CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-19 Demonstrations	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10707	**Date: March 31, 2021**
	Change Request 11887

Transmittal 10558, dated January 8, 2021, is being rescinded and replaced by Transmittal 10707, dated, March 31, 2021 to change the reference of contractor to either plural or singular in Business Requirements (BRs) 11887.4, 11887.4.1, 11887.5, 11887.5.1, 11887.12, 11887.19.1, 11887.20, 11887.21.1, 11887.29.1, 11887.29.2 and 11887.29.3, removes FPS from BR 11887.18 and adds the A/B Part A MACs to BR 11887.19.1, and to revise BRs 11887.10.2, 11887.11, 11887.19, 11887.21 11887.29 and 11887.31.1. This correction also removes BR 11887.14 and adds BR 11887.21.2. All other information remains the same.

NOTE: This Transmittal is no longer sensitive and is being re-communicated May 17, 2022. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

SUBJECT: Implementation of the Value in Opioid Use Disorder (OUD) Treatment Demonstration Program

I. SUMMARY OF CHANGES: This Change Request (CR) is applicable to the Multi-Carrier System (MCS), the Common Working File (CWF), the Fiscal Intermediary Shared System (FISS), and Medicare Administrative Contractors (MACs). The purpose of this CR is to implement the proposed Value in OUD Treatment Demonstration Program. None of the information in the background document of this analysis CR should be construed as final.

EFFECTIVE DATE: April 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 5, 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	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: 10707	Date: March 31, 2021	Change Request: 11887

Transmittal 10558, dated January 8, 2021, is being rescinded and replaced by Transmittal 10707, dated, March 31, 2021 to change the reference of contractor to either plural or singular in Business Requirements (BRs) 11887.4, 11887.4.1, 11887.5, 11887.5.1, 11887.12, 11887.19.1, 11887.20, 11887.21.1, 11887.29.1, 11887.29.2 and 11887.29.3, removes FPS from BR 11887.18 and adds the A/B Part A MACs to BR 11887.19.1, and to revise BRs 11887.10.2, 11887.11, 11887.19, 11887.21 11887.29 and 11887.31.1. This correction also removes BR 11887.14 and adds BR 11887.21.2. All other information remains the same.

NOTE: This Transmittal is no longer sensitive and is being re-communicated May 17, 2022. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

SUBJECT: Implementation of the Value in Opioid Use Disorder (OUD) Treatment Demonstration Program

EFFECTIVE DATE: April 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 5, 2021

I. GENERAL INFORMATION

A. Background: This Change Request (CR) is applicable to the Multi-Carrier System (MCS), the Common Working File (CWF), the Fiscal Intermediary Shared System (FISS), and Medicare Administrative Contractors (MACs). The purpose of this CR is to implement the proposed Value in OUD Treatment demonstration program. None of the information in the background document of this implementation CR should be construed as final. The information included in the background section is for purposes of implementing the program only.

Value in OUD Treatment is a 4-year demonstration program authorized under section 1866F of the Social Security Act (Act), which was added by section 6042 of the SUPPORT Act. The purpose of Value in OUD Treatment is to "increase access of applicable beneficiaries to opioid use disorder treatment services, improve physical and mental health outcomes for such beneficiaries, and to the extent possible, reduce Medicare program expenditures." As required by statute, Value in OUD Treatment will be implemented no later than April 1, 2021.

As required by statute, Value in OUD Treatment will create two new payments for highly coordinated and integrated OUD treatment services furnished to applicable beneficiaries:

1. A per beneficiary per month OUD Care Management Fee (CMF), which the participant may use to "deliver additional services to applicable beneficiaries, including services not otherwise eligible for payment under [Title XVIII]"; and

2. A performance-based incentive, that would be payable based on the participant's performance with respect to criteria specified by CMS, which may include evidence-based Medication-Assisted Treatment (MAT), as well as patient engagement and retention in treatment.

