CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-19 Demonstrations	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 10281	**Date: August 7, 2020**
	Change Request 11896

SUBJECT: Primary Care First (PCF) and Serious Illness Patient (SIP) Models: Part 2: FFS Payments and other claims-based adjustments

I. SUMMARY OF CHANGES: The Innovation Center has secured approval for a new Primary Care First (PCF) model with two separate but related components: (1) the PCF component and (2) the Seriously Ill Population (SIP) component. Both components will test alternative payments and the provision of technical support to primary care practices. Practices may participate in one or both components, although individual beneficiaries may only be covered under one component at a time. Primary care practices participating in PCF and/or SIP will receive a combination of claims and non-claims-based payments based on their attributed Medicare fee-for-service (FFS) beneficiaries. With fewer reporting requirements, PCF-only practices will have the flexibility to implement their own strategies that best target outcomes within PCF. SIP-only practices will deliver care to a separate patient population that is both higher risk and shows fragmented patterns of care. This CR is a follow-on to CR 11419.

EFFECTIVE DATE: January 1, 2021 - Applicable to the PCF component (Excludes beneficiaries and providers from the SIP component); April 1, 2021 - Applicable to the SIP component
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2021

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: 10281	Date: August 7, 2020	Change Request: 11896

SUBJECT: Primary Care First (PCF) and Serious Illness Patient (SIP) Models: Part 2: FFS Payments and other claims-based adjustments

EFFECTIVE DATE: January 1, 2021 - Applicable to the PCF component (Excludes beneficiaries and providers from the SIP component); April 1, 2021 - Applicable to the SIP component
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2021

I. GENERAL INFORMATION

A. Background: Section 1115A of the Social Security Act established a new Center for Medicare and Medicaid Innovation (the Innovation Center) within the Centers for Medicare & Medicaid Services (CMS) to test new payment and service delivery models that have the potential to reduce Medicare, Medicaid, and CHIP expenditures while maintaining or improving the quality of care for beneficiaries.

The Innovation Center has secured approval for a new Primary Care First (PCF) model with two separate but related components: (1) the PCF component and (2) the Seriously Ill Population (SIP) component. Both components will test alternative payments and the provision of technical support to primary care practices. These PCF and/or SIP participants will receive a combination of claims and non-claims-based payments based on their attributed Medicare fee-for-service (FFS) beneficiaries. With fewer reporting requirements, PCF component practices will have the flexibility to implement their own strategies that best target outcomes. SIP component practices will deliver care to a separate patient population that is both higher risk and shows fragmented patterns of care.

Participants in the PCF model are primary care practices that may participate in one or both components, although individual beneficiaries may only be covered under one component at a time. A primary care practice may include one or more physicians, as well as non-physician providers such as nurse practitioners. Every participating practice will be given a unique practice ID by the CMS implementation support contractor. Providers in a practice will be uniquely defined by the combination of each provider's tax ID number (TIN) and national provider identifier (NPI).

The first cohort of PCF and SIP component participants will begin operation during the following dates:

• PCF component: January 1, 2021 – December 31, 2026

• SIP component: April 1, 2021 – December 31, 2026

The second cohort of PCF and SIP component participants will start one year after the first PCF component cohort:

• PCF and SIP components (Cohort #2): January 1, 2022 – December 31, 2027

CMS will create a provider file that lists all participating providers, their PCF component and/or SIP component practice affiliation, and the effective and termination dates of their participation in the PCF model. A given provider (as defined by the concatenation of TIN and NPI) may only be active in one PCF practice at a time. Providers within a practice may have different effective and termination dates (e.g., as they are hired or leave the practice), but the practice itself will have its own effective and termination date for participation in the model. CMS will also create a beneficiary file detailing all attributed, (which also referred to as aligned) Medicare FFS beneficiaries to participants in PCF and/or SIP components. CMS will detail all information specific to the provider and beneficiary files within the Interface Control Document (ICD). CMS will upload this file in the following location within eCHIMP:

- Change Request (CR) Form/Files/Interface Control Documents

Please note this PCF CR is a follow-on to CR 11419 and addresses the following objectives for the January 2021 Release.

- Flat Visit Fee (FVF) HCPCS codes detailed in Appendix A (Applicable to PCF and SIP components)
- HCPCS code G2020 (Applicable to only the SIP component)
- Prohibited HCPCS codes detailed in Appendix B (Applicable to PCF and SIP components)

B. Policy: Under the Primary Care First (PCF) and Seriously Ill Population (SIP) models, the Innovation Center will engage up to 8,000 primary care practices respectively. Practices may participate in either or both of the models at the same time. While beneficiaries may be eligible for both and, in fact, it is likely that some beneficiaries who start out as SIP participants will transition to participation in PCF, beneficiaries shall only participate in one component of the model at a time.

Under the model, PCF/SIP participating providers shall continue to bill evaluation and management (E&M) and other HCPCS codes (under Appendix A) for all patients as they normally do under the traditional Medicare program. For beneficiaries attributed to them, however, the payment for services covered under the model (listed in Appendix A) will be paid at a geographically adjusted flat visit fee (FVF) amount per visit. Please note the FVF will not vary by HCPCS code. Participating providers submitting multiple HCPCS codes on the same date of service for the same beneficiary will receive one FVF from Medicare. Under the PCF/SIP model, beneficiary cost sharing shall remain unchanged and should adhere to traditional fee for service.

The beneficiary attribution process will be conducted outside of the claims system although a list of beneficiaries attributed to each model shall be provided to contractors for the purposes of claims adjudication every month. Patient coinsurance and deductible will, however, be calculated based on traditional fee for service processing for the original E&M code that the provider billed. The FVF also waives the 15% reduction on claims submitted by non-physician providers. The removal of the 15% reduction shall take effect after coinsurance has been applied so that beneficiaries are not adversely impacted by increased coinsurance.

In addition, SIP participating providers shall also be eligible to bill for a one-time initial visit fee with a SIP beneficiary: HCPCS Code G2020 prolonged initial face-to-face visit. G2020 shall not be subject to coinsurance and deductible and only one SIP code shall be paid per the lifetime of each SIP beneficiary. Similar to the FVF, the PCF model will waive the 15% non-physician provider reduction for G2020.

The G2020 service must be provided and billed at least one day before any other services subject to the flat visit fee may be reimbursed accordingly. In the event HCPCS code G2020 is provided after OR on the same date of service as FVF HCPCS codes, the following will occur for SIP beneficiaries only:

- If the HCPCS code G2020 has the same date of service as FVF HCPCS codes CMS shall deny claim lines with any FVF HCPCS codes
- If a FVF HCPCS code has been rendered prior to HCPCS code G2020 experience, the claim lines with FVF HCPCS codes will be processed under traditional FFS.

CMS acknowledges some claims are submitted non-sequentially, which will require claims reprocessing. CMS will address this specfic issue in a separate instruction.

Separate from these PCF and SIP component FFS payments, PCF/SIP participating providers may receive per beneficiary per month payments for attributed beneficiaries as well as performance-based payments. These payments shall be processed outside the fee for service claims processing system and do not require input from FFS contractors.

PCF/SIP participating providers are prohibited from billing HCPCS Codes listed in Appendix B on any of their attributed beneficiaries. CMS has determined Appendix B HCPCS Codes (99487, 99489, 99490, 99491, 99339, and 99340) are duplicative of the non-claims-based payments participants are receiving under PCF and/or SIP components.

Except as otherwise specified, PCF/SIP claims shall be subject to all other adjustments (e.g. sequestration) and policies applicable to other fee for service claims.

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	
11896.1	For claims with dates of service on or after April 1, 2021, contractors shall accept claims for HCPCS code G2020 under the SIP component.		X				X		X	
11896.1.1	Contractors shall be aware of the long and short descriptors for HCPCS code G2020: **Long descriptor:** Services for high intensity clinical services associated with the initial engagement and outreach of beneficiaries assigned to the SIP component of the PCF model. (Do not bill with Chronic Care Management codes.) **Short descriptor:** Hi inten serv for SIP model		X						X	ACO OS, CMS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	EFF Date for testing: 10/01/2020 **EFF Date: 04/01/2021** **TOS = "01"** **Note: For testing this CR apply Effective Date of 10/01/2020 for HCPCS G2020.** **CWF shall also allow demonstration code "96" to be accepted with a date of service on or after 10/01/2020 for testing only but implementation shall be effective on 01/01/2021 for demonstration code "96". Please note the demonstration code "96" and HCPCS code G2020 have different effective dates.**									
11896.1.2	Contractors shall not apply coinsurance and deductible to HCPCS code G2020.		X							
11896.1.3	Contractors shall use the following messages for claim lines processed and paid in accordance with the rules of the PCF/SIP model, unless otherwise specified in this CR: Claims Adjustment Reason Code (CARC) 132: "Prearranged demonstration project adjustment" Group Code: CO (Contractual Obligation) MSN 60.4: This claim is being processed under a demonstration project. Spanish Translation: Esta reclamación está siendo procesada bajo un proyecto especial.		X							
11896.2	Contractors shall apply beneficiary cost-sharing based on traditional FFS rules for Appendix A procedures.		X				X			
11896.3	The Multi-Carrier System (MCS) shall apply demonstration code "96" for the PCF model (inclusive of both the PCF and SIP components) to professional claims submitted on the CMS-1500 (or electronic equivalent) where:						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• The beneficiary HIC Number (HICN) and billing provider Tax Identification Number (TIN) match those listed in the beneficiary file; and • The billing provider TIN and rendering NPI match those listed on the PCF/SIP provider participant file; and • The PCF/SIP Model Identifier match between the beneficiary and provider participant alignment files; and • The date of service for the detail line is between the effective start date and end date (inclusive) for the matching records in the beneficiary alignment and provider participant files; and • Medicare is the primary payer for the service. AND Once the following situations reflect the HCPCS codes billed on the claim line: • The HCPCS code listed on the detail line is G2020 or one of the eligible codes listed in Appendix A or B of this CR; and • HCPCS code G2020 listed on the detail line has dates of service on or after April 1, 2021; or • Appendix A or B HCPCS code listed on the detail line has dates of service on or after January 1, 2021.									
11896.3.1	MCS shall apply the ACO ID and benefit enhancement indicator of 'D' to aligned details with procedure G2020, and the bene has a population indicator of 'S' and the provider has a record type of 'D'.						X			IDR
11896.3.2	MCS shall apply the ACO ID and benefit enhancement 'E' to aligned details with procedures from Appendix A or B, and the provider has a record type of 'E'.						X			IDR
11896.4	For PCF/SIP participating providers, contractors shall reject or return as unprocessable claim lines that		X				X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	contain HCPCS codes listed in Appendix B and shall use the messages below: Claims Adjustment Reason Code (CARC): 132 “Prearranged demonstration project adjustment” Remittance Advice Remark Code (RARC): N83 “No appeal rights. Adjudicative decision based on the provisions of a demonstration project." Group Code: CO (for contractual obligation)									
11896.5	CMS shall issue guidance in a separate CR in the event any changes made to Appendices A and B subsequent to the release of this CR. **Note:** CMS anticipates any changes made to Appendices A and B shall only occur on an annual basis. The CMS operations contractor contacts are: Salauddin Shaik (Salauddin.Shaik@softrams.com); Vivek Trehan (Vivek.Trehan@softrams.com); Yani Mellacheruvu (Yani.Mellacheruvu@cms.hhs.gov); Aparna Vyas (Aparna.Vyas@cms.hhs.gov)									ACO OS, CMS
11896.6	MCS shall plug demonstration code "96" to the first blank demonstration code field if at least one claim detail line meets the PCF or SIP model component criteria. **Note:** If multiple demo codes are on a claim demo “96” should come after all other demo codes.						X			IDR
11896.6.1	CWF shall ensure all demonstration code fields are read for processing the edits and IURs for the PCF and SIP model components.								X	
11896.7	MCS shall add claim processing logic to apply the Flat Visit Fee (FVF) detail line allowed amount from the Medicare Physician Fee Schedule Data Base (MPFSDB) file in field 31EE to impacted claims subject to the flat visit fee (FVF).						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Note: HCPCS Code G2020 shall be added to the MPFSDB and does not apply like the HCPCS Codes from Appendix A. This only pertains to FVF HCPCS Codes from Appendix A.									
11896.7.1	MCS shall use the 31EE value as the provider paid amount, before sequestration, for payable FVF detail procedures.						X			
11896.8	Contractors shall return as unprocessable an incoming claim if the provider appends a demonstration code of "96" on the CMS-1500 (or electronic equivalent). Contractors shall use the following messages: Claims Adjustment Reason Code (CARC): 132 “Prearranged demonstration project adjustment.” Remittance Advice Remark Code (RARC): N763 "The demonstration code is not appropriate for this claim; resubmit without a demonstration code." Group Code: CO (for contractual obligation)		X							
