CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-19 Demonstrations	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13479	**Date: November 20, 2025**
	Change Request 14215

SUBJECT: Transforming Episode Accountability Model (TEAM) Telehealth Waiver – Implementation

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to create a mechanism to allow demonstration code A9 to be associated with Telehealth claims, and implement changes required to support the processing of the TEAM provider participant file to be utilized by the Fiscal Intermediary Shared System (FISS) for the telehealth waiver requirements.

EFFECTIVE DATE: January 1, 2026
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 6, 2026 - April 6, 2026 - Model starts on January 1, 2026

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

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I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to create a mechanism to allow demonstration code A9 to be associated with Telehealth claims, and implement changes required to support the processing of the TEAM provider participant file to be utilized by the Fiscal Intermediary Shared System (FISS) for the telehealth waiver requirements.

II. GENERAL INFORMATION

A. Background: Section 1115A of the Social Security Act (the Act) authorizes the Centers for Medicare & Medicaid Services' (CMS) Center for Medicare and Medicaid Innovation (Innovation Center) to test innovative payment and service delivery models to reduce Medicare, Medicaid, and Children's Health Insurance Program (CHIP) expenditures while preserving or enhancing the quality of care furnished to beneficiaries. The CMS Innovation Center is using this authority to test the Transforming Episode Accountability Model (TEAM), an episode-based payment model that aims to reduce Medicare expenditures while preserving or enhancing the quality of care, and to further advance care coordination across acute and chronic medical care settings.

Under TEAM, participating acute care hospitals (TEAM participants) will be responsible for the cost and quality of care for selected surgical procedures. These responsibilities will span from the time of surgery through the first 30 days after a Medicare beneficiary's discharge from an inpatient stay or an outpatient procedure. Each episode includes all items and services related to the initial hospitalization or outpatient procedure, encompassing both facility and professional services.

CMS anticipates that beneficiaries treated under TEAM will benefit from enhanced communication and coordination among healthcare providers, improved discharge planning and facility transfers, a reduction in unnecessary or redundant procedures, fewer avoidable readmissions, more efficient utilization of post-acute care, and an overall higher quality of care throughout the episode. These improvements aim to foster greater patient engagement in their care and shorten the lengths of stay in both acute care hospitals and post-acute care settings.

TEAM is set to launch on January 1, 2026, and will run for five years, concluding on December 31, 2030. The timeline for the model's Performance Years (PYs) is as follows:

- PY1: January 1, 2026 - December 31, 2026
- PY2: January 1, 2027 - December 31, 2027
- PY3: January 1, 2028 - December 31, 2028
- PY4: January 1, 2029 - December 31, 2029

- PY5: January 1, 2030 - December 31, 2030

As a mandatory model, outlined in regulations at 42 Code of Federal Regulation (CFR) 500-596 (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-H/part-512/subpart-E?toc=1), all policies under TEAM are proposed and finalized through rulemaking, most notably in the Fiscal Year 2025 and Fiscal Year 2026 Inpatient Prospective Payment System (IPPS)/Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) proposed and final rules (https://www.federalregister.gov/documents/2024/08/28/2024-17021/medicare-and-medicaid-programs-and-the-childrens-health-insurance-program-hospital-inpatient).

Future updates to the model would also be proposed and finalized via rulemaking.

As part of this mandatory model, specific provisions of the traditional Medicare Fee-For-Service (FFS) program will be waived with regard to payment for certain SNF stays and certain telehealth services. This CR will focus on allowing demonstration code A9 to be associated with telehealth claims involved in the model.

General Model Parameters Participants

TEAM requires acute care hospitals, paid under the IPPS and the Outpatient Prospective Payment System (OPPS), and those that are located within a Core Based Statistical Areas (CBSA) selected to participate in TEAM, to be participants in the model. TEAM also allowed a one-time opportunity for hospitals that participate until the end of the last day of the last performance period in the BPCI Advanced model or the last day of the last performance year in the Comprehensive Care for Joint Replacement (CJR) model to voluntarily opt-in to TEAM. Hospitals participating in the model, either mandatorily or voluntarily, are held accountable for quality and cost performance for all episode categories in the model.

TEAM includes three participation tracks that allow for a glide-path to full financial risk. Track 1 is an upside only risk track that is available to all hospitals in performance year 1 (Calendar Year (CY) 2026). Safety net hospitals can remain in Track 1 for the first three performance years. Track 2 is a two-sided risk track, with lower levels of financial risk and reward, that is available starting in performance year 2 (CY2027) and limited to certain hospital types, including safety net hospitals, rural hospitals, Medicare Dependent Hospitals, Sole Community Hospitals, and Essential Access Community Hospitals. Track 3 is a two-sided risk track, with higher levels of risk and reward, that is available starting in performance year 1 (CY 2026). For more information on TEAM participation tracks, see 42 CFR 512.520 (https://www.ecfr.gov/current/title-42/section-512.520).

Episodes

In TEAM, an episode begins with a hospital inpatient stay, called an anchor hospitalization, or a hospital outpatient procedure, called an anchor procedure, for one of the following surgical procedures/episode categories: lower extremity joint replacement, surgical hip femur fracture treatment, spinal fusion, coronary artery bypass graft, and major bowel procedure. Each episode will end on the 30th day following the date of the anchor procedure or the date of discharge from the anchor hospitalization.

Episodes are identified by Medicare Severity Diagnosis Related Groups (MS–DRGs) for anchor hospitalizations, or by Healthcare Common Procedure Coding System (HCPCS) codes for anchor procedures. For a complete list of MS-DRGs and HCPCS codes associated with TEAM's anchor hospitalization and anchor procedures, see 42 CFR 512.525(d) (https://www.ecfr.gov/current/title-42/part-512/subpart-E#p-512.525(d)).

Each episode includes all items and services related to the initial hospitalization or outpatient procedure, encompassing both facility and professional services. Additionally, all non-excluded Medicare Part A and Part

B items and services provided within the 30-day post-discharge period are included, such as follow-up care in SNFs, outpatient visits, and physician services. There are certain items and services excluded from the total episode cost, including certain hospital admissions, new technology add-on payments, transitional pass-through payments, and certain Medicare Part B drugs and biologicals. For a list of items and services included and excluded from an episode, see 42 CFR 512.525(e) (https://www.ecfr.gov/current/title-42/part-512/subpart-E#p-512.525(e)) and 42 CFR 512.525(f) (https://www.ecfr.gov/current/title-42/part-512/subpart-E#p-512.525(f)), respectively.

Pricing and Payment

TEAM participants (the participating acute care hospital) and all Medicare providers and suppliers will continue to bill Medicare as usual under the traditional FFS system for items and services furnished to Medicare FFS beneficiaries. However, prior to each performance year, TEAM participants are provided with a target price that will represent most Medicare spending during an episode of care. TEAM participants can use the target price and other data provided by CMS to identify areas for efficiency and improvements that can spur spending reductions.

After each performance year concludes, CMS will perform a reconciliation calculation. Reconciliation compares each TEAM participant's total performance year FFS spending for attributed episodes for each episode category to their final target price for each episode category. Reconciliation amounts are subject to adjustments to account for quality performance and limits on gains or losses. After adjusting for post-episode spending as needed, the TEAM participant will have either a Reconciliation Payment from CMS or a Repayment Amount to CMS. For additional information about TEAM's pricing and payment methodology, see 42 CFR 512.540 (https://www.ecfr.gov/current/title-42/section-512.540), 42 CFR 512.545 (https://www.ecfr.gov/current/title-42/section-512.545), and 42 CFR 512.550 (https://www.ecfr.gov/current/title-42/section-512.550).

Reconciliation payments and repayment amounts will be processed directly with the Medicare Administrative Contractors (MACs).

B. Policy: Identifying TEAM claims

CMS is associating the Demonstration Code A9 with the TEAM initiative to identify TEAM episodes that will use the telehealth waiver.

Policy

To enhance care coordination across the post-acute spectrum and support participant hospitals in managing beneficiary care, CMS is allowing to conditionally waive certain Medicare payment requirements for beneficiaries in TEAM episodes, effective for episodes starting on or after January 1, 2026 (the start of TEAM Performance Year 1). Specifically, CMS is waiving the geographic site and originating site requirements, as outlined in regulations at 42 CFR 512.580(a) (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-H/part-512/subpart-E#p-512.580(a))

Under standard Medicare rules, Medicare typically covers and pays for telehealth services when beneficiaries are located in specific geographic areas. Within those areas, beneficiaries must be in one of the healthcare settings specified in the statute as eligible originating sites. The service provided must be on the list of approved Medicare telehealth services. Medicare pays a facility fee to the originating site and provides separate payment

to the distant site practitioner for the service. More detailed information about Medicare telehealth services is available in the Medicare Benefit Policy Manual (Pub 100-04), chapter 12.

In alignment with other CMS Innovation Center episode-based payment models, under TEAM, CMS will allow beneficiaries in any geographic area to receive services via telehealth during a TEAM episode. CMS will also permit a home or place of residence to serve as an originating site for beneficiaries in a TEAM episode. In order to allow for the payment of claims for telehealth services delivered to beneficiaries at home or place of residence, regardless of geographic location, CMS will waive telehealth requirements under the following conditions:

- The beneficiary receiving the telehealth services must have been discharged from a hospital participating in TEAM. TEAM participants are listed on the CMS Innovation Center website (https://www.cms.gov/priorities/innovation/innovation-models/team-model) and updated regularly.
- The beneficiary must have been discharged from the TEAM participant hospital for one of the TEAM episode MS-DRGs or HCPCS codes.
- The telehealth services must be provided within 30 days after the beneficiary is discharged from the hospital or hospital outpatient department.
- Telehealth services cannot replace in-person home health visits for patients under a home health episode of care.
- Telehealth services performed by social workers for patients under a home health episode of care will not be covered under TEAM.
- The telehealth geographic waiver and the allowance of the home as an originating site do not apply when a physician or approved Non-Physician Practitioner (NPP) conducts a face-to-face encounter to certify patient eligibility for the Medicare home health benefit.
- If the beneficiary is at home, the physician cannot furnish any telehealth service with a descriptor that precludes delivering the service in the home (e.g., a hospital visit code).
- If the physician provides an Evaluation and Management (E/M) visit via telehealth to a beneficiary at home, the visit must be billed using one of the TEAM specific G-Codes listed in Table 1, which corresponds to different levels of E/M services based on time.
- For level 4 and 5 TEAM telehealth home visits, the physician must document in the medical record that licensed auxiliary clinical staff were available on-site in the patient's home during the visit or document the reason why such a high-level visit did not require the presence of such personnel.
- The facility fee paid by Medicare to an originating site for a telehealth service will be waived if the service originates from the beneficiary's home.
- The beneficiary receiving the telehealth services must meet all the following criteria upon admission for an anchor procedure or anchor hospitalization:
    - Are enrolled in Medicare Parts A and B
    - Are not eligible for Medicare on the basis of having end-stage renal disease
    - Are not enrolled in any managed care plan (for example, Medicare Advantage, health care prepayment plans, or cost-based health maintenance organizations)
    - Are not covered under a United Mine Workers of America health care plan
    - Have Medicare as their primary payer

