that MCCM services shall be excluded from the hospice CAP and reporting in the hospice cost report.			X						PS&R
9136.41	MCCM claims shall be included on the Providers 5010 835 Remittance Advice.					X				
9136.42	CMS shall provide the contractors a list of CARCs and RARCs to be used for MCCM.			X						CMS
9136.43	Paid Model claims shall be included on the MSN using message #60.4.					X				
9136.44	FISS shall handle MCCM claims per the standard Benefits Coordination & Recovery Center (BCRC) and Coordination of benefits (COB processes. a. NOEs with demo code "73" shall not crossover b. TOB 81X and 82X with demo code "73" (with the exception of the NOE) shall crossover.					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: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Marcie O'Reilly, marcie.oreilly@cms.hhs.gov; or Alexandre Laberge, alexandre.laberge@cms.hhs.gov; or Valarie Lazerowich, valarie.lazerowich@cms.hhs.gov.

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

VI. FUNDING

Section A: 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.

ATTACHMENTS: