Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model

Outcome-Aligned Payment (OAP) Billing Guidelines

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I. Overview

The Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model Outcome-Aligned Payment (OAP) Billing Guidelines provides detailed guidance for billing the OAP Healthcare Common Procedure Coding System (HCPCS) G-codes.

II. Billing Guidelines

Each monthly OAP represents one (1) unit of service per claim. Claims are processed as zero-paid claims by Medicare Administrative Contractors (MACs). Payments are issued by CMS and are subject to Clinical Outcome Adjustments (COA) and Substitute Spend Adjustments (SSA) as calculated by CMS, as well as the 2% sequestration reduction established by the Budget Control Act of 2011, Pub. L. No. 112-25, § 302, 125 Stat. 240 (2011).

III. Billing Cadence, Date of Service, and Claim Submission Timeline

ACCESS Participants bill a claim for each month in which they deliver ACCESS services to an aligned beneficiary, as defined in the Participation Agreement. On each claim, the ACCESS Participant must bill the date of service (DOS) as the first day that the service was provided to the beneficiary for that month. An ACCESS Participant may bill as early as the first day of the care period, which corresponds to the date of alignment, so long as the ACCESS Participant furnishes Active Care Delivery (as defined in the Participation Agreement). The first day of the care period does not need to align with the first day of a calendar month.

Claims must be submitted no later than 90 days following the DOS; any claims submitted later than 90 days from the DOS will not be payable. Claims may only be paid and processed if the ACCESS Beneficiary is aligned to the ACCESS Participant for the DOS on the claim.

IV. Place of Service

ACCESS Participants must report the Place of Service (POS) code that most accurately reflects the setting in which ACCESS services were delivered. ACCESS Participants should use POS code 10 (Telehealth Provided in Patient's Home) as the default POS code for claims if the majority of ACCESS services are asynchronous and are most commonly received by beneficiaries in their home setting. ACCESS Participants should use

POS code 02 (Telehealth Provided Other than in Patient's Home) only when they have affirmative knowledge that the beneficiary received services at a location other than their home. If another POS code more accurately reflects the setting in which ACCESS services were delivered, ACCESS Participants should report that code instead. The POS code on the claim does not affect OAP payment rates.

V. Clinician Roster

Maintenance of a complete and up-to-date Clinician Roster is required for all ACCESS Participants; only practitioners whose National Provider Identifiers (NPIs) are identified on the Clinician Roster will be eligible to bill for ACCESS services as rendering practitioners. ACCESS Participants must submit and maintain their Clinician Roster through the ACCESS Participant portal, ensuring that all Medicare-enrolled practitioners furnishing or supervising care under the ACCESS Participant's Taxpayer Identification Number (TIN), and who have reassigned their Medicare billing rights to the ACCESS Participant in Provider Enrollment, Chain, and Ownership System (PECOS), are included on their Clinician Roster prior to billing. Additions and removals must be submitted within 15 days of the change. Bulk upload, or simultaneous upload of multiple entries, of the Clinician Roster will be supported through the ACCESS Participant portal submission process to streamline roster management for ACCESS Participants with many employed practitioners.

VI. Practitioner Type

No specific practitioner type is required for rendering or supervising practitioners, beyond model-specific requirements as described in the Participation Agreement. This includes the requirements that practitioners furnishing or supervising services for which individual Medicare enrollment is required must be Medicare-enrolled and in good standing, with billing rights reassigned to the Participant's TIN, and in compliance with all applicable federal and state laws and regulatory requirements, including licensure and scope-of-practice standards under 42 C.F.R. § 424.516. ACCESS Participants must also maintain a Medicare-enrolled physician Medical Director consistent with model requirements; however, the Medical Director need not be identified on the claim.

VII. Rendering/Supervising Practitioner

The NPI of a Medicare Part B–enrolled practitioner responsible for furnishing or supervising ACCESS services must be included on all billed claims. Only practitioners listed on the ACCESS Clinician Roster can bill for ACCESS-specific OAP G-codes.

How to report the NPI depends on how services are furnished:

- **Directly furnished by a Medicare-enrolled practitioner**: If ACCESS services are directly furnished by a Medicare-enrolled physician or non-physician practitioner, report the NPI of the practitioner who had primary clinical responsibility for furnishing ACCESS services during the billed period as the rendering practitioner.
- **Furnished by auxiliary personnel under general supervision**: If ACCESS services are furnished by auxiliary personnel, as defined at 42 CFR 410.26, under general supervision, report the supervising Medicare-enrolled practitioner's NPI as both the rendering practitioner and the supervising practitioner.

The Provider Type of the rendering/supervising NPI on the claim does not affect OAP payment rates.

VIII. Billing Practitioner

The billing practitioner must be the ACCESS Participant, identified by its Type 2 NPI and TIN, reported on all claims including OAPs, consistent with Medicare Part B billing requirements.

IX. Referring Practitioner

Reporting a referring practitioner NPI is generally encouraged, if applicable.

Reporting a referring practitioner NPI is required for the eCKM and CKM tracks when the ACCESS Participant is billing the Initial Period payment based on a referral—that is, when the beneficiary was referred by another practitioner for the qualifying eCKM or CKM condition and the ACCESS Participant is relying on that referral to qualify for the Initial Period payment rate. In this circumstance, the referring practitioner's NPI must be reported in Item 17 (Referring Provider) on the CMS-1500 claim form, or in the corresponding electronic loop/segment.

