DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

The Centers for Medicare & Medicaid Services (CMS) is launching a new instrument for 2013 called the MAC Satisfaction Indicator (MSI). The MSI is a tool that measures providers' satisfaction with their Medicare claims administrative contractor(s). Your input will help your MAC to improve the services that they offer you. Participation is voluntary, but you must register to participate. Complete the application at https://adobeformscentral.com/?f=eMRKPqaWpqMxNOmTQpSKDA on the Internet. For more information, visit http://www.cms.gov/Medicare/Medicare-Contracting/MSI on the CMS website.

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The Affordable Care Act and Model 4 Bundled Payments for Care Improvement

Note: This article was revised on September 23, 2013, to add clarifying language on page 3 (**bold**). This article was previously revised on July 26, 2013, to reflect a revised Change Request (CR). The CR added Part B MAC responsibility to the CR's business requirement 18.3. The release date, transmittal number and link to the CR were also changed. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for hospitals, physicians, and non-physician providers participating in the Model 4 Bundled Payments for Care Improvement (BPCI) initiative and submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and A/B Medicare Administrative Contractors (MACs)) for services to Medicare beneficiaries.

What You Need to Know

This article provides an overview of Medicare's implementation of the Model 4 Bundled Payments for Care Improvement initiative. General program information is provided along with separate sections

containing information of special interest to hospitals and physicians and non-physician providers. It addresses issues related to readmissions, claims crossover, remittance advice, and claims submission, among others. This pilot program is being conducted under the Centers for Medicare & Medicaid Services (CMS) Innovation Center's model testing authority. The program is slated to be implemented in October 2013.

Background

The Affordable Care Act provides a number of new tools and resources to help improve health care and lower costs for all Americans. Bundling payment for services that patients receive during a single episode of care, such as heart bypass surgery or a hip replacement, is one way to encourage doctors, hospitals, and other health care providers to work together to better coordinate care for patients, both when they are in the hospital and after they are discharged. Such initiatives can help improve health, improve quality of care, and lower costs.

CMS is working in partnership with providers to develop models of bundling payments through the BPCI initiative. On August 23, 2011, CMS invited providers to apply to help test and develop four different models for bundling payments. Model 4, one of these four models, is discussed in this article. In Model 4, the episode of care is defined as the acute care hospital stay and includes inpatient hospital services, Part B services furnished during the hospitalization, and hospital and Part B services for related readmissions.

Information in this article is based on the change requests implemented for Bundled Payments for Care Improvement Model 4, including CRs 7887, 8070, and 8196.

General BPCI Model 4 Information

Beneficiary Eligibility

In order to be eligible for Model 4, the beneficiary must meet the following requirements:

- Beneficiary is eligible for Part A and enrolled in Part B;
- At the time of admission, beneficiary either (a) has at least 1 day of utilization left and that day is also a day of entitlement or (b) has at least one lifetime reserve day remaining;
- Beneficiary does not have End-Stage Renal Disease;
- Beneficiary is not enrolled in any managed care plans;
- Beneficiary must not be covered under the United Mine Workers; and
- Medicare must be the primary payer.

If the beneficiary does not meet all of these requirements, the following codes will be assigned to rejected or cancelled NOAs:

- Claims Adjustment Reason Code (CARC) B5: Coverage/program guidelines were not met or were exceeded.
- Remittance Advice Remarks Code (RARC) N564: This patient did not meet the inclusion criteria for the demonstration project or pilot program.

Model 4 Bundled Payment Provision

Hospitals that participate in the BPCI Model 4 initiative will receive a prospectively established bundled payment for agreed upon Medicare Severity Diagnosis Related Groups (MS-DRGs).

- This will not apply to claims that are paid on a transfer per-diem basis.
- This payment will include both the DRG payment for the hospital and a fixed amount for the Part B services anticipated to be rendered during the admission. Separate payment for providers' professional services rendered during the inpatient hospital stay will not be made.
- Participating Model 4 hospitals will receive a Model 4 payment and will be responsible for payment to providers who would otherwise be paid for professional services under the Physician Fee Schedule (PFS). As such, physicians and non-physician practitioners should seek payment for professional provider services from the Model 4 hospital.
- Per the conditions of the Agreement between CMS and the Model 4 hospital, payment to physicians and non-physician practitioners must be made at a rate that is equivalent to the amount that would otherwise apply under the PFS, unless a different amount has been agreed to in writing by the Model 4 hospital and the physician.
- Claims from physicians will be processed as no-pay claims if they occur between the inpatient hospital admission and discharge date in order to prevent duplicate payment of physicians under the bundled payment.

