CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12239	**Date: September 6, 2023**
	Change Request 13248

Transmittal 12148 issued July 21, 2023, is being rescinded and replaced by Transmittal 12239, dated September 6, 2023, to remove TOB 41X from Business Requirements (BR) 13248.1, 13248.3, 13248.3.1, 13248.10, and 13248.12. In addition, IDR and NCH was added to BR 13248.3. All other information remains the same.

SUBJECT: Instructions To Process Services During Disenrollment From The Programs Of All-Inclusive Care For The Elderly (PACE)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to implement system changes when a Programs of All-Inclusive Care for the Elderly (PACE) patient has an inpatient stay that cannot be split during disenrollment from the PACE. We are clarifying how Medicare contractors shall process inpatient claims for services during a PACE disenrollment.

EFFECTIVE DATE: January 1, 2024 - (Claims received on or after effective date 01/01/2024)
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2024

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	3/100/100.10/Requirements for Processing Programs of All-Inclusive Care for the Elderly (PACE) Disenrollment's during an Inpatient Stay

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:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 12239	Date: September 6, 2023	Change Request: 13248

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SUBJECT: Instructions To Process Services During Disenrollment From The Programs Of All-Inclusive Care For The Elderly (PACE)

EFFECTIVE DATE: January 1, 2024 - (Claims received on or after effective date 01/01/2024)
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2024

I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to support language found in §1862(a) (3) of the Social Security Act (the Act): Medicare is precluded from making payment for services or items that are paid for directly or indirectly by another government entity. Programs of All-Inclusive Care for the Elderly (PACE) paid claims, therefore, represent a Medicare program exclusion rather than an indication of Medicare Secondary Payer (MSP).

When a Medicare beneficiary is eligible for PACE benefits the law, prohibits Medicare from paying for these claims. Medicare has already paid the PACE for care rendered to the beneficiary.

The Programs of All-Inclusive Care for the Elderly (PACE) is an innovative model that provides a range of integrated preventative, acute care, and long-term care services to manage the often complex medical, functional, and social needs of the frail elderly. PACE was created as a way to provide clients, family, caregivers and professional health care providers the flexibility to meet a person's health care needs while continuing to live safely in the community.

Although the PACE program has certain fundamental similarities to Medicare Advantage and managed care organizations, PACE is not a Medicare Advantage plan. The Balanced Budget Act (BBA) established distinct requirements for the PACE program. PACE is similar to some Medicare Advantage options in these ways: it is capitated; it is risk based; it provides managed care; and it is an elective option. However, PACE differs significantly from a Medicare Advantage plan in other ways such as: it is not available nationwide (only in a limited number of states); it includes statutory waivers that expand the scope of Medicare covered services; it is not available to all beneficiaries (only to a defined subset of frail elderly); and it is a joint Medicare/Medicaid program. The BBA in sections 1894(f)(3)(A) and 1934(f)(3)(A) of the Act directed CMS to consider some of the requirements established for Medicare Advantage programs while developing regulations for the PACE program relating beneficiary protections and program integrity.

The purpose of a PACE program is to provide pre-paid, capitated, comprehensive health care services that are designed to:

• Enhance the quality of life and autonomy for frail, older adults;

• Maximize dignity of and respect for older adults;

• Enable frail, older adults to live in their homes and in the community as long as medically and socially feasible; and

• Preserve and support the older adult's family unit.

PACE organizations offer Medicare Part D prescription drug coverage. Persons who join a PACE program will get Part D-covered drugs and all other necessary medication from the PACE program. Persons in a PACE program do not need to join a separate Medicare Part D prescription drug plan. Joining a separate Medicare drug plan will cause a person to be disenrolled from the PACE program.

B. Policy: There is no new policy. CMS is using the MSPPAY module as a tool to process PACE entitled beneficiaries for admissions that straddle two months and one of the months the PACE program was responsible for processing but the beneficiary disenrolls prior to discharge from the inpatient admission which occurs in the subsequent month(s). Medicare requires condition code (CC) '35' - **PACE eligible patient disenrolls during an inpatient admission** and value code (VC) '42' - Code indicates the amount shown is that portion of a higher priority VA **or PACE** payment made on behalf of a Medicare beneficiary that the provider is applying to Medicare charges on this bill.

