CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-19 Demonstrations	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 198	**Date: June 27, 2018**
	Change Request 10314

Transmittal 196, dated August 27, 2017, is being rescinded and replaced by Transmittal 198, dated, June 27, 2018 to revise the dates in Business Requirements (BRs) 10314.3.1.4 and 10314.3.1.6, and to revise the edit code list in BR 10314.7.1 and BR 10314.7.2. All other information remains the same.

SUBJECT: Comprehensive ESRD Care (CEC) Model Telehealth - Implementation

I. SUMMARY OF CHANGES: Background: The Comprehensive ESRD Care (CEC) Model is designed to identify, test, and evaluate new ways to improve care for Medicare beneficiaries with End-Stage Renal Disease (ESRD). Through the CEC Model, CMS will partner with health care providers and suppliers to test the effectiveness of a new payment and service delivery model in providing beneficiaries with person-centered, high-quality care.

Policy: The CEC Model will implement design elements with implications for the Fee-for-Service (FFS) system for its third performance year that includes benefit enhancements to give Accountable Care Organizations (ACOs) the tools to direct care and engage beneficiaries in their own care. The model also offers increased monitoring to account for different financial incentives and the provision of enhanced benefits. The model's quality requirements are similar to Shared Savings Program (SSP) and Pioneer, modified as needed to take into account unique aspects of dialysis care, in keeping with the agencies initiatives to unify and streamline quality measurement and requirements.

1) Telehealth Waiver

In order to emphasize high-value services and support the ability of ESRD Seamless Care Organization (ESCOs) to manage the care of beneficiaries, CMS plans to design policies, as well as, use the authority under section 1115A of the Social Security Act (section 3021 of the Affordable Care Act) to conditionally waive certain Medicare payment requirements as part of the CEC Model. The CMS will make available to qualified ESCOs a waiver of the originating site requirement for services provided via telehealth. This benefit enhancement will allow beneficiaries to receive qualified telehealth services in nonrural locations and locations that are not specified by statute, such as homes and dialysis facilities. The waiver will apply only to eligible aligned beneficiaries receiving services from ESCO providers.

An aligned beneficiary will be eligible to receive telehealth services through this waiver if the services are otherwise qualified with respect to (1) the service provided, as designated by Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes and (2) the remote site. Notwithstanding these waivers, all telehealth services must be furnished in accordance with all other Medicare coverage and payment criteria, and no additional reimbursement will be made to cover set-up costs, technology purchases, training and education, or other related costs. In particular, the services allowed through telehealth are limited to those described under section 1834(m)(4)(F) of the Social Security Act and subsequent additional services specified through regulation with the exception that claims will ***not*** be allowed for the following telehealth services rendered to aligned beneficiaries located at their residence:

- Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or Skill Nursing Facilities (SNFs). HCPCS codes G0406 – G0408.

- Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days. CPT codes 99231 – 99233.
- Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days. CPT codes 99307 – 99310.
- Telehealth consultations, emergency department or initial inpatient. HCPCS codes G0425-G0427
- Telehealth Consultation, Critical Care, initial. HCPCS code G0508
- Telehealth Consultation, Critical Care, subsequent. HCPCS code G0509
- Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service. CPT codes 99356-99357

EFFECTIVE DATE: October 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 1, 2018

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	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: 198	Date: June 27, 2018	Change Request: 10314

Transmittal 196, dated August 27, 2017, is being rescinded and replaced by Transmittal 198, dated, June 27, 2018 to revise the dates in Business Requirements (BRs) 10314.3.1.4 and 10314.3.1.6, and to revise the edit code list in BR 10314.7.1 and BR 10314.7.2. All other information remains the same.

SUBJECT: Comprehensive ESRD Care (CEC) Model Telehealth - Implementation

EFFECTIVE DATE: October 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 1, 2018

I. GENERAL INFORMATION

A. Background: The Comprehensive ESRD Care (CEC) Model is designed to identify, test, and evaluate new ways to improve care for Medicare beneficiaries with End-Stage Renal Disease (ESRD). Through the CEC Model, CMS will partner with health care providers and suppliers to test the effectiveness of a new payment and service delivery model in providing beneficiaries with person-centered, high-quality care. The Model builds on Accountable Care Organization (ACO) experience from the Pioneer ACO Model, Next Generation ACO Model, and the Medicare Shared Savings Program to test Accountable Care Organizations for ESRD beneficiaries.

More than 600,000 Americans have ESRD and require life sustaining dialysis treatments several times per week. Many beneficiaries with ESRD suffer from poorer health outcomes, often the result of underlying disease complications and multiple co-morbidities. These can lead to high rates of hospital admission and readmissions, as well as a mortality rate that is higher than that of the general Medicare population.

According to the United States Renal Data System, in 2014, ESRD beneficiaries comprised less than 1% of the Medicare population, but accounted for an estimated 7.2% of total Medicare Fee-For-Service (FFS) spending, totaling over $32.8 billion. Because of their complex health needs, beneficiaries often require visits to multiple providers and follow multiple care plans, all of which can be challenging for beneficiaries if care is not coordinated. The CEC Model seeks to create incentives to enhance care coordination and to create a person-centered, coordinated, care experience, and to ultimately improve health outcomes for this population.

In the CEC Model, dialysis clinics, nephrologists and other providers join together to create an ESRD Seamless Care Organization (ESCO) to coordinate care for aligned beneficiaries. ESCOs are accountable for clinical quality outcomes and financial outcomes measured by Medicare Part A and B spending, including all spending on dialysis services for their aligned ESRD beneficiaries. This model encourages dialysis providers to think beyond their traditional roles in care delivery and supports them as they provide patient-centered care that will address beneficiaries' health needs, both in and outside of the dialysis clinic.

The CEC Model includes separate financial arrangements for larger and smaller dialysis organizations. Large Dialysis Organizations (LDOs), which have 200 or more dialysis facilities, will be eligible to receive shared savings payments. These LDOs will also be liable for shared losses, and will have higher overall levels of risk compared with their smaller counterparts.

Non-Large Dialysis Organizations (Non-LDOs) include chains with fewer than 200 dialysis facilities, independent dialysis facilities, and hospital-based dialysis facilities. Non-LDOs will have the option of participating in a one-sided track where they will be able to receive shared savings payments, but will not be liable for payment of shared losses, or participating in a track with higher risk and the potential for shared

losses. The one-sided track is offered in recognition of non-LDOs more limited resources.

The CEC Model began October 1, 2015 and will run until December 31, 2020. The CEC Model released a solicitation in 2016 to add more ESCOs for Performance Year two (2) of the Model to start January 1, 2017. The Model has no current plans for another round of solicitation.

The CEC Model LDO payment track and Non-LDO two-sided payment track are considered Alternative Payment Models (APMs) for the purpose of the Quality Payment Program.

B. Policy: Section 1115A of the Social Security Act (the Act) (added by section 3021 of the Affordable Care Act) (42 U.S.C. 1315a) authorizes the Center for Medicare and Medicaid Innovation (CMMI) to test innovative health care payment and service delivery models that have the potential to lower Medicare, Medicaid, and the Child Health Insurance Program (CHIP) spending while maintaining or improving the quality of beneficiaries' care.

The CEC Model will implement design elements with implications for the FFS system for its third performance year. The Model also offers increased monitoring to account for different financial incentives and the provision of enhanced benefits. The Mmodel's quality requirements are similar to Shared Savings Program (SSP) and Next Generation ACO Model, modified as needed to take into account unique aspects of dialysis care, in keeping with the agencies initiatives to unify and streamline quality measurement and requirements.

1) Telehealth Waiver

In order to emphasize high-value services and support the ability of ESCOs to manage the care of beneficiaries, CMS plans to design policies, as well as, use the authority under section 1115A of the Social Security Act (section 3021 of the Affordable Care Act) to conditionally waive certain Medicare payment requirements as part of the CEC Model. The CMS will make available to qualified ESCOs a waiver of the originating site requirement for services provided via telehealth. This benefit enhancement will allow beneficiaries to receive qualified telehealth services in nonrural locations and locations that are not specified by statute, such as homes and dialysis facilities. The waiver will apply only to eligible aligned beneficiaries receiving services from ESCO providers.

An aligned beneficiary will be eligible to receive telehealth services through this waiver if the services are otherwise qualified with respect to (1) the service provided, as designated by Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes and (2) the remote site. Contractors shall apply claims processing edit logic, audit, medical review, MSP, and fraud and abuse activities, appeals and overpayment processes for CEC claims in the same manner as normal FFS claims. Notwithstanding these waivers, all telehealth services must be furnished in accordance with all other Medicare coverage and payment criteria, and no additional reimbursement will be made to cover set-up costs, technology purchases, training and education, or other related costs. In particular, the services allowed through telehealth are limited to those described under section 1834(m)(4)(F) of the Social Security Act and subsequent additional services specified through regulation with the exception that claims will ***not*** be allowed for the following telehealth services rendered to aligned beneficiaries:

- Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or Skilled Nursing Facilities (SNFs). HCPCS codes G0406 – G0408.
- Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days. CPT codes 99231 – 99233.
- Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days. CPT codes 99307 – 99310.
- Telehealth consultations, emergency department or initial inpatient. HCPCS codes G0425-G0427
- Telehealth Consultation, Critical Care, initial. HCPCS code G0508
- Telehealth Consultation, Critical Care, subsequent. HCPCS code G0509

- Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service. CPT codes 99356-99357

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	
10314.1	Effective October 1, 2018, contractors shall prepare their systems to process Comprehensive ESRD Care (CEC) claims with dates of service October 1, 2018 and later.					X	X		X	
10314.2	Contractors shall consider claims with demo code 85 in the first DEMO code field to be CEC telehealth claims.					X	X		X	HIGLAS
10314.2.1	SSMs shall not consider demo code 85 if the other DEMO code fields on the claim record are populated with other demo codes.					X	X		X	HIGLAS
10314.2.2	Providers submitting electronic 837 claims will have entered the DEMO 85 in the REF segment 2300 Loop Demonstration Project Identifiers. Providers will include Qualifier P4. FISS shall move the demo code 85 from the REF segment 2300 Loop Demonstration Project Identifiers to the demo code field. Providers submitting paper claims will have entered the DEMO 85 in the treatment authorization field. FISS shall move the demo code 85 from the treatment authorization field to the demo code field.					X				
10314.3	The ACO-OS shall send the Fiscal Intermediary Shared System (FISS)/Multi-Carrier System (MCS) the initial provider files for each ESRD Care Organization (ESCO) that will bill under the waiver. The file will include a header and trailer record. CMS shall include the following data elements/fields on the provider alignment file: 1. Detail records consisting of: a. Record Identifier; b. ESCO Identifier 2. Participating Tax Identification Number (TIN)					X	X			CMS, VDCs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	3. Participating National Provider Identifier (NPI) 4. Participating CMS Certification Number (CCN) 5. Effective Start Date in the CEC telehealth waiver 6. Effective End Date in the CEC telehealth waiver 7. A record type (benefit enhancement flag values identified by a single character). A benefit enhancement flag value of '6' would identify a CEC telehealth provider.									
10314.3.1	SSMs shall be prepared to accept the above listed data elements in 10314.3 on the initial provider files for each ESCO.					X	X			
10314.3.1.1	The STC shall provide to ACO-OS the provider and beneficiary data to create the test files by June 12, 2018. To assist with the testing files creation, STC shall provide a list of at minimum 15 beneficiaries (as indicated by HICN) and 15 providers (as indicated by TIN and NPI). Providers may be primary care providers, nephrologists, dialysis facilities and other diverse providers. These sample beneficiaries and providers will be provided in a single Comma Separated Value (CSV) file using the layout of HICNs, TINs, and NPIs. The primary OIT point of contact is Yani Mellacheruvu (Yani.Mellacheruvu@cms.hhs.gov) and the secondary OIT point of contact is Tej Ghimire (Tej.Ghimire@cms.hhs.gov).									CMS, STC, VDCs
10314.3.1.2	The ACO-OS shall provide the provider alignment and beneficiary alignment test and final files to STC on or before the week of July 9, 2018.									CMS, STC, VDCs