- The authorizing statute allocates $10 million per year FY21 – FY24 to pay for a care management fee and performance based incentive payment. CMS will also count costs associated with the beneficiary cost sharing wavier against this $10 million.
- Under the demo, participants will be eligible to bill a new g-code for a demonstration CMF payment. The CMF is a monthly payment being paid quarterly: a lump sum for the 3 months. MACs will pay the claims for the demo CMF as they would for any other claim. In PY1, the payment amount will be $375 for a calendar quarter period ($125 per applicable beneficiary per month times three months). In PY2 the payment will be $356.25 ($125 per applicable beneficiary per month times three months, minus 5% quality withhold). In PY3-PY4, the payment amount will be $337.50 ($125 per applicable beneficiary per month times three months, minus 10% quality withhold). The g-code may be billed only once for a given beneficiary in a calendar quarter period; CWF will create an edit and track this. These payments will be subject to sequestration.

B. Policy: Value in OUD Treatment will be implemented under the authority of Section 1866F of the Social Security Act (the Act).

CMS will implement the CMF required by statute as a calendar quarterly payment to participants, based on billed claims for applicable beneficiaries. The payment rate will be the same for all participants. A given participant may bill Medicare no more than one time in a calendar quarter period per applicable beneficiary. CMS would likely establish demonstration-specific code for the CMF. The CMF would be considered Part B payments. There would be no coinsurance, co-payment, or deductible applicable to these services. Medicare will be the primary payer for any Medicaid dual-eligible beneficiaries.

A portion of CMF payments will be subject to a quality withhold, such that a certain percentage (0% in performance year 1; 5% in performance year 2; and thereafter, 10% for performance years 3-4) of the CMF will be withheld for each quarterly payment. Participants who meet quality criteria, to be specified in the participation agreement, during a given performance year will be eligible to earn back withheld monies. CMS is considering the following claims-based measures for inclusion in the Value in Treatment performance-based incentive:

• Retention in treatment

• Emergency Department utilization

• Use of Pharmacotherapy for Opioid Use Disorder

• Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)

• Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Participants must meet minimum criteria, including a minimum patient volume and threshold for quality relative to a nationwide benchmark, to be eligible to earn back withheld monies. These measures may be adjusted to account for demographics, regional variation, or other factors. CMS may pool participants who do not meet minimum patient volume criteria. Final measure specifications and risk adjustment methodology will be outlined in the participation agreement.

The CMF and performance based incentive payments made to participants through Value in Treatment will be made in addition to payments made for medication, counseling, and behavioral therapies, treatment planning, and care coordination services that Medicare already covers.

Value in Treatment has been designed to address barriers to high quality MAT that have been identified by stakeholders. Specifically, Value in Treatment will provide participants with the resources and flexibility needed to: 1) furnish OUD treatment services, as appropriate, including services not otherwise eligible for payment under Medicare; 2) hire or contract with multi-disciplinary care team members to address health related social needs; and 3) provide these OUD treatment services in settings or by provider types that are not otherwise covered by Medicare, or are difficult to provide under existing Medicare payment rules.