III. 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	
14215.1	The contractors shall prepare their systems to process TEAM Demonstration Model Telehealth claims with dates of service on or after January 1, 2026.	X				X				
14215.2	Contractors shall use Demonstration code A9 to identify TEAM Demonstration Model Telehealth claims.	X				X	X			
14215.3	Contractors shall identify the TEAM Demonstration Model with a Model identifier that begins with 'T'.	X				X	X			
14215.4	Effective for TEAM Demonstration Model with "From" Dates of Service on or after January 1, 2026, Contractors shall ensure that providers submit the appropriate TEAM Demonstration Code when submitting claims for Telehealth services: Contractors shall ensure the Demonstration Code 'A9' is submitted for Transforming Episode Accountability Model Telehealth Claims in the following fields: Electronic transactions: 2300 REF02 Segment, where REF01=P4. For Direct Data Entry (DDE) or paper Claims, Providers shall be instructed to use fields: 5/MAP1715 (for DDE) or Treatment Authorization field #63 (for paper).					X				
14215.5	Contractors shall identify TEAM Telehealth claims by the following criteria: • TOB = 13X • Demo Code 'A9' is present in the first Treatment Authorization Code field • HCPCS Code G0660 through G0668 is present as the only service on Revenue Code 0780 • The Provider is aligned to the TEAM Model • The claim's "From" Date falls within the Effective and Termination Dates of the Provider's participation in the TEAM Model	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
14215.6	Contractors shall automatically move Demo Code 'A9' to the DEMO CD 1 field when 'A9' is not present in the first Treatment Authorization field, but the claim meets all other criteria in Business Requirement 14215.5					X				
14215.7	Contractors shall apply Benefit Enhancement 2 to Telehealth claims that qualify for the TEAM model. Contractors shall apply Benefit Enhancement 2 to the Benefit Enhancement Flag 1 field for qualifying TEAM Model Telehealth claims.					X				
14215.8	Contractors shall RTP TEAM Telehealth claims when not submitted on TOB 13X. Contractors shall create a new Reason Code to assign when Demo Code 'A9' is present in the first treatment authorization field, on a non-TOB 13X claim.	X				X				
14215.9	Contractors shall reject any claims for the TEAM model when a TOB 13X is received with TEAM Telehealth HCPCS Codes, G0660 through G0668, but the Provider is not participating in the TEAM Demonstration. Contractors shall assign Claim Adjustment Reason Code/Remittance Advice Remark Code (CARC/RARC) when a TOB 13X claim is submitted with TEAM Telehealth HCPCS Codes G0660 through G0668 and the provider is not participating in the TEAM Demonstration. Contractors shall use the following codes on claims rejected: Group Code: CO CARC: 132 - Prearranged demonstration project adjustment. RARC: N763 -The demonstration code is not appropriate for this claim; resubmit without a	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	demonstration code.									
14215.10	Contractors shall create a new Reason Code to RTP any claims for the TEAM model when the Treatment Authorization Code field contains an 'A9' and the "From" Date is before January 1, 2026.	X				X				
14215.11	Contractors shall create a new Reason Code to RTP claims for the TEAM model when a TOB 13X claim is submitted with a provider participating in the TEAM model, the claim's Demo Code 'A9' is present in the first Treatment Authorization Code field, and a TEAM Telehealth HCPCS Code G0660 through G0668 is not present.	X				X				
14215.12	Contractors shall create a new Reason Code to RTP TEAM Claims as defined in 14215.5 when any of the G0660 through G0668 HCPCS Codes are not billed with revenue code 0780.	X				X				
14215.13	Contractors shall modify existing edits to reject (R) claims for TEAM Telehealth services if the beneficiary is ineligible to participate according to the following model beneficiary eligibility criteria: • Beneficiaries do not have both Medicare Part A and Part B; • Beneficiaries whose eligibility for Medicare is based on having end-stage renal disease; • Beneficiaries enrolled in a managed care plan (for example, Medicare Advantage, health care prepayment plans, or cost-based health maintenance organizations); • Beneficiaries covered under a United Mine Workers of America health care plan; • Beneficiaries for whom Medicare is not the primary payer. Contractors shall use the following codes on claims rejected:	X				X			X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Group Code: CO CARC: 132 - Prearranged demonstration project adjustment. RARC: N763 -The demonstration code is not appropriate for this claim; resubmit without a demonstration code.									
14215.14	Contractors shall modify claims rejected due to an ineligible beneficiary by performing the following actions: • Remove Demo Code 'A9' from the claim • Populate Condition Code 'B1' • Move 'T' to DEMO-PROCESS-IND Reset the Demo Flag to 'N'					X				