10314.3.1.3	The MACs shall provide to ACO-OS the provider and beneficiary data to create the test files on or about the week of July 9, 2018. To assist with the testing files creation, the MACs shall provide a list of at minimum 15 beneficiaries (as indicated by HICN) and 15 providers (as indicated by TIN and NPI). Providers may be primary care providers, nephrologists, dialysis facilities and other	X	X							CMS, VDCs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	diverse providers. These sample beneficiaries and providers will be provided in a single excel file using the layout of HICNs, TINs, and NPIs. The ACO-OS will provide a template of this excel document. These files will be sent with password protection by the MACs to an OIT contact. This OIT contact will unlock them and place them on CMS Sharepoint. The primary OIT point of contact is Yani Mellacheruvu (Yani.Mellacheruvu@cms.hhs.gov) and the secondary OIT point of contact is Tej Ghimire (Tej.Ghimire@cms.hhs.gov).									
10314.3.1.4	The ACO-OS shall push the test files to the VDCs on or about July 9, 2018 for STC and September 10, 2018 for UAT to transmit the test files.									CMS, VDCs
10314.3.1.5	The VDCs shall transmit the provider and beneficiary alignment test file responses via EFT.									CMS, VDCs
10314.3.1.6	CMS shall push test files with aligned beneficiaries and providers to FISS by September 7, 2018					X				
10314.3.2	SSMs shall maintain an update-date in their internal file, which will reflect the date the updated files were loaded into the shared systems. The creation date will be reflected for records captured for the initial load of records. The field shall be viewable to the Medicare Administrative Contractors (MACs).					X	X			
10314.3.2.1	The STC will be sent an updated provider file.									STC
10314.3.2.2	The STC can submit changes to the provider file on or before August 7, 2018.									STC
10314.3.3	CMS shall send the provider file to MCS. MCS shall send the provider file to FISS. CMS shall include a header record on the provider file to identify the ESCO provider file and the reporting period. The file layout will be aligned with the file layout used by the Next Generation ACO Model for beneficiary enhancements. The provider file will be a national file.					X	X			CMS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10314.3.3.1	MCS shall receive and edit the provider files.						X			
10314.3.3.2	MCS shall push the provider files to FISS.					X	X			
10314.3.4	The contractor shall process CEC claims as telehealth claims when the provider is indicated as being a telehealth provider based on the benefit enhancement flag value of '6.'						X			
10314.4	CMS (ACO-OS) shall send CWF the initial beneficiary alignment files detailing beneficiaries aligned to participating ESCOs. The file layout will be aligned with the file layout used by the Next Generation ACO Model in CR9151 for beneficiary enhancements. The beneficiary file will be a national file. **Note:** The beneficiary alignment file will be a national file accessible by all MACs.					X			X	CMS, VDCs
10314.4.1	CWF shall provide the beneficiary file with the most current Health Insurance Claim Number (HICN) to MCS/FISS					X	X		X	
10314.4.2	SSMs shall be prepared to accept the above listed data elements in 10314.4 on the initial beneficiary files for each ESCO.					X	X			
10314.5	CMS (ACO-OS) shall include the following data elements on the aligned beneficiary file: • Unique Key: • ESCO ID (E####) • Bene HICN • Eff Start Date of Alignment to ESCO • Eff End Date of Alignment to ESCO • Deleted Beneficiary = Value D • Beneficiary Medical Data Sharing Preference Indicator The same data elements shall be included by CWF on the beneficiary alignment file they share.								X	CMS
10314.5.1	SSMs shall maintain an update-date in their internal file, which will reflect the date the updated file was					X	X		X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	loaded into the shared system. The creation date will be reflected for records captured for the initial load of records. The field shall be viewable to the MACs.									
10314.5.1.1	The STC will be sent an updated beneficiary file.									STC
10314.5.1.2	The STC can submit changes to the beneficiary file on or before August 7, 2018.									STC
10314.5.2	CWF shall apply the ESCO BENE file to the current ACOB Auxiliary File that carries the Update Date.								X	
10314.6	The CMS (ACO-OS) shall provide the provider and beneficiary alignment files to the Virtual Data Center (VDCs) when they become available. **NOTE**: BRs 10314.6.2 shall be applicable to all test files.								X	CMS, VDCs