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	
11887.1	The contractor shall be prepared to accept an OUD data file from CMS containing the following provider participant information: • Provider Tax Identification Number (TIN) • Provider National Provider Identifier (NPI) • Participating CMS Certification Number (CCN) • Effective Start date of the provider's eligibility in the OUD model • Effective End date of the provider's eligibility in the OUD model • Beneficiary Capacity for providers (CAP) - (Number of claims a provider can submit between the effective Start date through effective End date for the NPI/TIN/CCN combination.) • NOTE: Please refer to the OUD response file layout - (Attachment file name: ViT_Participant Provider File Format-CR.11887.docx)						X			CMS
11887.2	MCS shall share the accepted records from the OUD model provider files with FISS.						X			
11887.3	The Shared System Maintainers (SSMs) shall produce a response file to CMS that indicates that the OUD provider file was received, validated, and contained no errors if no validation errors were encountered. • NOTE: Please refer to the OUD response file						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	layout - (Attachment file name: **ViT_Participant Provider File Format-CR.11887.docx**)									
11887.4	The contractors shall be able to accept an update to the OUD model provider file quarterly. The update file shall be a full replacement file.					X	X			CMS
11887.4.1	The contractors shall process the updated OUD model provider file as a full replacement file.					X	X			
11887.5	The contractors shall provide a method to display the accepted OUD provider file for MAC reference					X	X			
11887.5.1	The contractors 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 shall be reflected for records captured for the initial load of records. The field shall be viewable to the MACs.					X	X			
11887.6	The contractor shall be prepared to accept an OUD Provider test file with 2020 effective and term dates on or about January 2021. The contractor shall supply a test response file to CMS.						X			CMS
11887.6.1	The Single Testing Contractor (STC) and the MACs shall provide to CMS the provider data to create the test files on or about January 1, 2021. To assist with the creation of the test files the STC and MACs shall: Provide a list of at a minimum 5 to 15 providers (as indicated by TIN/NPI and CCN for Part A MACs). These sample providers shall be provided in an Excel spreadsheet. Attached Provider Excel file name: **"ViT_Provider**	X	X							STC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	File_Mock Template_CR11887" Send encrypted data to: **ValueinTreatment@cms.hhs.gov**									
11887.6.2	CMS shall push the test files to the Virtual Data Centers (VDCs) on or about February 1, 2021, for the STC and March 1, 2021, for the User Acceptance Testing (UAT) to transmit the test files.									CMS
11887.6.3	The VDCs shall transmit the OUD model provider file test file responses via Electronic File Transfer (EFT)									VDC
11887.6.3.1	CMS shall push test files with provider file information to the SSMs on or about February 1, 2021.									CMS
11887.7	CMS shall provide the final OUD model provider file from the CMS mainframe prior to the go-live date of the Model. Functional Work Groups (FWGs) will be informed by email once available.									CMS
11887.8	The contractors shall deny the claim detail for the Healthcare Common Procedure Coding System (HCPCS) code G2172 with dates of service on and after April 1, 2021 when the rendering provider TIN/NPI combination is not found on the Participation CAP file and for institutional claims when the billing provider CCN/NPI combinations is not found.	X	X			X	X			
11887.8.1	The contractors shall use the following messaging when denying claims: Group Code: CO (contractual obligation) Claim Adjustment Reason Code (CARC) 96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Remittance Advice Remark Code (RARC) N83 – No appeal rights. Adjudicative decision based on the provisions of a demonstration project. Medicare Summary Notice (MSN) Message Number **60.37**: This provider isn't participating in the Value in Opioid Use Disorder Treatment demonstration. Spanish translation: Este proveedor no participa en la demostración de Value in Opioid Use Disorder Treatment.									
11887.9	For claims with dates of service on or after April 1, 2021, contractors shall deny the claim detail line for G2172 with dates of service that do not fall within the provider's effective and end date on the provider file.	X	X			X	X			
11887.9.1	The contractors shall use the following messaging when denying claims: Group Code: CO CARC 96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. RARC **N83** – No appeal rights. Adjudicative decision based on the provisions of a demonstration project. MSN Message Number 60.35: This claim is being processed under a demonstration project. Service cannot be covered because the date of service falls outside the provider's effective and end date within the project. Spanish translation: Este reclamo se está procesando	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	bajo un proyecto de demostración. El servicio no puede estar cubierto porque la fecha del servicio está fuera de la fecha de inicio y final del proveedor en el proyecto.									
11887.10	For claims with dates of service on or after April 1, 2021, contractors shall return as unprocessable HCPCS code G2172 unless submitted with one of the following diagnosis codes: See attachment file**: ICD-10 Codes VIT_CR.11887**		X				X			
11887.10.1	The contractor shall use the following messaging when returning claims as unprocessable: Group Code: CO CARC 16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. RARC M76 – Missing/incomplete/invalid diagnosis or condition.		X							