11896.9	MCS shall create a new reject for a Part B claim detail line if the SIP HCPCS code G2020 is billed under the following conditions: 1. The beneficiary has been not identified as a SIP beneficiary during the applicable dates of service 2. The provider is not eligible to bill the SIP HCPCS code G2020 during the applicable effective/end dates						X			
11896.10	CWF shall create a new Part B Utilization edit to not allow more than one SIP HCPCS code G2020 per beneficiary per lifetime. CWF shall read the SURG Aux file to determine this.								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11896.10.1	If a submitted claim has more than one claim line with HCPCS code G2020 MCS shall handle these multiple claim lines accordingly: • MCS shall process the G2020 claim line with the earliest date of service that meets all model requirements. • MCS shall deny all subsequent claim lines with HCPCS code G2020.						X			
11896.10.1.1	For all denied claim lines containing HCPCS code G2020, contractors shall communicate the following message: Claims Adjustment Reason Code (CARC): 132 “Prearranged demonstration project adjustment” Remittance Advice Remark Code (RARC): N117 "This service is paid only once in a patient’s lifetime." Group Code: CO (for contractual obligation) MSN 20.12: This service was denied because Medicare only covers this service once a lifetime. Spanish Translation: Este servicio fue negado porque Medicare sólo cubre este servicio una vez en la vida.		X							
11896.11	A/B MACs Part B shall refer all provider inquiries regarding claims and/or claim lines subject to the rules of the PCF model (applicable to PCF and/or SIP components) to PCF Model Help Desk. Below are the contact details for the PCF Model Help Desk: PCF Model Help Desk Telephone (Toll Free Number): 888-517-7753 Email: PCF@telligen.com		X							CMS
11896.12	MCS shall not apply the non-physician provider (NPP) reduction to the following:						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• All claim details subject to the FVF with dates of service on or after January 1, 2021 • All claim details subject to the SIP HCPCS code G2020 with dates of service on or after April 1, 2021									
11896.12.1	Beneficiary liabilities (coinsurance/deductible) for FVF details otherwise subject to the NPP reduction, shall be calculated as they would have been under the traditional Medicare FFS program. That is, bypassing this reduction shall not result in an increase in beneficiary liability under the model.		X				X			
11896.13	Contractors shall process non-PCF/SIP claim lines as normal FFS when billed on the same claim as PCF/SIP claim lines.		X				X		X	
11896.14	Contractors shall create a new Part B edit to not allow more than one paid PCF/SIP FVF visit per date of service if the benefit enhancement indicator of 'E' is present.		X				X		X	
11896.14.1	If more than one FVF HCPCS codes are billed on the same claim for the same date of service processed as a demo "96" claim, MCS shall validate and apply the FVF to the first claim line processed and shall reduce the detail provider paid amount to zero on any subsequent claim lines for the FVF eligible HCPCS codes listed in Appendix A. **Note:** The detail is reduced to zero after beneficiary cost sharing, but before sequestration.		X				X			
11896.14.2	CWF shall create a new Part B edit to not allow more than one of the PCF/SIP FVF visit per date of service when demonstration code "96" is present and enhancement 'E' indicator is present on different claims								X	
11896.14.2.1	CWF shall not set the Part B edit if FVF HCPCS code claim lines are zero paid.								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11896.14.3	The contractor shall reduce the detail provider paid amount to zero in the above circumstances after beneficiary coinsurance and deductible have been calculated. **Note:** Coinsurance and deductible shall be calculated the same as they would have been under traditional Medicare FFS.		X				X			
11896.14.4	Contractors shall use the following messages on claim and/or claim lines subject to zero payment with applicable beneficiary cost sharing noted in BR 14.1 and BR 14.3: Claims Adjustment Reason Code (CARC): 132 "Prearranged demonstration project adjustment" Remittance Advice Remark Code (RARC): N83 "No appeal rights. Adjudicative decision based on the provisions of a demonstration project." Group Code: CO (for contractual obligation) **Note: These are not denied claims.**		X							
11896.15	MCS shall return as unprocessable Appendix A procedures for aligned beneficiaries and providers when the date of service (DOS) matches the G2020 date of service on the same claim.						X			
11896.15.1	For all claim lines rejected or returned as unprocessable, contractors shall communicate the following message for all impacted claims lines with HCPCS code G2020 and/or Appendix A HCPCS codes: Claims Adjustment Reason Code (CARC): 132		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	"Prearranged demonstration project adjustment" Remittance Advice Remark Code (RARC): N83 "No appeal rights. Adjudicative decision based on the provisions of a demonstration project." Group Code: CO (for contractual obligation)									
11896.16	CWF shall create a new Part B Utilization edit to not allow FVF Appendix A procedures under the following conditions: • When the date of service matches the G2020 date of service posted in CWF • Demonstration code "96" is present • Benefit Enhancement Indicator 'E' is present								X	
11896.16.1	Contractors shall use the following messages on claims rejected or returned as unprocessable when the date of service for HCPCS codes listed in Appendix A matches the date of service for HCPCS code G2020: Claims Adjustment Reason Code (CARC): 132 "Prearranged demonstration project adjustment" Remittance Advice Remark Code (RARC): N83 "No appeal rights. Adjudicative decision based on the provisions of a demonstration project." Group Code: CO (for contractual obligation)		X							