10314.6.1	The CMS (ACO-OS) shall transmit the provider and beneficiary alignment files through Electronic File Transfer (EFT).									CMS
10314.6.2	The CMS (ACO-OS) shall notify the contractors of the provider and beneficiary alignment file names and when they will become available.	X	X			X	X		X	CMS, STC, VDCs
10314.7	SSMs shall create response files to the ACO-OS when they have received and validated the provider (MCS) and beneficiary alignment (CWF) files. These validation result files will indicate that the file was processed and contained no errors if no validation errors were encountered.						X		X	
10314.7.1	MCS shall produce a response file for CEC provider file received from ACO OD that indicates specific records and fields that did not pass the validation checks using defined error codes listed in the Interface Control Document (ICD) if any errors are encountered. The SSM shall use the following error codes listed below: Code Description/Explanation: • 00 = Success/The record was processed						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	successfully. • 10 = Header Record ID Error/The Header contains a Record ID but the last three characters are not PRV or BEN. • 11 = Header Record Date Error/The Header Record date is missing or invalid. • 30 = Trailer Record ID Error/The Trailer contains a Record ID but the last three characters are not PRV or BEN. • 31 = Trailer Record Date Error/The Trailer Record date is missing or invalid. • 32 =Trailer Record Count Error/ The Trailer Record Count in the Trailer does not equal the number of detail records sent by CMS. • 98 = Header Record Missing/The Header record is missing or does not begin with HDR. • 99 = Trailer Record Missing/The Trailer record is missing or does not begin with TRL.									
10314.7.2	CWF shall produce a response file for CEC beneficiary alignment file received from ACO OS that indicates specific records and fields that did not pass the validation checks using defined error codes listed in the Interface Control Document (ICD) if any errors are encountered. The SSM shall use the following error codes listed below: Code Description/Explanation: • 00 = Success/The record was processed successfully. • 10 = Header Record ID Error/The Header contains a Record ID but the last three characters are not PRV or BEN. • 11 = Header Record Date Error/The Header Record date is missing or invalid. • 20 = Detail Record ID Error - The data in the file does not conform to the file layout specified for the file transfer. The data format of the field or the data in the field does not conform to the list of valid values specified. • 21 = ACO ID Error - ACO ID is missing or invalid. • 25 = Effective Start Date Error - The Effective Start Date is missing or invalid. • 26 = Effective End Date Error - The Effective								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	End Date is missing or invalid. • 29 = Beneficiary HICN Error - The Beneficiary HICN is missing or invalid. • 30 = Trailer Record ID Error/The Trailer contains a Record ID but the last three characters are not PRV or BEN. • 31 = Trailer Record Date Error/The Trailer Record date is missing or invalid. • 32 =Trailer Record Count Error/ The Error occurs when the record count does not equal the number of data records. • 98 = Header Record Missing/The Header record is missing or does not begin with HDR. • 99 = Trailer Record Missing/The Trailer record is missing or does not begin with TRL.									
10314.8	CMS (ACO-OS) shall provide the final provider and beneficiary alignment files from the CMS mainframe on or about October 1, 2018.									CMS, VDCs
10314.9	On or about October 1, 2018 the CMS shall push the final files to the MACs and datacenters specific to their contractor workload(s).									CMS, VDCs
10314.10	SSMs shall produce response files via EFT acknowledging receipt of the provider (MCS shall produce the provider response files) and beneficiary (CWF shall produce the beneficiary response files) final files.						X		X	
10314.10.1	The VDCs shall transmit the provider and beneficiary alignment final file responses via EFT.									CMS, VDCs
10314.11	CMS (ACO-OS) shall send updated aligned beneficiary files and provider files as often as monthly.									CMS, VDCs
10314.11.1	CMS shall not send aligned beneficiary or provider files if there are no updates									CMS, VDCs
10314.12	SSMs shall process the updated provider and aligned beneficiary files as full replacement files.					X	X		X	