11887.10.2	For claims with dates of service on or after April 1, 2021, contractors shall create a reason code to return to provider (RTP) when HCPCS code G2172 is submitted without the following: • TOB 13X, 71X, 76X, 77X, 85X or 87X • Provider is participating in the OUD Model • One of the following Diagnosis codes in the attachment file: ICD-10 Codes VIT_CR.11887 See attachment file**: ICD-10 Codes VIT_CR.11887**	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11887.11	For claims with dates of service on or after April 1, 2021 from OTPs (provider specialty D5) that have a TIN/NPI combination found on the Participation CAP file, contractors shall accept the following: G2172 billed as the only line item; G2067-G2080 in addition to the G2172; G2067-G2080 without the G2172.		X				X			
11887.12	The contractor shall apply Demonstration Code "99" to claims with procedures G2172 or G2067-G2080 or G2086-G2088 from providers on the participant list when the following criteria are met: • The provider/supplier is listed on the Participating CAP file. • The claim contains a diagnosis code identified on the list below. • The dates of service on the OUD claim are equal to or within the Effective and End dates associated with the provider/supplier record. **Note:** Demo code 99 should take precedence over other demo codes if any other demo should apply to the claim with the exception of submitted demo codes. Submitted demo codes will take precedence. <u>ICD-10 Diagnosis Code:</u> See attachment file**: ICD-10 Codes VIT_CR.11887**						X			
11887.12.1	Contractors shall create an edit to return as un-processable ViT Demo 99 model claims that are submitted with non-OUD VIT model services. (procedures other than G2172 or G2067-G2080 or G2086-G2088)						X			
11887.12.2	Contractors shall use the following messages when rejecting non-OUD services.		X				X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	CARC 96: Non-covered charge(s). RARC N61: Rebill services on separate claims Group Code: CO (contractual obligation).									
11887.13	The contractors shall waive deductible and coinsurance on the services specific to Demo 99.		X				X			
11887.14	This business requirement has been deleted.						X			
11887.15	The contractor shall accept and process the Participant file from Multi Carrier System (MCS).					X				
11887.16	The contractor shall prepare their systems to process Opioid Use Disorder (OUD) treatment claims with dates of services April 1, 2021, and later.					X				
11887.17	The contractor shall use Demonstration (DEMO) code 99 to identify OUD Treatment claims.					X				IDR
11887.18	The contractors shall ensure the OUD claims are passed to the downstream systems including but not limited to National Claims History (NCH) and Integrated Data Repository (IDR)					X			X	IDR, NCH
11887.19	The contractor shall apply a DEMO Code 99 to all claims received for the OUD model. • Type of Bill (TOB) is 13x, 71x, 76x, 77x, 85x, or 087x; and • The provider is participating in the OUD model per the file received from CMS; and • HCPCS codes G2067-G2080; or G2086-G2088 or G2172 are present; and • One of the following Diagnosis codes in the attachment file: ICD-10 Codes VIT_CR.11887 • NOTE: Deductible and coinsurance should not be applied to the services. • Please Note: TOBs 71x, 76x, and 77x cannot bill HCPCS codes G2067-G2080. If these TOBs/codes are billed, edit W7116 will assign.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11887.19.1	Contractor shall create a Reason Code to return to provider (RTP) when Demo 99 model claims are submitted with non-OUD model services (services other than G2172, G2067-G2080, or G2086-G2088). This Reason Code shall be bypassed for encounter/visit revenue lines on RHC 71X and FQHC 77X claims when OUD Model Services are present on the claim.	X				X				
11887.20	The contractor shall apply sequestration to OUD treatment claims with demo 99. NOTE: This needs to be MAC controlled, so they can disallow during the PHE if needed.					X				
11887.21	The contractor shall pay for the quarterly visit HCPCS code G2172 on TOBs 13x, 71x, 76x, 77x, 85x, or 087x based off the rate from the HCPCS file for dates of services April 1, 2021 or after with demo code 99. Deductible and coinsurance do not apply.					X				
11887.21.1	The contractors shall create a reason code to RTP the claim when HCPCS code G2172 is submitted with more than one unit.	X				X				
11887.21.2	The contractor shall manually update the rate for HCPCS G2172 in the system with an effective date of April 1, 2021. All rate fields should be updated with a rate of $375.00. Deductible and coinsurance should not be applied. **Note:** • In PY1, the payment amount will be $375 for a calendar quarter period ($125 per applicable beneficiary per month times three months). • In PY2, the payment will be $356.25 ($125 per applicable beneficiary per month times three months, minus 5% quality withhold). • In PY3-PY4, the payment amount will be $337.50 ($125 per applicable beneficiary per month times three months, minus 10% quality	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	withhold). • The G2172 should be billed only once for a given beneficiary in a calendar quarter period.									
11887.22	The contractors shall allow payment for HCPCS codes G2172 with or without an encounter/visit on Rural Health Clinics (RHC), TOB 71x and Federally Qualified Health Center (FQHC), TOB 77x claims.					X				IOCE
11887.23	The contractor shall send a payment indicator flag of '2' for HCPCS codes G2172 for FQHC PPS claims									IOCE
11887.24	The Integrated Outpatient Code Editor (IOCE) shall not allow HCPCS G2172 to be reported with modifier CG on RHC claims.									IOCE
11887.25	The contractor shall modify edits 5244 and 5246 to assign on Institutional Claims and professional claims with demo code 99 with HCPCS G2172, G2067 through G2080, and HCPCS G2086 through G2088 when the beneficiary does not meet the following criteria: • Beneficiaries is not enrolled in both Medicare Part A and Part B; or • Beneficiaries is enrolled in Medicare Part C. This should also be included for BDS.								X	