X. Diagnosis Reporting

Diagnosis codes must reflect the track-specific qualifying condition(s) and must be reported using the highest level of specificity of ICD-10-CM code available for that diagnosis, not just a general category. Please note that the absence of at least one diagnosis code that is applicable for the given track will result in a denied claim.

XI. Coinsurance Indicator for Beneficiary Cost-Sharing Support

The coinsurance indicator associated with claims including billed OAPs reflects the ACCESS Participant's election to waive or collect beneficiary cost-sharing. The coinsurance indicator will be appended to the claim by CMS. ACCESS Participants who wish to change their cost-sharing election must notify CMS of their updated decision by emailing the ACCESS Help Desk at ACCESSModelTeam@cms.hhs.gov.

XII. Rural Add-On

A $15 rural add-on payment will be paid to Participants when eCKM and CKM beneficiaries are located in qualifying rural areas. CMS will determine eligibility based on whether the patient's ZIP code on their Medicare mailing address is in a rural area, as defined by the Health Resources and Services Administration's (HRSA) Federal Office of Rural Health Policy (FORHP).[1] CMS will automatically pay the rural add-on in the first monthly OAP payment for each eligible beneficiary, conditioned on the successful reporting of the eligible beneficiary's baseline OAP Measure data. No additional action is required from the Participant to receive the add-on payment.

XIII. Multi-Track Discount

The discount applied to the Monthly OAPs for months when the ACCESS Beneficiary is aligned to more than one Clinical Track with the same Participant will be set to 0%. CMS may adjust this discount in the future.

[1] The FORHP definition uses Rural-Urban Commuting Area (RUCA) codes and Road Ruggedness Scale (RRS) codes, which accounts for characteristics of rurality, such as low population density and geographic isolation. FORHP's data files list rural areas by county, census tract, and ZIP code, and they were updated September 2025 using 2020 census tracts. Available at: https://www.hrsa.gov/rural-health/about-us/what-is-rural/data-files.

XIV. OAP G-Codes

A. Initial Period Codes

Exhibit 1. ACCESS OAP G-Codes for the Initial Care Period

HCPCS G-Code	Clinical Track	Allowed Amount*	Description	Short Descriptor
G0669	eCKM	$30.00	Outcome-Aligned Payment (OAP) for management of early cardio-kidney-metabolic (eCKM) conditions (hypertension, or two or more of: dyslipidemia, obesity/ overweight with central obesity marker, prediabetes); initial 12-month period; per month.	eCKM OAP–initial period
G0671	CKM	$35.00	Outcome-Aligned Payment (OAP) for management of cardio-kidney-metabolic (CKM) conditions (one or more of: diabetes mellitus, chronic kidney disease stage 3a or 3b, atherosclerotic cardiovascular disease); initial 12-month period; per month.	CKM OAP–initial period
G0673	MSK	$15.00	Outcome-Aligned Payment (OAP) for management of musculoskeletal (MSK) conditions (chronic musculoskeletal pain); initial 12-month treatment period; per month.	MSK OAP–initial period
G0674	BH	$15.00	Outcome-Aligned Payment (OAP) for management of behavioral health (BH) conditions (one or more of: depression, anxiety); initial 12-month period; per month.	BH OAP–initial period

* Allowed Amounts for the OAPs are all represented in monthly payment amounts. CMS pays 80% of the Allowed Amount.

Note: All Medicare payments are subject to the 2% sequestration reduction established by the Budget Control Act of 2011, Pub. L. No. 112-25, § 302, 125 Stat. 240 (2011).

B. Follow-On Period Codes

Exhibit 2. ACCESS OAP G-Codes for the Follow-On Care Period

HCPCS G-Code	Clinical Track	Allowed Amount*	Description	Short Descriptor
G0670	eCKM	$15.00	Outcome-Aligned Payment (OAP) for management of e arly cardio-kidney-metabolic (eCKM) conditions (hypertension, or two or more of: dyslipidemia, obesity/ overweight with central obesity marker, prediabetes); follow-on 12-month period; per month.	eCKM OAP–follow-on period(s)
G0672	CKM	$17.50	Outcome-Aligned Payment (OAP) for management of cardio-kidney-metabolic (CKM) conditions (one or more of: diabetes mellitus, chronic kidney disease stage 3a or 3b, atherosclerotic cardiovascular disease); follow-on 12-month period; per month.	CKM OAP–follow-on period(s)
G0675	BH	$7.50	Outcome-Aligned Payment (OAP) for management of behavioral health (BH) conditions (one or more of: depression, anxiety); follow-on 12-month period; per month.	BH OAP–follow-on period(s)

* Allowed Amounts for the OAPs are all represented in monthly payment amounts. CMS pays 80% of the Allowed Amount.

Note: The MSK track does not have a Follow-On Period.

Note: All Medicare payments are subject to the 2% sequestration reduction established by the Budget Control Act of 2011, Pub. L. No. 112-25, § 302, 125 Stat. 240 (2011).