The A/B MACs (A) shall continue to send PACE claims payment information to the MSPPAY module when a PACE beneficiary has services performed at an inpatient facility and the PACE has made partial payment on the claim.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13248.1	Medicare contractors shall accept value code '42' with primary payer code I on inpatient claims with type of bill codes 11X, 18X and 21X for PACE disenrollment overlap claims.	X				X				
13248.2	Medicare contractors shall not require a CWF MSP record (alpha code 'I') for value code '42' for Medicare to make payment for covered Medicare charges not covered by the PACE.	X							X	
13248.3	Medicare contractors shall allow the new NUBC approved condition code '35' on inpatient claims with type of bill codes 11X, 18X and 21X and ensure that this new condition code is loaded in the global solution.	X				X				HIGLAS, IDR, NCH

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	Note: Condition Code ''35' defined as "PACE eligible patient disenrolls during an inpatient admission".									
13248.3.1	Medicare contractors shall update the new NUBC approved condition code '35' on inpatient claims with type of bill codes 11X, 18X and 21X and ensure that this new condition code is loaded in the global solution. Note: Condition Code ''35' defined as "PACE eligible patient disenrolls during an inpatient admission". Note: Please see Attachment.A PACE	X								
13248.4	Medicare contractors shall use the MSP PAY module to calculate the Medicare payment for an inpatient claim when condition code '35' and value code '42' are present on a claim.					X				
13248.5	Medicare contractors shall create/modify edits to return to the provider (RTP) the claim if CC '35'' is present without VC '42' or if VC '42' is present without CC '35' or '26.	X				X				
13248.6	Medicare contractors shall create a new edit to return to provider on claims with CC '35' and the VC '42' has a value of	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	all zeros.									
13248.7	The Medicare contractor shall NOT capture or report MSP Savings for VC 42 claims when these claims are processed through the MSPPAY module. NOTE: MSPPAY usually sends MSP savings information to FISS after calculating Medicare's Secondary payment. FISS shall ignore the savings information sent back from MSPPAY.					X				
13248.8	Medicare contractors shall utilize the current CARC, Group and MSN messages listed below, when a primary payer has made a partial payment and Medicare is making a secondary payment. • MSN message 29.25 • Group CO • CARC 45	X				X				
13248.9	Medicare contractors shall accept VC 42 with primary payment amount and the group and CARC codes for amounts not paid by the primary payer found on the incoming claim.	X				X				
13248.10	Medicare contractors shall append payer only condition code 'Z0' (zero not O) on inpatient claims with type of bill codes 11X, 18X and 21X when condition code 35 and value code 42 with					X				

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	an amount greater than zero are present along with the primary payer group name PACE and/or primary payer group number 251T00000X. Note: Payer Only Condition Code ‘'Z0' defined as “PACE”.									
13248.10.1	Medicare contractors shall update the new Payer Only condition code ‘Z0’ (zero not O) in the global solution. Note: Payer Only Condition Code ‘'Z0' defined as “PACE”. Note: Please see Attachment A PACE (NUBC Code Table)	X								HIGLAS
13248.11	The Medicare contractor shall bypass inpatient claim with type of bill codes 11X, 18X, and 21X, with value code '42' and condition code ‘35’ and payer only condition code 'Z0' when a valid effective HMO ID for a PACE plan is present on the beneficiary’s record and the termination date of the HMO ID overlaps the admission date on the incoming claim. **Note:** To determine that the claim being sent for bypass is for a valid HMO ID that is for a PACE plan and not a Medicare Advantage plan, PACE will be identified by Payer Only								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	code Z0 on the claim.									
13248.12	The Medicare contractor shall bypass any other HMO edits when the HMO ID is for a PACE plan for an inpatient claim with type of bill codes 11X, 18X and 21X with value code '42' , condition code '35' and payer only condition code 'Z0'. **Note:** To determine that the claim being sent for bypass is for a valid HMO ID that is for a PACE plan and not a Medicare Advantage plan, PACE will be identified by Payer Only Code Z0 on the claim.								X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13248.13	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.	X				

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: CR9818 - Instructions to Process Services Not Authorized by the Veterans Administration (VA) in a Non-VA Facility Reported With Value Code (VC) 42

V. CONTACTS

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

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 1

Attachment A-NUBC Code Table

Record Type	Code	Effective Date	Termination date	Date Type Field	Payer Only Code	CWF	Narrative
C	35	01/01/2024		R	N	Y	PACE eligible patient disenrolls during an inpatient admission.
C	Z0	01/01/2024		R	Y	Y	PACE

Medicare Claims Processing Manual Chapter 3 – Inpatient Hospital Billing

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(Rev. 12239; Issued: 09-06-23)

100.10 – Requirements for Processing Programs of All-Inclusive Care for the Elderly (PACE) Disenrollments during an Inpatient Stays

(Rev. 12239; Issued: 09-06-23; Effective: 01-01-24; Implementation: 01-02-24)

Medicare is precluded from making payment for services or items that are paid for directly or indirectly by another government entity. For inpatient claims where the PACE is the Payer, the covered PACE services are exclusions to the Medicare program per Section 1862 of the Social Security Act. If the PACE doesn't approve all the services due to disenrollment from the program, any Medicare covered services not considered by the PACE program may be billed to the Medicare program. The provider should identify PACE in the group name and or the PACE taxonomy code 251T00000X in the group number.

When a PACE beneficiary is inpatient and has been disenrolled in PACE, the facility shall use Condition Code 35 *to indicate the patient is a PACE eligible patient that has disenrolled during an inpatient stay and value code 42 with the amount of the PACE payment for the authorized days during enrollment in the PACE program.*