11887.25.1	The contractors shall deny the claims with the following ANSI information: Group code: CO CARC: 272 Coverage/program guidelines were not met. RARC: N564 Patient did not meet the inclusion criteria for the demonstration project or pilot program. RARC: N211 - Alert: You may not appeal this		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	decision. MSN Message Number 21.21: This service was denied because Medicare only covers this service under certain circumstances. Spanish translation: Este servicio fue denegado porque Medicare solamente lo cubre bajo ciertas circunstancias. NOTE: No appeal rights are afforded.									
11887.25.2	The contractor shall accept the Common Working File (CWF) edits 5244 and 5246. A new reason code shall be created when claims with Demo Code 99 receive CWF edits 5244 and 5246.					X				
11887.25.3	The contractors shall reject claims with the reason code created in 11887.25.2 with the following ANSI information: Group code: CO CARC: 272 Coverage/program guidelines were not met. RARC: N564 Patient did not meet the inclusion criteria for the demonstration project or pilot program. RARC: N211 - Alert: You may not appeal this decision. MSN Message Number 21.21: This service was denied because Medicare only covers this service under certain circumstances. Spanish translation: Este servicio fue denegado porque Medicare solamente lo cubre bajo ciertas circunstancias.	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11887.26	The contractor shall identify Demo code 99 for OUD demonstration claims. This shall apply to outpatient (HUOP) and Part B (HUBC) claim types.								X	
11887.27	The contractor shall modify consistency edit '0014' to include Demo Code '99' as a valid Demo when received on Outpatient (HUOP) and Part B (HUBC) claims.								X	
11887.28	The contractor shall apply CMF Demonstration HCPCS code G2172 to the OPID Aux file. CWF shall post the new HCPCS G2172 as a full global component for Outpatient and Part B claims.								X	
11887.28.1	The contractor shall modify the Opioid Treatment Services tab on the MCSDT Other HIMR window to accommodate the new format of the CWFM HIMR OPID AUX screens and display the updated fields.						X			
11887.29	The contractor shall create an overrideable edit for outpatient and Part B to only allow HCPCS code G2172 to be billed once every 90 days per beneficiary for claims with Dates of Service on or after April 1, 2021. CWF shall read the Dates of Service on the claim as the first day and count 89 days. Example Detail line item date is April 1, 2021, this is day one, count 89 days and next allowable date is June 30, 2021.								X	
11887.29.1	The contractors shall accept the new CWF edit and allow the edit to be overrideable.	X				X				
11887.29.2	The contractor shall reject the claims with the following ANSI information. Group Code: CO CARC: 96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. RARC: N640 Exceeds number/frequency approved/allowed within time period. RARC: N211 - Alert: You may not appeal this decision. MSN Message Number 15.6: The information provided does not support the need for this many services or items within this period of time. Spanish translation: La información proporcionada no confirma la necesidad de estos servicios o artículos en este periodo de tiempo.									
11887.29.3	The contractor shall deny the claims with the following ANSI information. Group Code: CO CARC: 96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. RARC: N640 Exceeds number/frequency approved/allowed within time period. RARC: N211 - Alert: You may not appeal this decision. MSN Message Number 15.6: The information provided does not support the need for this many services or items within this period of time		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Spanish translation: La información proporcionada no confirma la necesidad de estos servicios o artículos en este periodo de tiempo. NOTE: No appeal rights are afforded.									
11887.30	The contractor shall recognize, accept demo code 99 to identify OUD Treatment claims.									HIGLAS
11887.31	CWF shall load the new HCPCS G2172 effective April 1, 2021. The description is: G2172 All inclusive payment for services related to highly coordinated and integrated opioid use disorder (OUD) treatment services furnished for the demonstration project. The TOS is **1**: Under the demo, participants will be eligible to bill the new code of G2172 for a demonstration CMF payment. The CMF is a monthly payment being paid quarterly: a lump sum for the 3 months.								X	
11887.31.1	The contractor shall manually update the rate for HCPCS G2172 with a rate of $375.00 and an effective date of April 1, 2021. Note: • In PY1, the payment amount will be $375 for a calendar quarter period ($125 per applicable beneficiary per month times three months). • In PY2 the payment will be $356.25 ($125 per applicable beneficiary per month times three months, minus 5% quality withhold). • In PY3-PY4, the payment amount will be $337.50 ($125 per applicable beneficiary per month times three months, minus 10% quality withhold). The G2172 should be billed only once for a given beneficiary in a calendar quarter period.		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11887.32	The Contractor shall return as unprocessable an incoming claim if the provider appends a demo code of '99' in Item 19 of the CMS-1500 or its electronic equivalent, 2300 Loop REF Segment 'Demonstration Project Identifier' (REF01=P4 and REF02=99). The Contractor shall use the following messages: • CARC 132 – "Prearranged demonstration project adjustment." • RARC: N763 - "The demonstration code is not appropriate for this claim; resubmit without a demonstration code. • Group Code: CO (Contractual Obligation)		X							
11887.33	Contractors shall be available for up to two meetings during UAT to discuss any questions and issues around testing.	X	X			X	X		X	VDC