14215.15	Contractors shall modify the DEMONSTRATION PROGRAMS MAIN MENU (MAP1C4A) to add Demo Code 'A9' as a valid selection option. Contractors shall modify MAP1C4A, DEMONSTRATION PROGRAMS MAIN MENU, to include Demo Code 'A9' for the TEAM model as a selectable option.					X				
14215.16	Contractors shall modify/create a new screen to display the following TEAM Participant information, populated from the TEAM Provider Alignment File. • Demo Identifier: T • Demo Code: A9 • Records Type/Benefit Enhancement Indicator • Participant CMS Certification Number (CCN) • Participant National Provider Identifier (NPI) • Status Indicator • Effective Start Date of the Provider in the model	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• Termination Date of the Provider from the model • Creation Date of the Provider Record • The most recent maintenance date of the Provider Record Contractors shall modify and create new screen MAP1C4H, Team Telehealth Waiver, to include the provider information as listed in this BR.									
14215.16.1	Contractors shall display information received from the TEAM Provider Alignment file on the new TEAM Telehealth Waiver screen.	X				X				
14215.17	Contractors shall receive and process the quarterly TEAM Provider Alignment File as a full-file replacement.	X				X				
14215.17.1	Contractors shall maintain a maintenance date in their internal file, which will reflect the date the updated Provider Alignment File was loaded into the Shared System Maintainers (SSMs). The field shall be viewable to the MACs. Contractors shall maintain a maintenance date in their internal file, which will reflect the date the updated Provider Alignment File was loaded into the SSMs. FISS shall make the field viewable to the MACs.	X				X				
14215.18	Contractors shall RTP TEAM Telehealth claims submitted or combined on a claim form TOB 13X with other services covered under traditional Medicare FFS benefits and inform providers that they must resubmit the services on the RTP claims on a separate TOB 13X claims form.	X				X				
14215.19	Contractors shall return to providers (RTP) for resubmission any claim for TEAM Telehealth visits that are submitted using HCPCS Codes G0660 – G0664.	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Contractors shall assign a new Reason Code when a TEAM Telehealth TOB 13X claim is submitted with HCPCS Codes G0660-G0664.									
14215.20	Contractors shall allow TEAM Telehealth Demo 'A9' claims to flow to the downstream systems. Contractors shall allow TEAM Telehealth claims to flow to downstream systems.	X				X				
14215.21	Contractors shall reject adjusted claims due to the presence of the TEAM-specific Telehealth G0660 through G0668 codes when the adjusted claim was a previously paid TEAM Telehealth claim and was adjusted because the provider has been retroactively removed as a TEAM participant, and the claim's "From" Date is no longer within the Provider's Effective Start Date and Termination Date on the Provider Alignment File after a quarterly file update. Contractors shall use the following codes on claims rejected: Group Code: CO CARC: 132 - Prearranged demonstration project adjustment. RARC: N763 -The demonstration code is not appropriate for this claim; resubmit without a demonstration code.	X				X				
14215.22	Contractors shall adjust previously rejected claims with a valid TEAM Telehealth HCPCS Code when a provider is retroactively added as participating in the TEAM model and the claim's "From" Date is within the Provider's Effective Start Date and Termination Date on the Provider Alignment File after a quarterly	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	file update.									
14215.23	Contractors shall apply the standard Medicare FFS Coinsurance and deductible to all TEAM Telehealth services.	X				X				
14215.24	Contractors shall apply standard Coordination of Benefits (COBC) processing to all TEAM Telehealth services.	X				X				
14215.25	Contractors shall RTP TEAM Telehealth submitted claims when the beneficiary's home or place of residence is not the originating site, as defined below, for Telehealth services. Contractors shall create a new Reason Code to assign on TEAM Telehealth claims when the beneficiary's address (Permanent or Temporary) is not the same as the facility address serving as the originating site for Telehealth services.	X				X				
14215.26	Contractors shall use 'T' as the TEAM Telehealth Model identifier. Note: CWF's Health Insurance Master Record (HIMR) will not display 'T' = TEAM. 'T' will only be used on the TEAM Provider Alignment File.	X							X	
14215.27	Contractors shall process TEAM claims received with Benefit Enhancement Indicator '2' (Telehealth) and Demo Code 'A9' for TEAM Telehealth services.	X							X	
14215.28	Contractors shall add the following TEAM Telehealth HCPCS to the system. TEAM G-Codes Short Descriptor Corresponding Office/ Outpatient E/M Current Procedural Terminology (CPT) Code	X				X			X	CVM