10314.12.1	CWF shall generate an Informational Unsolicited Response (IUR) for claims with demo code 85 and benefit enhancement flag of '6' when there is a change								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	to the beneficiary alignment file. Specifically, an IUR will be generated for claims with service dates greater than 90 Days after the effective end date of a beneficiary.									
10314.12.1.1	CWF shall carry the new benefit enhancement flag of '6' representing CEC Telehealth.								X	
10314.12.1.2	FISS should process an IUR as an adjustment if it is received. The adjustment will remove demo code 85 and the benefit enhancement flag of 6 and reprocess the claim as a non-demo service.					X				
10314.12.1.3	MCS should process an IUR as an adjustment if it is received. The adjustment will remove the benefit enhancement flag of 6 and reprocess the claim as a non-demo service.						X			
10314.13	SSMs shall update the provider record of ESCO aligned providers according to the update in BR 10314.12.					X	X			
10314.14	SSMs shall update the system with aligned beneficiary data according to the update in BR 10314.12.					X	X		X	
10314.15	SSMs shall consider the beneficiary dropped when the Effective and End dates are the same.					X	X		X	
10314.16	SSMs shall consider a beneficiary aligned if the from date on the date of service on the claim is on or after the effective start date and on or before 90 days after the effective end date.					X	X		X	
10314.17	SSMs shall identify CEC telehealth claims at the header level (claim level) by the claim identifier of demo code 85.					X	X			
10314.17.1	SSMs shall populate the demo code 85 in the demo code field when the provider has submitted it.					X				
10314.17.2	SSMs shall process claims and append benefit enhancement indicator of '6' as Telehealth claims					X	X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	under certain conditions.									
10314.17.2.1	FISS shall process institutional claims and append benefit enhancement indicator of '6' as CEC Telehealth claims when the claim includes: • An aligned provider with a telehealth indicator of '6'; • An aligned beneficiary; • At least one claim detail line for the rendering providers that includes one of the CPT or HCPCS codes in 10314.20; • Demo code 85 in the header; and • No other demo codes in the header besides demo code 85 (since claims with other demo codes will not be paid as CEC telehealth claims in accordance with BR 10314. 2.1) FISS shall populate the benefit enhancement indicator of '6' at the claim header level.					X				
10314.17.2.1.1	If a claim has a demo code of 85 and FISS finds that the claim also goes to another demonstration, then FISS shall remove the demo code of 85.					X				
10314.17.2.2	MCS shall process professional claims and append benefit enhancement indicator of '6' as CEC Telehealth claims when the claim includes: • An aligned provider with a telehealth indicator of '6'; • An aligned beneficiary; • At least one claim detail line for the rendering Part B providers that includes one of the CPT						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	or HCPCS codes in 10314.19; • Demo code 85 in the header; and • No other demo codes in the header besides demo code 85 (since claims with other demo codes will not be paid as CEC telehealth claims in accordance with BR 10314. 2.1) MCS shall populate the benefit enhancement indicator of '6' at the claim line level.									
10314.17.2.3	SSMs shall send the CEC ID, demo code and the benefit enhancement flag to CWF on the transmit file using the fields currently used for NGACO claims.					X	X			
10314.18	SSMs shall ensure the claim identifier (demo code 85) at the header level will flow to downstream systems including but not limited to: National Claims History (NCH), Integrated Data Repository (IDR), and Chronic Condition Warehouse (CCW).					X	X		X	FPS, IDR, NCH
10314.19	Contractors shall process CEC telehealth claims with Place of Service (POS) = 02 (Telehealth) when the provider is an ESCO provider and the beneficiary is aligned to the same ESCO for the Date of Service (DOS) on the claims and when the claim contains the demo code 85 and one of the following CPT or HCPCS codes: • 90785 • 90791 • 90792 • 90832 • 90833 • 90834 • 90836 • 90837 • 90838 • 90839 • 90840 • 90845 • 90846 • 90847		X				X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• 90951 • 90952 • 90954 • 90955 • 90957 • 90958 • 90960 • 90961 • 90963 • 90964 • 90965 • 90966 • 90967 • 90968 • 90969 • 90970 • 96116 • 96150 • 96151 • 96152 • 96153 • 96154 • 96160 • 96161 • 97802 • 97803 • 97804 • 99201 • 99202 • 99203 • 99204 • 99205 • 99211 • 99212 • 99213 • 99214 • 99215 • 99354 • 99355 • 99406 • 99407 • 99495 • 99496 • 99497 • 99498 • G0108									