III. PROVIDER EDUCATION TABLE

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

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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): Abdallah Ibrahim, Abdallah.Ibrahim@cms.hhs.gov , Rebecca VanAmburg, 410-786-0524 or Rebecca.VanAmburg@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: 3

Record Identifier	CMS Certification Number (CCN)	Provider Type * (See Tab below)	Tax Identification Number (TIN)	National Provider Identification (NPI)

Participant Effective Start Date	Participant Effective End Date	Status Change* (See Tab Below)	CAP	Filler	Bill Type**	Provider** Transaction Access Number (PTAN)

Provider Type - Possible values:

N = 1 - 9, where:

1 = Physician
2 = Group Practice
3 = Hospital Outpatient Department
4 = Federally Qualified Health Center
5 = Rural Health Clinic
6 = Community Mental Health Center
7 = Certified Community Behavioral Health Clinic
8 = Opioid Treatment Program
9 = Critical Access Hospital

Status Change

Identify whether the record was added, changed or removed

1 = "Changed": indicates that any information for a given active participant has been updated since the last file. "Changed" will not be used if the participant meets the criteria for either "Added" or "Removed."

2 = "Removed": indicates that a participant was once on the approved list and is currently on the excluded list. The "STATUS_CD" will remain as "Removed" for every file iteration, unless CMS changes the status to active (not excluded). If status is changed to active, the "STATUS_CD" variable will be null.

3 = "Added": indicate that a participant was not present in the prior file.