11896.16.2	CWF shall create a new IUR if a SIP beneficiary has a previously paid Part B claim under Medicare FFS for any procedure listed in Appendix A and an incoming record is accepted with a claim line for G2020 with the same date of service and demonstration code "96".								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11896.17	For claims subject to the PCF/SIP FVF adjustment, MCS shall include on the CWF claim transmission record (HUBC) the adjustment amount attributable to each line in the "Other Amounts Applied" field, using the following: • The Other Amount Indicator 'A2' to indicate the amount by which each line was reduced for the FVF adjustment. • The Other Amount Indicator 'A3' to indicate the amount by which each line was increased for the FVF adjustment.						X			
11896.17.1	CWF shall allow an Other Amount Indicator of 'A2' and/or 'A3' for claims with dates of service on or after implementation.								X	
11896.17.1.1	CWF shall modify Part B consistency edit '92x5' to accept a reduction to the reimbursement amount when Other Amount Indicator 'A2' is received.								X	
11896.17.1.2	CWF shall modify Part B consistency edit '92x5' to accept an increase to the reimbursement amount when Other Amount Indicator 'A3' is received.								X	
11896.17.1.3	CWF shall modify Part B consistency edit '97x1' to accept the new value(s) in the Other Amount Indicator field 'A2'.								X	
11896.17.1.4	CWF shall modify Part B consistency edit '97x1' to accept the new value(s) in the Other Amount Indicator field 'A3'.								X	
11896.18	Contractors shall send the new PCF/SIP payment adjustment message and amount to the IDR claims file.		X				X			
11896.19	MCS shall process all Medicare secondary payer claims as normal FFS claims.						X			
11896.20	Contractors shall subject PCF and SIP claims to sequestration, MIPS, and any other adjustments that the claim line would otherwise be subject to unless otherwise specified in this CR.		X				X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11896.21	CWF shall create an IUR if a beneficiary alignment record file identifies a claim in history with demonstration code "96" and dates of service are no longer during the beneficiary alignment period.								X	
11896.22	MCS shall create an IUR if a provider participant record file identifies a claim in history with demonstration code "96" and the dates of service are no longer during the provider participant period.		X				X			
11896.23	CWF shall modify Part B consistency edit ‘0014’ in HUBCCED to accept demonstration code “96”. Error Message: '0014'								X	
11896.24	CWF shall update the SURG Aux file in HIMR to carry HCPCS G2020 for Part B claim for a SIP Bene with demonstration code “96”.								X	
11896.25	CWF shall ensure that demonstration code “96” is carried to the claim history and transmitted to the NCH file when present on HUBC claims.								X	NCH
11896.26	For all claims with demonstration code “96”, CWF shall include the new HCPCS code G2020 to display on the SURG AUX file in HIMR.								X	
11896.27	CWF shall track SIP HCPCS code G2020 payment and on the date of service of which they are provided so that the one-time SIP payment is only ever allowed once per beneficiary per lifetime.								X	
11896.28	HIGLAS/MAC Contractors shall process PCF/SIP Overpayment with Shared System Reason Code ‘34’ HIGLAS shall map the Shared System Reason code ‘34’ to the HIGLAS Reason Code ‘34’ for A/B MACs Part B.		X							HIGLAS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Note: A/B MAC Part B contractors shall use any of the existing Discovery Codes based on the determination if CMS, MAC, or Provider initiated the overpayment.									
11896.29	Medicare contractors shall use the following verbiage for the 'Reason for Overpayment' in the Provider Part B demand letter enclosure for the new HIGLAS Reason code '34': “Your overpayment was identified through reports identifying claims either initially processed under the rules of the Primary Care First (PCF) advanced alternative payment model that were subsequently retroactively re-processed as a result of updated information about a beneficiary’s attribution status with your practice and/or your status as a participating provider in this model. Such changes could include corrections to the effective and/or termination dates as well as other factors impacting eligibility for payment. These claims have now been re-processed and resulted in a net overpayment to your practice.”		X							HIGLAS
11896.30	Medicare contractors shall use the following verbiage for the 'Reason for Overpayment' in the Beneficiary Part B demand letter enclosure for the new HIGLAS Reason Code '34': "The claim was processed incorrectly causing an overpayment to be made." Spanish Translation: "La reclamación fue procesada incorrectamente ocasionando un pago en exceso."		X							HIGLAS
11896.31	Contractors shall handle all PCF/SIP model claims and/or claim lines as non-935 eligible. **Note: PCF/SIP model claims and/or claim lines are not eligible for 935 appeal rights.**		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11896.32	A/B MACs Part B shall use an appropriate Discovery Code and Reason Code '34' when initiating the PCF/SIP overpayment adjustments.		X							
11896.33	A/B MACs Part B shall ensure the 935 indicator is set to 'N' for these adjustment claims as they are not eligible for the Section 935 Appeals.		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): Donna Schmidt, donna.schmidt@cms.hhs.gov , Yani Mellacheruvu, Yani.Mellacheruvu@cms.hhs.gov , Aparna Vyas, Aparna.Vyas@cms.hhs.gov , Mark Baldwin, 410-786-8139 or mark.baldwin@cms.hhs.gov , Emily Johnson, 410-786-4015 or emily.johnson@cms.hhs.gov , Christopher Coutin, 410-786-5698 or christopher.coutin@cms.hhs.gov , Cynthia Thomas, 410-786-8169 or Cynthia.Thomas@cms.hhs.gov , Charles Campbell, Charles.Campbell@cms.hhs.gov , Tammy Luo, tammy.luo@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: 2