Co-payments, Co-insurance, and Deductibles

- The regular Part A deductible, including the Part A blood deductible, and daily coinsurance amounts (when applicable) will continue to be applied to the claim.
- The fixed Part B portion of the negotiated bundled payment will first be applied to the Part B deductible, if applicable.
- A fixed Part B copayment will be applied to the claim. This will be the responsibility of the beneficiary and will be calculated as an approximation of what the Part B coinsurance would have been in the absence of Model 4.
- Both the copayment and the deductible to be paid by the beneficiary for the Part B services will appear on the MSN along with the Part A deductible and any applicable coinsurance.

Appeals

Payments made under Model 4 have no rights of appeal, except in the case of calculation errors.

- RARC N83: No appeal rights. Adjudicative decision based on the provisions of a demonstration project.

Information for Hospitals

Notification of Admission (NOA)

Hospitals participating in this initiative should submit a Notice of Admission (NOA) when a beneficiary expected to be included in the model is admitted. Timely filing of the NOA allows subsequent Part B claims submitted before the hospital claim to be properly processed as "no-pay" claims, which indicates that payment for these claims are to be included in hospital payments under Model 4. By extension, these Part B claims will then be included timely on weekly Part B reports provided to the hospital to be used in calculating payments for Part B providers.

- Hospitals will be paid a $500 payment upon submission of the NOA and will receive the balance of the prospectively established bundled payment when the hospital claim is processed.
  - RARC N568: Initial payment based on the Notice of Admission (NOA) under the Bundled Payment Model IV initiative.
  - If the patient ultimately does not qualify for a Model 4 prospective payment based on the MS-DRG ultimately assigned to their inpatient stay, or if the NOA is cancelled, the $500 NOA payment will be recouped.
  - Medicare systems will initiate a "look back" into the claims history records upon receipt of a canceled NOA to identify Model 4 BPCI claims- i.e., Part B physician or other professional claims - which were processed as "no pay" as a result of the NOA being opened. If such claims were processed, the Medicare contractor will adjust the claims automatically and remit payment for services rendered based on regular Medicare Fee-for-Service claims processing rules.
  - Hospitals must submit the final claim within 60 days of the beneficiary's hospital admission or submit an interim claim during that time period to demonstrate that the beneficiary is still an inpatient. Otherwise, the beneficiary will be considered not subject to episode payment and the $500 will be recouped.
    - The following codes will be assigned when a Model 4 claim matches an NOA for admission date and beneficiary, but not provider.
      - CARC 208: National Provider Identifier - Not matched
      - RARC N562: The provider number of your incoming claim does not match the processed Notice of Admission (NOA) for this bundled payment
    - The following codes shall be assigned when an NOA is cancelled because a matching claim is not received within 60 days. A match consists of beneficiary, admit date, and provider.
      - CARC 226: Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete
      - RARC N560: This pilot program requires an interim or final claim within 60 days of the Notice of Admission. A claim was not received

Readmissions

Model 4 hospitals will not be paid for readmissions that occur to the same hospital (i.e., another admission with a date of admission within 30 days of discharge of the Model 4 stay) under this model unless the MS-DRG assigned to that readmission is expressly excluded as unrelated to the MS-DRG assigned to the original admission.

- Unrelated readmissions have been defined by CMS, and a list of DRGs defining unrelated readmissions has been provided for each included MS-DRG to every Model 4 participating hospital. This list can also be found on the Bundled Payments collaboration site, accessible to Model 4 Awardees.
- Related readmissions to a hospital other than the original treating hospital, as well as payments for physicians' services during related readmissions to hospitals other than the original treating hospital, will be reconciled retrospectively by a BPCI payment reconciliation contractor and payment will be recouped, as applicable, by the Model 4 awardee.
    - If claims for a Model 4 anchor admission and a readmission are submitted out of order, the readmission claim will be canceled and must be resubmitted to receive payment. The following codes will be used in this situation:
        - CARC 249: This claim has been identified as a readmission.
        - RARC N561: The bundled payment for the episode of care includes payment for related readmissions. You may resubmit your claim to receive a corrected payment.