Bill Type - Possible Values

PB' = where PB is Medicare Part B

** ***Note:*** May not be applicable to all

Table 1 - ViT Participant File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator that identifies the line entry is header information for the ViT Participant file	1	7	CHAR	HDR_PRV
File Creation Date	Date the file is created	8	8	CHAR	CCYYMMDD
Filler		16	85	CHAR	Blank

Table 2 - ViT Participant Response File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator that identifies the line entry is header information for the ViT Participant file	1	7	CHAR	As Provided by CMMI
Response Code	Response code indicating if the record was processed successfully or not	8	2	NUM	Valid values are documented and explained in Appendix I: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	CCYYMMDD (Provided by CMMI)
Filler		18	83	CHAR	Blank

Table 3 - ViT Participant Record Detail

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator that identifies the line entry is record detail information for the ViT participant file	1	7	CHAR	DTL_PRV
Participant CMS Certification Number (CCN)	The CCN for the ViT participant	8	6	CHAR	Blank allowed
Provider Type*	Not used for ViT	14	1	CHAR	Blank
Participant Tax Identification Number (TIN)*	The TIN for the ViT Participant	15	9	NUM	Numbers
Participant National Provider Identifier (NPI)*	The National Provider Identifier (NPI) for the ViT participant	24	10	NUM	Numbers
Participant Effective Start Date*	Effective start date of the participant's eligibility in the ViT model	34	8	CHAR	CCYYMMDD
Participant Effective End Date	Effective end date of the participant's eligibility in the ViT model	42	8	CHAR	CCYYMMDD Blank allowed
Status Change	Identify whether the record was added, changed or removed 1 = "Changed": indicates that any information for a given active participant has been updated since the last file. "Changed" will not be used if the participant meets the criteria for either "Added" or "Removed." 2 = "Removed": indicates that a participant was once on the approved list and is currently on the excluded list. The "STATUS_CD" will remain as "Removed" for every file iteration,	50	1	NUM	1 2 3 Blank allowed

Table 3 - ViT Participant Record Detail

Data Field	Description	Start Position	Length	Format	Valid Values
	unless CMS changes the status to active (not excluded). If status is changed to active, the "STATUS_CD" variable will be null. 3 = "Added": indicate that a participant was not present in the prior file.				
CAP	CAP (the number of claims a provider can submit between the effective Start date through effective End date for the NPI/TIN/CCN combination.)	51	5	NUM	Numbers
Filler		56	45	CHAR	Blank

Data Fields marked with an asterisk (*) are required.

Table 4 - ViT Participant Response Record Detail

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator that identifies the line entry is record detail information for the ViT participant file	1	7	CHAR	DTL_PRV
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix I: Response Codes and Explanations
Participant CMS Certification Number (CCN)	The CMS Certification Number (CCN) for the ViT participant	10	6	CHAR	As provided by CMMI

Table 4 - ViT Participant Response Record Detail

Data Field	Description	Start Position	Length	Format	Valid Values
Provider Type*	Not used for ViT	16	1	CHAR	Blank
Participant Tax Identification Number (TIN)*	The Tax Identification Number (TIN) for the ViT participant	17	9	NUM	As provided by CMMI
Participant National Provider Identifier (NPI)*	The National Provider Identifier (NPI) for the ViT Participant	26	10	NUM	As provided by CMMI
Participant Effective Start Date*	Effective start date of the participant's eligibility in the ViT model	36	8	CHAR	As provided by CMMI
Participant Effective End Date	Effective end date of the participant's eligibility in the ViT model	44	8	CHAR	As provided by CMMI
Status Change	Identify whether the record was added, changed or removed	52	1	NUM	As provided by CMMI
CAP	CAP (the number of claims a provider can submit between the effective Start date through effective End date for the NPI/TIN/CCN combination.)	53	5	NUM	As provided by CMMI
Filler		58	43	CHAR	Blank

Data Fields marked with an asterisk (*) are required.

Table 5 - ViT Participant File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator that identifies the line entry is trailer information for the ViT Participant file	1	7	CHAR	TRL_PRV
File Creation Date	Date the file is created	8	8	CHAR	CCYYMMDD
Detail Record Count	Number of detail rows sent by CMMI	16	10	NUM	Numbers
Filler		26	75	CHAR	Blank

Table 6 - ViT Participant Response File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator that identifies the line entry is trailer information for the ViT Participant file	1	7	CHAR	TRL_PRV
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix I: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	CCYYMMDD
Detail Record Count	Number of detail rows sent by CMMI	18	10	NUM	Numbers
Filler		28	73	CHAR	Blank

ERROR CODES: Response Codes and Explanations

10 = Header Record ID Error. Last three characters in Record ID are not PRV.