Primary Care First (PCF)
Appendix A
Flat Visit Fee (FVF) HCPCS Codes

HCPCS Codes	Service Type
99201	Office/Outpatient Visit E/M
99202	Office/Outpatient Visit E/M
99203	Office/Outpatient Visit E/M
99204	Office/Outpatient Visit E/M
99205	Office/Outpatient Visit E/M
99211	Office/Outpatient Visit E/M
99212	Office/Outpatient Visit E/M
99213	Office/Outpatient Visit E/M
99214	Office/Outpatient Visit E/M
99215	Office/Outpatient Visit E/M
99324	Home Care E/M
99325	Home Care E/M
99326	Home Care E/M
99327	Home Care E/M
99328	Home Care E/M
99334	Home Care E/M
99335	Home Care E/M
99336	Home Care E/M
99337	Home Care E/M
99341	Home Care E/M
99342	Home Care E/M
99343	Home Care E/M
99344	Home Care E/M
99345	Home Care E/M
99347	Home Care E/M
99348	Home Care E/M
99349	Home Care E/M
99350	Home Care E/M
99354	Prolonged E/M
99355	Prolonged E/M
99495	Transitional Care Management Services
99496	Transitional Care Management Services
99497	Advanced Care Planning
99498	Advanced Care Planning
G0402	Welcome to Medicare
G0438	Annual Wellness Visits
G0439	Annual Wellness Visits

Primary Care First (PCF)
Appendix B
Prohibited HCPCS Codes

HCPCS Codes	Service Type
99487	Chronic Care Management
99489	Chronic Care Management
99490	Chronic Care Management
99491	Chronic Care Management
99339	Home Care
99340	Home Care