Payment Rate Updates and Adjustors

Payment rates may be updated as often as quarterly to allow for ongoing updates to Medicare payment rates, including regular recurring changes made to the Physicians Fee Schedule (PFS) and Inpatient Prospective Payment System (IPPS). Indirect Medical Education (IME) and Disproportionate Share Hospital (DSH) payments, as well as outlier payments and hospital capital payments to Model 4 hospitals will be calculated based on the non-discounted base DRG payment that would have been made in the absence of the model. This is true for both anchor admissions and related readmissions to the Model 4 hospital. In the case of readmissions, these payments will be denoted by the following:

- CARC 249: This claim has been identified as a readmission.
- RARC N524: Based on policy this payment constitutes payment in full.

Other applicable payment adjustors will also be calculated based on the base DRG that would otherwise have applied to the case, as opposed to the prospectively established amount paid through this initiative, which will be higher as it includes payment for Part B services in addition to the base DRG payment.

Information for Physicians and Non-Physician Providers

Claims Submission and Processing

Physicians and non-physician practitioners shall submit claims for dates of service during an episode of care included in Model 4 BPCI as usual.

Physicians and non-physician practitioners shall be required to accept assignment for all claims covered under the Model 4 BPCI payment.

For those Part B services rendered during a Model 4 admission or a related readmission to that Model 4 hospital, Medicare will process claims as no-pay. In processing no-pay professional claims, Medicare will assign the following:

- CARC 234: This procedure is not paid separately.
- RARC N67: Professional provider services not paid separately. Included in facility payment under a demonstration project. Apply to that facility for payment, or resubmit your claim if: the facility notifies you the patient was excluded from this demonstration; or, if you furnished these services in another location on the date of admission or discharge from a demonstration hospital. If services furnished in a facility not involved in the demonstration on the same date the patient was discharged from or admitted to a demonstration facility, you must report the provider ID number for the non-demonstration facility on the new claim.

Physicians submitting claims should take care not to include on the same claim services that are both within the dates (admission and discharge) of a Model 4 BPCI episode and outside the dates of the episode. If such claims with both Model 4 and non-Model 4 services are received, Medicare contractors will reject the claims and advise the physician to separate the services and rebill. The following remittance messages will be used in this situation:

- CARC 239: Claim spans eligible and ineligible periods of coverage. Rebill separate claims.
- RARC N61: Rebill services on separate claims.

Incentive Payments

Bonus or incentive payments calculated by CMS, such as HPSA bonus payments, will not be affected by physician or non-physician practitioner participation in the Bundled Payments initiative.

Participation Declination

Physicians have the right to decline participation in this program. Declination will be indicated by including a HCPCS modifier on each claim. Further details will be provided at a future date.

Readmissions

Part B services provided during a related readmission to the original treating hospital will not be paid separately. If Part B claims were processed prior to receipt of the hospital's readmission claim, Medicare will take steps to recover payments to the physician.

- CARC A1: Claim/Service Denied; and
- RARC N68: Prior payment being cancelled as we were subsequently notified this patient was covered by a demonstration project in this site of service. Professional services were included in the payment to the facility. You must contact the facility for payment. Prior payment made to you by the patient or another insurer for this claim must be returned within 30 days.

Claims Crossover

In association with this initiative, CMS will make changes to allow for the reporting of two new Claim Adjustment Reason Codes (CARCs) within the 2320 Claim Adjustment Segment (CAS), so that supplemental payers can more easily determine these amounts when adjudicating Medicare Health Insurance Portability and Accountability Act (HIPAA) 837 institutional Coordination of Benefits (COB)/crossover claims.

- CARC 247 will be defined as "Part B deductible on a Part A claim."
- CARC 248 will be defined as "Part B coinsurance on a Part A claim."
- An adjusted RARC M137 will be defined as "Part B coinsurance under a demonstration project or pilot program.

This initiative will also result in the reporting of a new value code within the 2300 Health Care Information Codes (HI) Value Information (qualifier BE) portion of outbound HIPAA 837 institutional COB/crossover claims.

Additional Information

The official instruction, CR8070, issued to your Medicare contractor regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1251OTN.pdf on the CMS website. In addition, CR8196 is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1189OTN.pdf and CR7887 is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1240OTN.pdf on the CMS website.

If you have any questions, please contact your Medicare contractor at their toll-free number, which is available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.