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• G0109 • G0270 • G0396 • G0397 • G0420 • G0421 • G0438 • G0439 • G0442 • G0443 • G0444 • G0445 • G0446 • G0447 • G0459 • G0506 • G9481 • G9482 • G9483 • G9484 • G9485 • G9486 • G9487 • G9488 • G9489									
10314.19.1	Contractors shall not process as CEC telehealth claims that contain the following codes. Claims that contain these codes can be processed following existing claims processing logic: • HCPCS codes G0406 – G0408. • CPT codes 99231 – 99233. • CPT codes 99307 – 99310. • HCPCS codes G0425-G0427 • HCPCS code G0508 • HCPCS code G0509 • CPT codes 99356-99357		X				X			
10314.20	Contractors shall process CEC telehealth claims when the provider is an ESCO provider and the beneficiary is aligned to the same ESCO for the Date of Service (DOS) on the claims and when the claim is on a Type of Bill 12X, 13X, 22X, 23X, 71X, 72X, 76X, 77X,	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	and 85X and contains the demo code 85 and one of the following CPT or HCPCS codes: • 90785 • 90791 • 90792 • 90832 • 90833 • 90834 • 90836 • 90837 • 90838 • 90839 • 90840 • 90845 • 90846 • 90847 • 90951 • 90952 • 90954 • 90955 • 90957 • 90958 • 90960 • 90961 • 90963 • 90964 • 90965 • 90966 • 90967 • 90968 • 90969 • 90970 • 96116 • 96150 • 96151 • 96152 • 96153 • 96154 • 96160 • 96161 • 97802 • 97803 • 97804 • 99201 • 99202									