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	G0660 TEAM Remote E/M new pt 10mins 99201 G0661 TEAM Remote E/M new pt 20mins 99202 G0662 TEAM Remote E/M new pt 30 mins 99203 G0663 TEAM Remote E/M new pt 45mins 99204 G0664 TEAM Remote E/M new pt 60mins 99205 G0665 TEAM Remote E/M est. pt 10mins 99212 G0666 TEAM Remote E/M est. pt 15mins 99213 G0667 TEAM Remote E/M est. pt 25mins 99214 G0668 TEAM Remote E/M est. pt 40mins 99215									
14215.29	Contractors shall create logic to accept the TEAM Provider Alignment File.						X			
14215.29.1	The contractor shall transmit a recurring provider alignment file for TEAM Demonstration Model via the Model Claims Modernization (MCM) file transmission application using the flat file formats detailed in the standard model file Interface Control Document (ICD).						X			CMS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	NOTE: The file(s) will be a national file accessible by all Medicare Administrative Contractors (MACs). CMS Contacts are: Acumen (model implementation and payment contractor), CMMI-TEAM-Support@acumenllc.com									
14215.29.2	Contractors shall be prepared to accept the initial production model files on a quarterly cadence beginning on or about April 6, 2026, with additional, ad-hoc transmissions as needed. Each file will be a full replacement file. NOTE: The model effective period is controlled by the dates on the file(s). It is not necessary for SSMs to add any additional date controls surrounding the model's effective period.						X			
14215.29.3	The contractors shall perform validation and produce response files that indicate the file was processed and whether there were any errors as detailed in the standard model file ICD. The response files shall be accessible through the MCM application.						X			
14215.29.4	MCS shall be prepared to process the TEAM Demonstration Model accepted provider alignment file records and send the Part A records to the Fiscal Intermediary Shared System (FISS).					X	X			Hybrid Cloud Data Center (HCDC)
14215.29.5	Contractors shall receive model test files via MCM on or about January 5, 2026, from the TEAM payment contractor (Acumen) to validate the file format.						X			CMS
14215.30	The contractor shall update the standard Interface Control Document (ICD) on Confluence CMMI_FFS_SSM_ICD Document - CMMI Collaboration - Enterprise Confluence.						X			
14215.31	Contractors shall set the FISS threshold value at 75 records.						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
14215.32	Contractors shall update the MTDE Application for the TEAM Provider Participant File.						X			
14215.33	Contractors shall test the UI and extract process of the Model Test Data Entry (MTDE) application for the TEAM Provider Alignment File.						X			
14215.34	Contractors shall not apply precedence or overlap with other Demos since the G0660 through G0668 codes are unique to the TEAM Telehealth waiver.	X				X				
14215.35	Contractors shall move Demo Code ‘A9’ to the DEMO CD 1 field on the claim record and displayed on Claim Page 14, MAP103E, when a G0660 through G0668 Telehealth Code is present, and the Provider is TEAM aligned for the Dates of Service on a TOB 13X Telehealth claim.	X				X				
14215.36	Contractors shall use P4 in the REF01 field of the 837I 2300 loop when Demo Code ‘A9’ is sent in REF02.	X				X				
14215.37	Contractors shall use 'TEAMA9BE2' for the Operator ID assigned to the automatic adjustments created through retroactive updates to the TEAM Provider Alignment File.	X				X				
14215.38	Contractors shall use a TOB Frequency Code of ‘I’ is for the automatic adjustments created through retroactive updates to the Provider Alignment File.	X				X				
14215.39	The Contractor shall modify consistency edit “0014” to include Demo Code ‘A9’ for Outpatient claims.								X	
14215.40	Contractors shall RTP TOB 13X claims if more than one Demo Code is submitted in the Treatment Authorization field and one of the Demo codes is 'A9'.	X				X				
14215.41	Contractors shall display Demo Code ‘A9’ Benefit Enhancements "2" on claim page 12. The letter ‘T’ shall be inserted in the ACO ID space to reference TEAM.	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
14215.42	The Medicare Administrative Contractors (MACs) shall provide to CMS the provider data for the TEAM Model to create the test files for User Acceptance Testing (UAT) on or about the week of February 2, 2026 via Box Link: https://cmsbox.app.box.com/f/a5cd366ac1f94a0ebbb4b36c3305c80d If the MACs have any questions, they may contact CMS at: Janice.Maxwell@cms.hhs.gov and Jonathan.Rudy@cms.hhs.gov	X								
14215.42.1	To assist with the creation of the test files, the MACs shall: • Provide a list of at a minimum 5 to 15 providers as indicated by TIN-oNPI-CCN for Part A MACs.	X								
14215.42.2	The MACs shall key the providers into the Model Test Data Entry (MTDE) application, after the TEAM Model updates are applied to the MTDE, so they do not lose the data when the data is switched over to MTDE as the source of truth.	X								
14215.42.3	To assist with the creation of the beta test file, MIST shall provide to CMS the provider test data on or about January 5, 2026, via BOX Link.'									MIST
14215.43	Within three business days after the request is made, the SSMs, the MACs, and other contractors shall submit the names and email addresses of personnel assigned to testing this project to CMS. Please complete the Excel file named CMS CR14215 TEAM in the box link: https://cmsbox.app.box.com/f/a5cd366ac1f94a0ebbb4b36c3305c80d If you have issues with the link, please contact Janice.Maxwell@cms.hhs.gov	X				X	X		X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	or Jonathan.Rudy@cms.hhs.gov									
14215.43.1	CMS shall facilitate a 1-hour 'User Acceptance Testing' (UAT) Kickoff meeting to discuss testing, on or about the week of March 4, 2026. And potentially up to four (4) weekly calls to discuss testing issues beginning the week of March 9, 2026.									CMS
14215.43.2	Contractors shall make themselves available for a 1-hour 'User Acceptance Testing' (UAT) Kickoff meeting to discuss testing, on or about the week of March 4, 2026. And potentially up to four (4) 1-hour weekly calls during the UAT to discuss any testing issues beginning March 9, 2026.	X				X	X		X	
14215.44	The MACs shall perform UAT on or about the week of March 9, 2026.	X				X			X	

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part A

V. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

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

VI. CONTACTS

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

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0