11 = Header Record Date Error. Date is missing or invalid.

20 = Detail Record ID Error. Record contains invalid values.

22= TIN Error. TIN is not numeric.

25 = Effective Start Date Error. Date is missing or invalid.

26 = Effective End Date Error. Date is invalid.

30 = Trailer Record ID Error. Last three characters in Record ID are not PRV.

31 = Trailer Record Date Error. Date is missing or invalid.

32 = Trailer Record Count Error. Count is wrong or misplaced on file.

98 = Header Record Missing. Record is missing or does not begin with HDR_.

99 = Trailer Record Missing. Record is missing or does not begin with TRL_.

Medicare Accepted ICD-10 codes for Value in Treatment Demonstration CR-11887

- F11.10 Opioid abuse, uncomplicated
- F11.11 Opioid abuse, in remission
- F11.120 Opioid abuse with intoxication, uncomplicated
- F11.121 Opioid abuse with intoxication delirium
- F11.122 Opioid abuse with intoxication with perceptual disturbance
- F11.129 Opioid abuse with intoxication, unspecified
- F11.14 Opioid abuse with opioid-induced mood disorder
- F11.150 Opioid abuse with opioid-induced psychotic disorder with delusions
- F11.151 Opioid abuse with opioid-induced psychotic disorder with hallucinations
- F11.159 Opioid abuse with opioid-induced psychotic disorder, unspecified
- F11.181 Opioid abuse with opioid-induced sexual dysfunction
- F11.182 Opioid abuse with opioid-induced sleep disorder
- F11.188 Opioid abuse with other opioid-induced disorder
- F11.19 Opioid abuse with unspecified opioid-induced disorder
- F11.20 Opioid dependence, uncomplicated
- F11.21 Opioid dependence, in remission
- F11.220 Opioid dependence with intoxication, uncomplicated
- F11.221 Opioid dependence with intoxication delirium
- F11.222 Opioid dependence with intoxication with perceptual disturbance
- F11.229 Opioid dependence with intoxication, unspecified
- F11.23 Opioid dependence with withdrawal
- F11.24 Opioid dependence with opioid-induced mood disorder
- F11.250 Opioid dependence with opioid-induced psychotic disorder with delusions
- F11.251 Opioid dependence with opioid-induced psychotic disorder with hallucinations
- F11.259 Opioid dependence with opioid-induced psychotic disorder, unspecified
- F11.281 Opioid dependence with opioid-induced sexual dysfunction
- F11.282 Opioid dependence with opioid-induced sleep disorder
- F11.288 Opioid dependence with other opioid-induced disorder
- F11.29 Opioid dependence with unspecified opioid-induced disorder
- F11.90 Opioid use, unspecified, uncomplicated
- F11.920 Opioid use, unspecified with intoxication, uncomplicated
- F11.921 Opioid use, unspecified with intoxication delirium
- F11.922 Opioid use, unspecified with intoxication with perceptual disturbance
- F11.929 Opioid use, unspecified with intoxication, unspecified
- F11.93 Opioid use, unspecified with withdrawal
- F11.94 Opioid use, unspecified with opioid-induced mood disorder
- F11.950 Opioid use, unspecified with opioid-induced psychotic disorder with delusions
- F11.951 Opioid use, unspecified with opioid-induced psychotic disorder with hallucinations
- F11.959 Opioid use, unspecified with opioid-induced psychotic disorder, unspecified
- F11.981 Opioid use, unspecified with opioid-induced sexual dysfunction
- F11.982 Opioid use, unspecified with opioid-induced sleep disorder
- F11.988 Opioid use, unspecified with other opioid-induced disorder
- F11.99 Opioid use, unspecified with unspecified opioid-induced disorder