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• 99203 • 99204 • 99205 • 99211 • 99212 • 99213 • 99214 • 99215 • 99354 • 99355 • 99406 • 99407 • 99495 • 99496 • 99497 • 99498 • G0108 • G0109 • G0270 • G0396 • G0397 • G0420 • G0421 • G0438 • G0439 • G0442 • G0443 • G0444 • G0445 • G0446 • G0447 • G0459 • G0506 • G9481 • G9482 • G9483 • G9484 • G9485 • G9486 • G9487 • G9488 • G9489									
10314.20.1	Contractors shall not process as CEC telehealth claims that contain the following codes. Claims that contain	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	these codes can be processed following existing claims processing logic: • HCPCS codes G0406 – G0408. • CPT codes 99231 – 99233. • CPT codes 99307 – 99310. • HCPCS codes G0425-G0427 • HCPCS code G0508 • HCPCS code G0509 • CPT codes 99356-99357									
10314.21	Contractors shall process and flag CEC Telehealth originating site claims with benefit enhancement indicator "6" when this benefit enhancement is elected by the provider for the Date of Service (DOS) on the claim, when the beneficiary is aligned for the submitted claim, and the following HCPCS code: • Q3014	X	X			X	X			
10314.21.1	Contractors shall process CEC Telehealth claims for bill types 12X, 13X, 22X, 23X, 71X, 72X, 76X, 77X, and 85X, with revenue code 078X when this benefit enhancement is elected by the provider for the DOS on the claims and when the claim contains the following HCPCS code: • Q3014	X				X				
10314.22	Contractors shall retain the demo code 85 on the CEC telehealth claims even when the claim denied or rejected.					X	X			
10314.23	The contractor shall treat CEC patients the same as Medicare patients for cost reporting purposes.	X								
10314.24	Contractors shall return the professional claim if the provider appends demo code 85 and: • provider is not on CEC participant provider list with a telehealth record type; or • Date of service 'from date' is prior to the provider's telehealth effective date; or		X				X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• Date of service ' from date' is after the provider's telehealth termination date; or • The date of service 'from date' was prior to the beneficiary's effective date; or • The date of service 'from date' was more than 90 days after the beneficiary's termination date; or • The beneficiary was not aligned to the same ESCO with which the provider was participating (as identified by ESCO ID) • Other, non-telehealth services are billed on the same claim. In these cases, none of the services on the claim should be processed.									
10314.24.1	If the contractor identifies that the claim does not meet the terms of the demonstration based on 10314.24, Medicare contractors shall return the claim as unprocessable and shall assign: CARC 16 (Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.) & RARC N763 (The demonstration code is not appropriate for this claim; resubmit without a demonstration code.) Group Code: CO (contractual obligation). This does not require MSN information because the beneficiary does not need to take any action.		X							
10314.25	Contractors shall return institutional claim to the provider, if the provider appends demo code 85 and: • the provider is not on CEC participant provider list with a telehealth record type; or • Date of service 'from date' is prior to the provider's telehealth effective date; or • Date of service ' from date' is after the provider's telehealth termination date; or • The date of service 'from date' was prior to the beneficiary's effective date; or • The date of service 'from date' was more than 90 days after the beneficiary's termination	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	date; or • The beneficiary was not aligned to the same ESCO with which the provider was participating (as identified by ESCO ID); or • the Type of Bill is not 12X, 13X, 22X, 23X, 71X, 72X, 76X, 77X, or 85X; or • Other, non-telehealth services are billed on the same claim.									
10314.25.1	If the contractor identifies that the claim does not meet ther terms of the demonstration based on 10314.25, Medicare contractors shall return the claim to the provider (RTP). This does not require a Group Code because there is no CARC (and there cannot be one without the other). This does not require MSN information because the beneficiary does not need to take any action.	X								
10314.26	Contractors shall process CEC telehealth claims when demo code 85 is appended to the claim if all of the following conditions are met: • the Type of Bill is 12X, 13X, 22X, 23X, 71X, 72X, 76X, 77X, or 85X (Part A only requirement); and • The HCPCS or CPT codes are included in BR 10314.19 or 10314.20; and • the Date of Service (DOS) on the claim falls on or within the provider's active dates with the ESCO (i.e., is on or after the effective date and on or before the termination date of the provider); and • The DOS on the claim occurred when the beneficiary is active with the ESCO (i.e., on or after the effective date and on or before 90 days after the exclusion date of the beneficiary); and • the beneficiary and provider are associated with the same ESCO (as identified by ESCO ID).	X	X			X	X			
10314.26.1	Contractors shall generate the MSN Message on claim details identified as related to the new CEC Telehealth	X	X			X	X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	enhancement. The MSN message can be applied at the claim level. The MSN message number is 4.13. This is a new message. English You received this telehealth service from your ESRD Seamless Care Organization (ESCO) provider. You may have received this service because of your relationship with the ESCO. Ask your doctor to tell you more about your ESCO. Spanish Recibió este servicio de telesalud de parte de su proveedor de Organización de Cuidado Continuo para ESRD (ESCO en inglés). Es posible que haya recibido este servicio debido a su relación con la ESCO. Pregúntele a su médico a cerca de su ESCO.									
10314.27	SSMs shall send demo code 85 to the CERT in the Claim Demonstration (Identification) Number data element in the Claim Resolution File.					X	X			CERT
10314.28	Contractors shall use ACO information online screens to display CEC Provider file data to include file update history.					X	X			
10314.29	Contractors shall use ACO information online screens to display CEC Beneficiary file data to include file update history.					X	X			

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10314.30	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09	X	X			

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.					

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:
	N/A

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

V. CONTACTS

Pre-Implementation Contact(s): Zoe Hruban, 410-786-9753 or zoe.hruban@cms.hhs.gov , Maria Alexander, 410-786-3889 or maria.alexander1@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: 0